Assisting you with my hands in my pockets: How reablement in home care for older people transforms problems, roles and relations

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Abstract

The provision of home care is in many countries changing to a more active approach, reflecting ideas of social investment. One example is the introduction of reablement in Danish home care for older people in 2015. Municipalities are now required to assess if a person in need of home care services could benefit from a reablement scheme in the form of a short-term, intensive and goal-oriented intervention. Otherwise, conventional home care is provided. The purpose of reablement is to assist the older person in fully or partially regaining functional ability in daily activities, such as shopping, dressing, cleaning or mobility overall. The intervention is based on cooperation between staff and the user in identifying and on a daily basis working towards achieving specific outcome goals for the intervention. It is also based on close cross-disciplinary co-operation between care workers and occupational/physical therapists.

In this qualitative study, we apply an institutional ethnographic approach and examine how the introduction of reablement in Danish home care has transformed the overall understanding of what constitutes the problem to be solved and its solutions and how this affects user-staff as well as inter-disciplinary relations and co-operations. We base this on interviews with staff, managers and users as well as observations conducted in two Danish municipalities.

Introduction

Home care provision for frail older people is undergoing a silent revolution. Several countries are changing the focus from a so-called passive to a more active approach. This new approach goes under the name of restorative care in Australia, New Zealand and the US while in Denmark, Norway and England the term reablement is used instead (Aspinal et al, 2016; Glendinning et al, 2010; Lewin et al, 2013; Rostgaard, 2017; Tuntland et al, 2015 & 2017).

Reablement represents a fundamental break with former approaches to home care for frail older people. It is a short-term, goal-oriented, multisector intervention aiming for older persons to regain independence in daily activities. Its potential is wide, for quality of life for the individual as well as for ensuring a more sustainable eldercare. It is a policy practice recommended by the European Commission as part of social investment strategies, and particularly referring to the results in Denmark, where reablement has been tried out locally since 2007 (European Commission, 2013). In 2015, reablement was introduced on a national scale in Denmark and is now part of the legislation on home care.

Home care in Denmark reaches around 14% of the population 65+ in Denmark. It is a publically funded service and can be delivered by private for-profit or public providers. It includes practical assistance with cleaning as well as personal care. It normally includes a minimum of 30-45 minutes assistance per week or every second week and is free of charge. However, since January 2015, all municipalities in Denmark must now initially offer reablement before offering conventional home care. This means to a higher degree involving the older person in the various tasks and supporting that the older person is eventually able to perform these tasks on her/his own. Only if the older person is not able to participate or does not re-gain physical capacity, conventional home help will be offered. Reablement is goal-oriented, holistic and person-centered, requiring the cooperation between the older person and staff in the identification and negotiation of the focus and potential outcome of the intervention. It is also based on a new cross-disciplinary cooperation between social care workers and occupational or physical therapists in the means and professional approaches to be applied. There are no statistics and few systematic studies into how many older people receive reablement instead of home care and for how long but local reportings mention take-up rates up to 80% of new cases and with up to 60% success rate in regards to increasing functional ability, in some cases so much that the older person no longer needs assistance. One systematic evaluation of two municipalities reports that one in five older people can end provision of services entirely after the reablement intervention, 24% continue receiving practical assistance and 14% personal care and 42% continue receiving both forms of assistance (SFI, 2017).

This paper reports on a qualitative study in two municipalities in Denmark into how the introduction of reablement has transformed the identification of problems and solution as well as user-staff and cross-disciplinary relations and co-operations (Rostgaard and Graff, 2016). Applying a theoretical approach of institutional ethnography, we investigate professionals as well as users' perspectives on the reablement intervention while simultaneously analyzing organizational and relational aspects. This means investigating the overall rehabilitation paradigm and the organizational set-up, which defines the institutionalized understanding of what constitutes 'the problem' to be addressed and how actual interventions should be designed and executed in order to address such problems. Likewise, from the user's perspective, we investigate how the individual's life perspective, influenced by e.g. culture, life experiences, norms and personality, defines the individual's perception of the problem, expectations of the intervention, relations to the professionals as well as the expectations of the outcome of the intervention.

Analytical approach and data

The study's theoretical framework and design is inspired by an analytical approach to evaluating rehabilitation interventions: SIMREB (Systematic Inquiry into Models for Rehabilitation) (Høgsbro, 2010). With this particular approach, it is possible to cover both the professionals as well as the users' perspectives on the reablement intervention while simultaneously analyzing organizational and relational aspects.

Theoretical foundation

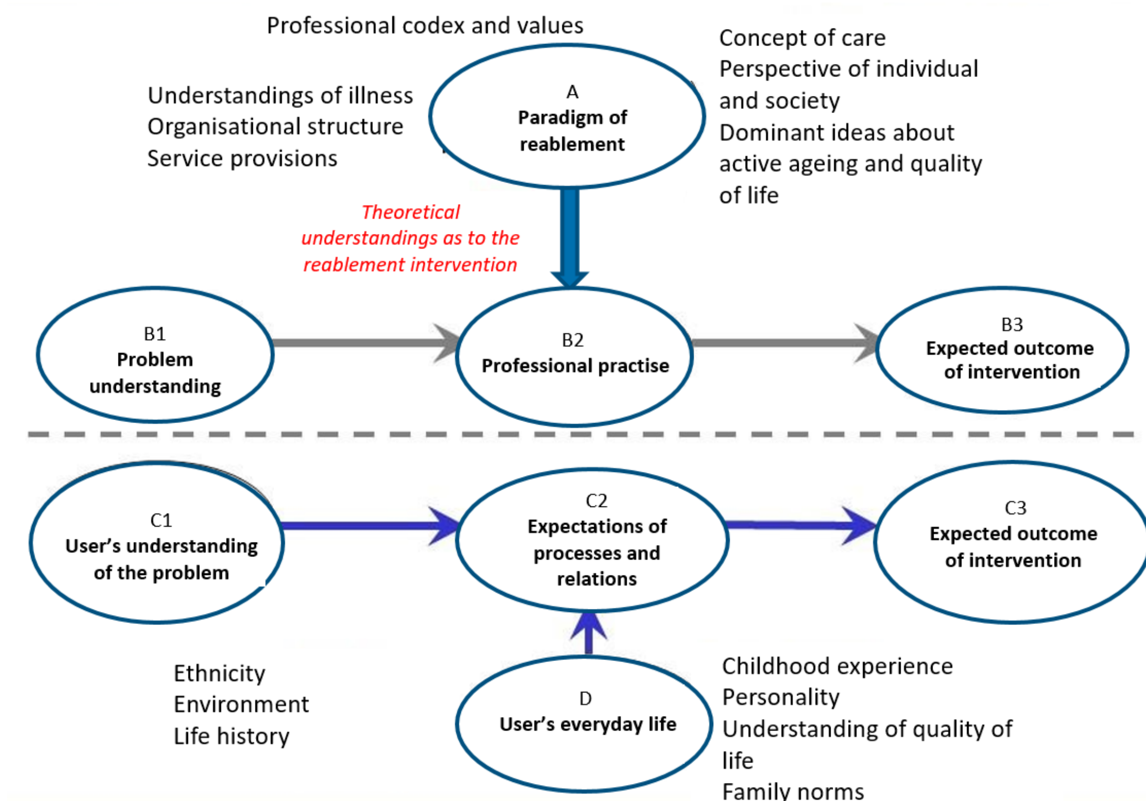
SIMREB is based on institutional ethnography with its focus on the social relations, activities and interactions that shapes society's organizations and not least the interactions between those and people. In both SIMREB and institutional ethnography, perceptions and actions are understood as affected by institutional factors not known to the actors themselves (Smith, 2005; Høgsbro, 2010). As Smith (2005) describes it, Institutional ethnography aims at uncovering the interactions between professionals and citizens in society's institutions, often with a specific focus on the premises and conditions that maintain

certain perceptions, ways of thinking and habits. Other sources of influence for SIMREB are discourse analysis and evaluation research (Høgsbro, 2010), from which this study also make use.

Levels of analysis

SIMREB is comprised of four levels, A through D, and three aspects labelled 1-3. The model illustrates a number of elements, which are included in different models of rehabilitation: the paradigm of reablement and thus the theoretical origin of the expectations comprised of the scientific and professional episteme and the theoretical discussions (A), which again defines the professionals' understanding of the problem (B1), their practice (B2) and expected outcome of the intervention (B3). Levels C and D mirror the A and B levels but from the user's perspective. The D level thus contains the individual's life perspective, which is influences by e.g. culture, life experiences, norms and personality. The D level influences the individual's perception of the problem (C1), expectations of processes and relations to the professionals (C2) and expectations of the results of the intervention (C3) (Høgsbro, 2010). By paradigm, we refer to overall rationalities and epistemologies, which guide and set limits for the way we search for recognition and steers our ways of understanding problems, goals and underlying values (Launsø and Rieper, 2011).

Figure 1. SIMREB



Source: Adapted from Høgsbro, 2010

The use of SIMREB as a theoretical and analytical framework has influenced the study in all phases. For example, the goal of uncovering the reablement paradigm in level A means that we included an extensive literature review. SIMREB also guided the empirical examination of reablement practice and – perceptions in the case study, e.g. in the formulation of themes for interview guides and analysis of the relationships between paradigm, organization and practice in the two municipalities.

Data

This qualitative study is based on a literature study and a case study in the home care services in two Danish municipalities. Data was collected between November 2015 – April 2016. The literature study was used to identify the epistemological and theoretical discussions and understandings behind reablement (the A level in SIMREB) through Danish and international literature and the two municipalities organization of home care and reablement courses. The literature for the latter part consisted of municipal documents, e.g. declarations of service and quality. Data in the case studies consisted of 8 focus group interviews with managers and employees (care workers, occupational therapists and care assessors) in home care, 28 individual interviews with older persons who were receiving a reablement intervention and their primary care worker, and 13 observational studies of reablement practice in different settings, e.g. at the elderly's home or of inter-disciplinary coordination meetings. The older persons were each interviewed twice: at the beginning of their reablement course and after the course was completed. Care system journals on the participating older persons were also included in the analysis. Interviews were transcribed in full and processed for analysis in NVIVO using abductive analysis strategies, where theory and data simultanesly interact (Pierce, 1955; Blaikie, 2007). The analysis is thus based on the theories that have been the foundation for the interview themes.

The paradigmatic foundation for reablement

With the application of the SIMREB model, we first investigate the paradigmatic foundation for reablement - and not least why and how reablement presents itself as a legitimate solution to a number of identified problems.

Ageing paradigms

First of all, reablement corresponds well with current ways of thinking about age and frailty. This includes the widely accepted integrative ICF bio-psycho-social model of functional ability, which considers bodily (mental and physical) functioning in conjunction with functioning in daily activities and participation, and taking into account environmental as well as personal factors. This model emphasizes that functional ability can be sustained and even improved over the life course, with proper interventions taking into account individual and structural factors (WHO, 2001). Reablement is equally framed by the idea of active ageing, which emphasizes a continuous involvement, engagement and activity, also well into old age, as a foundation for higher quality of life as well as longevity (Walker, 2002).

Current social and long-term care policy approaches

Secondly, it fits well into international ideas about social policy interventions that are aimed at facilitating change by means of activation and goal-oriented action plans (Torfing, 2003; Bach, 2002; Mik-Meyer, 2004). These ideas are evident also in ageing politics and policies. As Biggs (2001, 2004) argues present ageing policies are aimed at encouraging continued production and use of available resources, such as encouraging older people to volunteer once they have retired. Activation has been a core principle in the Danish legislation since the mid-1970s and has influenced also long term care policy, where the slogan 'help-to self help' was coined in the 1980s. Present understandings of quality of care in Denmark thus implies that interventions should facilitate autonomy and independence, but also that they should take into account individual differences in preferences and needs and ensure that the older person could upkeep as normal live as possible and continue to be engaged and participate, despite the dependence on others (Rostgaard, 2007).

The change from NPM to NPG

Lastly, reablement corresponds well with emerging ideas about the need for a change of governance and steering perspectives, a move from New Public Management (NPM) to New Public Governance (NPG). Denmark has to a high degree been influenced by NPM, not least in long-term care where the wide introduction of marketization, consumer choice, purchaser-provider model and extensive control- and documentation measures has lead Kröger (2011) to name Denmark as the Nordic champion in NPM. Reablement is part of an overall re-focusing of governance and steering principles where ideas of empowerment and co-production/co-creation gain influence, highly inspired by NPG. This includes a move away from strict control mechanisms, which are to be replaced by 'trust regimes' (Osborne, 1997; Sørensen and Torfing, 2015). Here, the older person is trusted in knowing what is best for him/her and in making decisions on the basis of this and in close cooperation with the care worker, who is equally (and once again) trusted to make daily decisions about need and provision of support. NPG also signals an end to mono-disciplinary approaches and breaking down organizational and professional silos (Sørensen and Thorfing, 2016), which is reflected in the close cooperation between social care workers and occupational therapists in reablement. Lastly, with the emphasis on co-production, the NPG perspective advocates greater third sector participation of public services, which we also find as part of reablement, and as we explain further down, this is seen not least when addressing the social dimension and needs of loneliness.

Problem understanding and solving

The paradigmatic foundation sets the scene for the overall theoretical understanding of what constitutes the problem and how to solve this. But how is this reflected in the actual organization and provision of reablement in two Danish municipalities? And does this overall understanding of problem and solution match the views of older people about their needs and the proper intervention? From here on we move to the B and C levels of the SIMREB model and draw on interviews with older people, care workers, occupational therapists, care assessors and managers as well as observations in order to understand whether and how reablement is considered a solution to identified problems.

A more effective and holistic approach to improve quality of life

Reablement is in fact by the care workers considered a more effective intervention to support further independence and self-reliance for older people. They explain that the 'help-to-self help' principle is now for the first time properly supported and legitimized in the organization of care. They find that there was a tendency with the former more passive ways of providing care to establish and maintain a dependency and service culture, which took any initiative away from the older person. Louise, a social care worker, exemplifies: 'There was this woman that I had actually taken care of for a while. Then one day she just sat down like this [crossing her arms]. Then I said "What now?" And then she says "Well, I need to be washed" and then I say "Well, you have two hands and a sponge!" "Oi, I usually don't do that [myself]?", "No, but now you do".'

The care workers often refer to quality of life when they want to explain the benefits of reablement, and see this above all as being independent of care and being able to make decisions for one self, or as Anja, care worker, says 'once again being master of the house'. For Anja and many of her colleagues, reablement is the best approach in addressing the problem of dependency and disempowerment.

The care workers acknowledge that reablement with its holistic approach is far better at capturing also non-physical needs. Whereas before they would concentrate on physical functional limitations that prohibited the older person from carrying out basic daily activities, it is far more common today to consider also the needs for social relations and contacts. As Jytte care assessor says, 'I think we have gained a more holistic image of the older person. And this is also part of reablement, to look at the whole picture not only

single parts when we end reablement.' The social dimension in this way becomes part of the problem to be solved and the reablement approach includes actual measures to identify the problem of loneliness and isolation. Reablement does however not include measures to address this problem directly. Instead, older people are increasingly referred to voluntary organizations and family members. As Jytte continues: 'Well, we can consider it as part of reablement, but we cannot provide services according to the Social Service Act.' The introduction of reablement has in this way accentuated which social problems are public responsibility and which are to be solved by non-public actors. Regardless the overall adherence to the holistic approach, with reablement the division of work has become more demarcated and the core tasks for the public provision of care has in fact been limited to provide for the needs for personal care and practical assistance.

Legitimate excuses and arguments

Despite the broad inclusion criteria, reablement nevertheless seems to work best for those older people who are highly motivated, typically because they are recently discharged from hospital and otherwise used to taking care of themselves. If on the other hand, the older person is less motivated, it is far more difficult to set up a reablement intervention. The precondition for a successful intervention is therefore that the older person is interested in self-reliance; such clients are as the care worker Christina frames it, 'delightful' to work with, as opposed who are less motivated who are often referred to as the 'heavy' users. Following this, it seems that it is the lack of motivation that becomes the problem to overcome, and to a lesser degree, whether or not reablement is the right intervention for all people. The lack of motivation is – not surprisingly - especially pronounced among those who previously received help with cleaning and who are now offered assistance in how to carry out cleaning themselves. Whereas there is general interest in becoming independent in carrying out task related to personal care, such as dressing and bathing, it seems less popular to receive training in how to become independent in cleaning. As Merete, assessor of care, says: "In regards to cleaning, you might say, it is more popular to 'contract-out'. This is where we need to set in with our most constructive arguments. The closer to the body we are, the easier it is [to motivate]."

Reablement is often associated with learning new skills and applying assistive devices that makes it easier for the older person to manage daily activities. With reablement and the general assumption that more or less everybody can re-learn or re-train lost skills, age has become less of a legitimate excuse for not being able to try to learn new skills – at least this is the care assessors' perspective. The care workers are more split and tend to agree with the older persons that there is an age limit to reablement. As Mette says, 'When we had that lady who was 102 years old, we had to write [to the care assessor]: "What are you on about?" That is so not okay.' And as Christina, care worker, says, is it more accepted by her - and perhaps also socially - that very old people refrain from being reabled: 'Someone who is 65 years old I can better put a bit of pressure on, than someone who is 95 years old…Because I find it deeply tragic if you're 65 and don't get going again.' Reablement in this way constitutes less of a solution to a problem for those who are in their fourth age.

The right to receive care as a long-time taxpayer is frequently mentioned and exemplifies how reablement breaks with the social rights dimension of the universal Danish welfare state. While there has never been an explicit right to receive home care as this is based on need, there is nevertheless a common understanding that home care should be provided for those who are not able themselves to carry out daily activities. As Karl, who reclined the offer for reablement says, 'I have paid my taxes since I was 14…so I think I am entitled to some help now that I am at a point of life where I need it…I have helped create and have contributed this society and happily paid my taxes, because I knew where the money went.'

Awareness of cost-effectiveness

As a final reflection on how reablement has helped re-create definitions of problem and problem-solving, it is noteworthy that the introduction of a goal-oriented approach has also led the care workers to have more focus on achieving the desired outcomes. They are aware of the economic investment which is being made with reablement and openly discuss whether they have met their targets, both in terms of how many older people are being referred to reablement and whether they afterwards can reduce or even be entirely without home care services. This suggests that the understanding of the problem is now also related to cost-effectiveness. Care workers as well as care assessors are conscious about openly being measured on whether they manage to reduce the use of services and once in a while need to reflect whether this agenda is becoming too dominant: 'We have discussed in the team that it is not a means to an end. It is good because it matters for the finances, but the end goal is not to achieve self-reliance as fast as possible, because [the older person] should also be able to cope with this in the long run. Sometimes I wonder, "hey, did we stop services too soon, were they ready for it?", because although they had the necessary resources, they might not be actually ready for it and then I sometimes wonder, "hey, did we move too fast here?".'

Implication for roles and relationships between user-staff

Reablement implies a re-negotiation of roles and relationships as it is based on cross-disciplinary cooperation and also cooperation between staff and the user in identifying and on a daily basis working towards achieving specific outcome goals for the intervention. In this section we particular focus on the elements of the analytical model which investigate the relationship between professional practice (B2) and the users' expectations to processes and practices (C2), as well as how both of these influence the expectations for outcomes (B3 and C3).

Fuzzy process of assessment

For the user-staff relationship, reablement first of all implies changes to the assessment for services. Today the care assessor very often only makes an overall assessment about the need for either conventional home care or reablement. This assessment may not require a personal conversation but can take place over the phone or even by speaking with a care worker who know the older person. The actual identification of needs and appropriate delivery of services is today more slowly unfolded in a cooperation between the older person and the care worker. One implication, however, is that the older person, unlike before reablement, no longer receives any written statement presenting the actual services to be provided. This is a change from the previous NPM regime where the contractual relation and explicit statements about the exact service delivery was emphasized (Rostgaard, 2011), and thus represents a weakening of social rights. During the interviews, it was clear that most users were not aware of what services they were to receive, when these would end and whether they could be entitled to any services afterwards, such as conventional home care.

Identifying the goals

For some users it is easy to identify with purpose of reablement. As Linda, care worker, explains: 'Some [older people] are totally straight forward and saying "I want to get rid of you as soon as possible", and others have perhaps not considered this much. They may be in the middle of a crisis and when they return [from hospital] their lives are turned upside down.' This includes identifying the goals for the intervention, which is a time consuming and changeable process based on a gradually closer relationship. Care workers mention that they need to pay full attention and listen to the older person in this slow unravelling of goals,

and use phrases as ‘cathcing it in the air’. Often users do not themselves express the wish to become independent of care and they need to be guided in that direction, and within limits of what the service delivery can achieve. As Marianne, who is an occupational therapist, says, she in fact needs to restain any wilds dream that the older person may have and guide the conversation towards more manageable goals.: ‘I go out there and say: “This is what it is about”. I need to do that ‘cause if I say ”What is your dream, what would you like to do? “Well, I would like to play golf again.” Well, now we have to focus on cleaning the house. “But I would rather play golf?!” Well, that doesn’t work, right? So you need to set boundaries’.

As Ulla, who works as an occupational therapist, says, it is in fact often difficult for the users to mention actual goals when asked, but if they mention that they want to be independent of care again, she may ask ‘what where you able to do before and what is important for you now?’ Perhaps surprising, is that the care workers in particular have no formalized and systematic tools to apply in this on-going conversation about identifying goals. They use instead any psychological insight they may have and slowly add any bits to a larger puzzle about the older person’s past and present life situation, personality and preferences.

Motivation in daily practice

This somewhat random professional approach is evident also once goals have been identified, in the daily work with motivating the older person to achieve the goals. The care workers have received only little formal training in reablement and base their work from leaning from experience and through their peers. They mention that they often need to be very innovative and think out of the box to identify what triggers the older person, both respecting the person’s integrity but also constantly pushing and pawing the way for progress. This includes questioning old habits as in the case of Gitte, care worker, and her client Inge. Gitte explains: ‘Inge is a classical example of these fights because “I cannot cook my breakfast myself because I cannot get my arms up here so I cannot reach the plates in the upper cupboard.” Well, then we can place the plates on the table or in the lower cupboard. “No.” And on it went. We come up with solutions and she finds new problems and we find solutions for these and in the end, one needs to say, “that’s the way we do it”, and then she finds that she is able to cook the breakfast. Which she also admitted.’

The motivational techniques also includes the ‘wait and see’ approach, or as may care workers phrase it, ‘the hands in the pocket approach’. When explaining previous professional practices before reablement they instead often use the figurative language of ‘putting their hands out’, in order to perform the task for the user, even before the user express the need. Lene agrees with the ‘wait and see’ approach: ‘Yeah, you can stand there with your hands in your pockets and the older person says “I need some food” and approach you with their rolator saying “I am actually not able to do it myself, so I need you to take the bread and the spread from the fridge”‘…where Lene says she would then reply in a quite direct manner, ‘I have my hands in my pockets. Why don’t you just get it yourself?” Another motivational approach is deliberately ‘to forget’ to carry out the task, in which case Gitte would reply, ‘”Oi, I forgot that. Wow, great that you managed [to take out the trash]”. Then they stand like this [shows a proud face], even if you left it on purpose, right? That is one way to back out…and deliberately leaving it there for them.’ In this way, Gitte does not need actively to encourage the user to take charge, and she also avoids a direct confrontation. A last motivational strategy which is applied early in the reablement intervention, is to ‘use the right sales strategy’ and present the negative alternative to reablement and being dependent of care, here referring indirectly to the poor quality of the conventional home care services. As Klaus, care worker, says, this is often very effective: ‘During the first visit you say, “Well, you have two alternatives: Option A, you participate in this and hopefully end up being independent of care so that you don’t need to wait around all day for the home care people to turn up. Option B is that you do not participate in this, you continue sitting still here in your chair and get worse and worse, and then you need help and have to spend

the rest of your life waiting for the home care to turn up"….then people can damned well see what is the best alternative of the two.'

A closer and reciprocal relationship

One obvious implication of the introduction of reablement is a closer relationship between user and care workers as reablement is often carried out by the same person. This is most often appreciated by the older person and is generally seen as a quality of care as this ensures continuity of care (Rostgaard, 2007). This also means that the care worker is able to build up the required understanding of the user's life situation and to know how best to motivate. Gitte, care worker, explains: 'I don't think I had this kind of relationship with the users before. You just went in and did your work, and then left again.' She also mentions that the new relationship requires a certain level of reciprocity, where she is expected also to contribute, 'I cannot expect that Mrs. Jensen tells me all about her life if I give her nothing in return but saying my name is Gitte and that I work in Middelfart municipality. You get nowhere in that way.' Other care workers mention that the relationship must not become too close. They need to keep some distance so that they can maintain a certain pressure and insist that the older person carries out the tasks him/herself. Børge, the husband of Rie, experienced such pressure from the home carer, Louise, and needed to leave the house as he could not bear it: 'I nearly told Louise off one time, because I felt she was too hard on Rie. But now I realise there was no way around it. You need to get started…one day Louise came…[now talking to Rie] you two had agreed you needed to take a shower, I think. "I won't do it. I want to stay in my bed." Then I took the opportunity to go to the supermarket. And I was anxious when I returned, and when I opened the door I heard you two chit-chatter out here. I couldn't believe my own ears, 'cause Rie is pretty strong principled. Once she says something, nothing can sway her…but that's how it went.'

The closer relationship also enables observations and questioning old habits, which is very much in line with reablement where taking new perspectives is encouraged. It for instance allows Mie, care worker, to wonder about whether Johanna really wanted porridge for her breakfast as she had had for the last 7 years: 'I accidentally asked her…"Um, I would actually like to have two cheese sandwiches and a cup of coffee. You are the first ever to ask me."...It was somewhat of a chock for me. From then on, I started asking people what they prefer for breakfast.'

The user as a means for the cross-disciplinary approach

Although the reablement intervention is on a daily basis carried out mainly by one person, the cross-disciplinary approach implies that the user is continuously assessed by staff with different professional backgrounds, often manifested in the beginning and ending of a reablement intervention. One way to set this up, is arranging a meeting in the user's home. This is what happened for Hans, where four members of staff with different professional backgrounds showed up in his small apartment for a meeting. Hans explains, 'I found it overwhelming…I was not told why there needed to be that many people.' He also experienced that each member of staff tried out various techniques with him for assisting him climbing the stairs: 'That care assessor then says – and I had only sat down again – "Well, try and have someone else helping you climb the stairs." God damned, I had just climbed those stairs. Was I again to...then I went down and then I went up. And I thought, enough is enough. [Then the care assessor said] "Well, maybe one more person could try with you." And then I said, "Now listen, I have kind of walked all the way up to the second floor now. I don't think I can anymore."' For Hans the purpose of this cross-disciplinary meeting was never apparent, he found it difficult to relate to the number of people and felt that his needs were not respected.

Implication for roles and relationships in the cross-disciplinary cooperation

Representing and presenting the user

Another forum, which facilitates cross-disciplinary cooperation, is the weekly coordinating meetings, which most municipalities in Denmark have now introduced as part of reablement. It is problem oriented and usually manifest around a care worker who represents and presents the case of the older person, in front of an audience of other colleagues, such as occupational therapists, physiotherapists, home nursing, dieticians, dementia coordinator, middle manager etc. She can then discuss any problems related to the specific reablement intervention. The meeting is closely orchestrated, with a limited time set of for each care worker to present her case and preferably with the use of appropriate professional terminology. During our observations, we noted how the care workers waited outside the door, somewhat anxious and prepared as they were about to enter an exam room. Despite this, all participants in the meetings expressed that it was very valuable for them to be able to meet and discuss under these terms. This includes the care workers, such as Christina, who explains to us: 'Yeah, I don't care, I use my own words. That's how it is. And if there is anything I don't understand, I may say, "What does that mean?".'

Professional allies

Generally, the care workers are positive about the cooperation across disciplines and in particular express that the close cooperation with occupational therapists has been the triggering factor for a successful implementation of reablement. Especially, they mention how the occupational therapist have inspired them to use basic assistive devices such as bathing stools, adaptive equipment for cooking and extendable reaching devices, which they to a much larger degree include in their daily work now. Also, the care workers seek advice from the occupational therapists to evaluate whether a user needs to be introduces to new ways of managing daily activities. The occupational therapists on the other hand express great respect for the care workers, and refer to them as the real daily experts as the care workers are the ones who know the user the best. One explanation is perhaps that the cooperation is not forced; the care workers can consult an occupational therapist when they find the need for a different professional perspective. Another likely reason for the very positive approach from the occupational therapists is that reablement in many ways resembles the occupational therapeutic approach. The introduction of reablement has in this way given them a central role in the provision of municipal home care.

Care workers also use the occupational therapists as allies when they want to re-negotiate the service plan with the care assessor. Here, some care workers find it difficult to argue and use the right professional terminology. Also, the care assessor may place more weight on the assessment from the occupational therapist. As Henriette, middle manager, explains: 'It is useful for the care workers to line up with the occupational therapists in those cases where they can't make their point. Now the older person has re-gained what is possible and it seems he or she will not become totally independent of care services. In such cases, it is very good for the care worker to ask the occupational therapist to describe this once more for the care assessor, because…it matters who says it. That's how it is.'

Status among care workers providing reablement vs. conventional home care

If the occupational therapists have a higher status with the care assessors, the care workers who work with reablement may in general find that they have more status than their colleagues providing conventional home care. This form of home care is certainly still needed, not least for the number of older people, who are not referred to reablement for various reasons. Nevertheless, there seems to be certain institutionalized practices, which underline the difference in status. This includes introducing special uniforms for the care workers providing reablement who wear yellow uniforms instead of blue. The management also decided to give them presents such as flowers to underline their importance. As Merete,

head of the home care section, explains this is part of an overall strategy: 'We may laugh a bit about introducing the yellow color and all that, but we do it to emphasize the new culture and state "this is the beginning of something entirely new. So what do we do?" "Well, you're special. We give you flowers and books, and we acknowledge you, and we say this is the most important…'cause we want you to work for this. We want you people in the reablement team to be truly dedicated.' Several of the care workers providing reablement explain that this may have contributed to creating some distance initially, also because the care workers providing conventional home care were afraid of losing their jobs. Over time, the difference, however, seem to have leveled out, especially in the one municipality where staff may interchange in providing reablement and conventional home care. Here, there seems to be a tendency that the reablement idea travels across the sectional divide and slowly is introduced as a founding principle, also in the provision of conventional care.

The change resistant home nurses

One professional group, which has consistently felt outside the cross-disciplinary cooperation in reablement, is, however, the home nurses. This came as a surprise for the middle managers especially in one of the municipalities, as they had hoped the home nurses would step forward in the transition towards reablement. They had also expected them to be the ones most adaptable to the organizational changes towards a more cross-disciplinary cooperation. Despite the various attempts to include them, the middle managers find that the home nurses resist the idea behind reablement, of increasingly letting the user take over the management of daily tasks, including the management of medication. As Merete, head of the home care section says, 'The home nurses in fact seem to reject the whole idea that the user can become independent.' She has experienced that they find it difficult to see the point of the cross-disciplinary weekly meetings and contributing with their professional insight in the cross-disciplinary discussions: 'We had home nurses who said "Do we really need to participate in those meetings?" "Yes, you do." "Well, couldn't we then just discuss our clients and then leave?" The main explanation seems to be that the introduction of reablement has not resulted in an actual re-organisation of the way home nurses are integrated in the provision of services. They are instead maintained in a professional role where they provide their usual mono-disciplinary services. There also seems to be a general concern among this profession whether the user is in fact capable of managing medical needs.

Conclusion

The introduction of reablement in Danish home care has had wide reaching implications. Any user who applies for home care assistance will now need to be assessed whether or not there is a potential for reablement instead. And reablement certainly seems the obvious approach. We find that reablement reflects to a high degree the current ideational paradigms of active ageing and the understanding of plasticity in old age where it is argued that functional ability can be sustained and even improved over the life course, with the application of proper interventions. It also fits well into the current understanding of quality of care as facilitation, which is dominant in Danish long-term care. This requires help and assistance to promote independence and self-reliance. Reablement also reflects current ideas about active social policy and the use of goal-oriented activation plans. Finally, we see the argument for a change from NPM towards NPG well reflected in the emphasis on empowerment, trust regimes and not least the cross-disciplinary cooperation as a way to fight off professional silos.

These ideas are evident once we look further into the identification of problems and their solutions. Reablement is a solution to what used to be a passive regime of care where the user had no say. It legitimizes a focus on independence and with reference to quality of care, and allows the user to actively

participate in the identification of goals, based on his/her daily life and own understanding of quality of life. Reablement also allows a more holistic approach which for the first time acknowledges the social dimension and thus the problem of loneliness as a social problem.

However, there are also some implicit weaknesses and challenges in the problems and solutions which can be identified. Not least, the assumption that the user is always interested in being reabled. This may often be the case with tasks which are close to the body such as bathing and getting dressed, but less so for cleaning. Also the assumption that it is the lack of motivation which makes the older person less interested in being reabled. With this approach, the problem becomes one of motivating the older person in the right way, not a consideration of whether reablement is perhaps (not) the right intervention. The care workers apply a number of quite innovative motivational techniques in order to motivate users, some of which are on the fringe of being unethical. The all-inclusive approach also rejects any argument about age and social rights as a taxpayer, which would otherwise entitle to services. This may be in accordance with the overall national and local policy line, but on the short run certainly challenges the general understanding among older people, their relatives and voters in general about a compassionate, generous and universal long-term care system. And while the reablement approach may acknowledge the problem of loneliness, solving this is now clearly left to non-public actors.

One may also question the degree to which the intervention is based on the user's preferences. The way reablement is applied allows a slow unravelling of the older person's background, personality and desires for the future, but there are strict boundaries for the intervention: it must be aimed at independence in daily activities where otherwise home care would be necessary. The process of daily adjustments of the intervention also implies that the older person is never certain of what is provided, for how long and what will follow after the reablement intervention. This weakens the social rights of the older person and is a significant break with former emphasis on a contractual relationship between the citizen and the system.

Reablement also assumes a new way of working across disciplines and professional groups and providing a service, which is to a high degree inspired by the occupational therapists. Somewhat surprising the care workers have shown much interest in the idea of reablement and have entered into a very successful cooperation with the occupational therapists. They are the favoured employees and a warning signal should be flared not to overlook the very important role of the care workers who 'only' provide conventional care. Likewise, it remains a challenge how to include the home nurses in the cross-disciplinary cooperation.

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