Rehabilitation and Disability

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|  | Rehabilitation is a complex process that involves a number of healthcare professionals, the individual and their family. Rehabilitation is becoming more of apriority in some countries, which prioritize rehabilitation in health care. The aim of this section is to discuss rehabilitation at a macro and micro level by:  • Discussing the history of rehabilitation  • Identifying the major government agendas related to rehabilitation  • Discussing what rehabilitation is both in terms of a process and a philosophy  • Exploring the related concepts of teamwork and quality of life.  In order to achieve this there are a number of theories and models which can be used to make sense of rehabilitation and which can assist rehabilitation professionals. |

History of rehabilitation

Rehabilitation is seen widely by many as being an essential part of a patient's care, as it is here that a person has the opportunity to fulfill his or her potential. Rehabilitation has attracted little attention and has been rarely mentioned within health and social policy, and, as a result, rehabilitation services have received poor funding. Because of the under-resourcing of rehabilitation, few areas have adequate services, which meant that individuals are unable to receive the support required. Such underfunding and general lack of focus received by rehabilitation within health and social policy can be attributed to several issues.

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| REHABILITATION | There are many definitions of rehabilitation within the literature but they all highlight similar defining attributes of rehabilitation: |
| **Process**  **Restoration** | Rehabilitation is generally described as being an active, dynamic, continuing process concerned with physical, social and psychological aspects. Rehabilitation is characterized as a continuous process and identifies the 'rehab cycle', which aims to improve an individual's health status and quality of life by minimizing the consequences of disease. The **cycle consists of five stages**:  • Identifying problems and needs  • Relating the problems to factors that are limiting and can be modified  • Defining target problems and target mediators and selecting appropriate measures  • Planning, implementing and coordinating interventions  • Assessing effects.  The last stage of the cycle may cause new problems and needs to be identified, in which case the cycle begins again.  In relation to rehabilitation, 'restoration' involves enabling the individual to regain lost elements of their life, such as physical functioning or personal and social identity. It also carries the sense of restoring the individual to society or to a purposeful and satisfying life.  The use of the word 'restore' can imply that the emphasis of rehabilitation is on the individual returning to their former life. However, the definitions tend to interpret 'restore' in terms of individuals adapting to changed circumstances and learning new skills rather than returning to their former life roles. Pryor (2002) identifies rehabilitation as being the reconstruction of individuals' lives in the light of injury, illness or surgery. She sees rehabilitation as being about lives that are lived in damaged or broken bodies. |
| **Effectiveness**  **Enabling and facilitating** | Rehabilitation is described as promoting effectiveness or optimal functioning for the individual. Optimal functioning is implied as being functioning that can be achieved given any limitations the individual may have. Functioning could be interpreted in terms of emotional and psychological functioning as well as physical functioning.  Rehabilitation is generally described as being an enabling and facilitating process rather than a 'passive, doing for' process. This is conducive to rehabilitation being active rather than passive. In order for healthcare professionals to take on this enabling and facilitating role the relationship between them and the individual may need to be different. An interesting question is: where does the power lie in this kind of relationship? |
| **Learning and teaching** | Learning and teaching is implied within some definitions, in terms of rehabilitation being described as an educational process that enables patients and careers to learn new skills. Wade (1990) describes it as an educational, problem-solving process aimed at reducing disability and handicap. Applying the International Classification of Functioning, Disability and Health (ICF; World Health Organization 2001), this could be interpreted as increasing an individual’s activity and participation. |
| **Autonomy** | Autonomy is implied in some of the definitions, in terms of enabling individuals to achieve goals that are important to them. In another different definition, the stress is that rehabilitation should be a process aimed at restoring personal autonomy in those aspects of daily living considered most relevant by individuals and their family careers. This idea of restoring personal autonomy fits in well with goal planning and the concepts of empowerment and advocacy. Taking autonomy one step further, Cardolet al (2002) suggests that autonomy should be the ultimate aim of rehabilitation. In order for this to happen, health-care professionals will need to explore the concepts associated with autonomy- e.g. power, empowerment- and their implications. |
| The International Classification of Functioning. Disability and Health | Rehabilitation can be considered in terms of the ICF (World Health Organization2001) under the classifications of **impairment, activity and participation.** Rehabilitation goals will be different related to each level. Using the ICF as a framework for rehabilitation ensures that the focus of rehabilitation is not only on the level of impairment and disability. It needs to focus on the individual's participation in the environment and in society. The goals at each level of the ICF will generally relate to each other. For example for an individual who has had a stroke the goals at each level might be as listed in Table1.1.  *Relationship of ICF categories to goals*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ICF Category Goal  Impairment To regain function in hemiplegic arm and to prevent  complication  Activity To be independent in washing and dressing  Participation To be able to return to work  The goals identified at the level of participation may be dependent on the achievement of goals at the levels of impairment and activity. The ICF in relation to rehabilitation is discussed later |
| **Philosophy** | As well as a process, rehabilitation can also be considered as **being a philosophy of care**. It is about the way professionals think about individuals and where they see their role in the process. As a philosophy, rehabilitation is about enabling, facilitating, empowering. Adopting this philosophy of rehabilitation means that health-care professionals:  • Value the patient as an individual, identifying their strengths and weaknesses; their past achievements; their hopes for their future. This is vital if professionals are to deliver client-centered care. Using assessment tools that assess individual's strengths, weaknesses, etc. can help to promote this value.  • Adopt strategies that facilitate and enable the individual to achieve their full potential. It is important that there is some continuity in the strategies used by rehabilitation professionals and that there is agreement as to what constitutes facilitating and enabling strategies.  • Realize that, although it may be necessary to devote more time to enabling individuals to achieve their full potential, this will be cost effective in the long term. It can be difficult to take this view, particularly in an environment where rehabilitation is not seen as a priority. The time involved is perhaps the most common factor identified by health-care professionals in acute settings as a barrier to rehabilitation. However, health-care professionals need to consider whether this is a valid argument when set against the consequences of not promoting rehabilitation, both for the individual and for health-care resources. Not promoting rehabilitation in the acute setting may mean, for example, that the individual will not achieve their full potential given their limitations and will therefore need more resources and support after being discharged.  • Should be thinking about how the individual and their family will manage in the future, even though the extent to which they are able to affect the individual's level of participation may be limited. The focus should be on individuals' future quality of life as they see it. |
| **Stages of Rehabilitation** | One of the remaining difficulties is that rehabilitation can be seen as something that happens in a specialized unit or ward whereas in reality it needs to commence the moment an individual enters the health-care system. This may be at the first contact with the GP or as an emergency case in Accident &Emergency. It can be helpful to consider this continuum of rehabilitation as having four stages. The aims of rehabilitation are different at each stage.  Stage 1  This is the initial critical stage when the individual is unconscious. The goal of rehabilitation at this stage is to preserve life. Interventions at this stage include:  • Preventing complications  • Providing verbal and tactile stimulation  • Supporting relatives.  Stage 2  At this stage the individual has recovered consciousness, is fully responsive and is beginning to regain some physical function. The goal of rehabilitation depends on the individual's needs. It may be to maintain a safe, comfortable environment, which may be an appropriate goal for an individual with a head injury who is agitated, or it may relate to the individual's functional and cognitive ability. Interventions may include:  • Managing challenging behavior  • Assessing the individual's functional and cognitive ability  • Establishing everyday activities, e.g. eating at a table, using the toilet rather than a commode  • Giving the individual choices, e.g. about diet, clothes  • Establishing alternative forms of communication  • Supporting and involving relatives.  Stage 3  A more active program of rehabilitation is required at this stage, which may take place in a rehabilitation ward or center. The goals of rehabilitation should be focused on the level of participation- being concerned with the individual's quality of life. This will involve:  • Facilitating and enabling individuals to achieve their maximum potential in washing, dressing, feeding, communication and mobility  • Ensuring that there is continuity of therapy programs between the different professional groups within the team  • Empowering individuals by giving them informed choice and by involving them in the setting of rehabilitation goals  • Providing psychological support to the individual and their family  • Providing a supportive, structured environment for the individual and family.  Stage 4  The individual will have reached their full potential at this stage. The focus will now be on enabling them to live with the disabilities they have and maintaining their quality of life in relation to work, hobbies and social life. At this stage they will either be at home or in an alternative setting, e.g. a nursing home. They may attend a young disabled unit for respite care or other day facilities, where the role of the team is to help them maintain their quality of life. In order for individuals to maintain their full potential, they may need follow-up appointments with the rehabilitation team, which may result in further assessments and interventions. |
| Rehabilitation and Disability | Looking at rehabilitation in terms of four stages highlights the need for rehabilitation to be a team activity. The goals of rehabilitation at each stage will depend on the individual's impairments and the resulting disability or the limitations that the impairment places on their activities. Because of the effect the individual's disabilities can have on the rehabilitation process and outcomes it is useful to consider the relationship between rehabilitation and disability.  . According to one survey on the meaning of rehabilitation and disability, professional and client groups view disability as being a dramatic life change for the individual, with rehabilitation being an enabling process in which a range of groups in society worked to meet the needs of the disabled person. This life change includes the way in which individuals see themselves and others. The report emphasized that disability should be related to the individual person with a disability rather than 'the disabled'. The use of disability languages is an important consideration. The term 'the disabled' is still used in the media and in literature, as well as in many countries. Disability languages are   * Person-first language( person with a disability * Disability –first language (disabled person)   This kind of language can be seen as discriminatory, as it implies that disabled people are not seen as individuals but are defined by their disability. There are views in the literature on the relevance of rehabilitation to people who are disabled. Some of these views highlight the framework of the ICF (WorldHealthOrganization2001) that includes the idea of level of participation, which identifies environment and societal factors. This enables disabilities to be described from the perspective of an individual's life circumstances and the impact these have on their experience. The focus on environmental and social factors fits in with Pryor's (2002) description of the creation of a 'rehabilitative milieu', by which she means an environment that enhances the process and outcome of rehabilitation. To enable this environment to be created, thought has to be given to the participants, the activities and the setting in which they take place (Pryor 2002). It is interesting to consider whether definitions of rehabilitation reflect the cultures of different countries. For example, in some countries rehabilitation may be seen as synonymous with physiotherapy. The goal of promoting autonomy and independence may not be congruent with the beliefs of individuals from different cultures. For example, a study comparing Asian people's attitudes to family values with those of white people in the UK found that Asian people valued conformity and self-direction less than the people in the UK. This may not be congruent with the concepts of autonomy and independence. It is therefore essential that rehabilitation is focused on the individual's needs and goals and that their values and beliefs are taken into account. It cannot be assumed that all individuals or professionals have the same views about rehabilitation. In order for professionals to deliver culturally competent rehabilitation care they need to:  • Be aware of their own attitudes towards diversity and examine these attitudes  • Be sensitive to and respect differences  • Be knowledgeable about different cultures to enable them to interpret behaviors appropriately  • Have cultural skills that enable them to respect and value culture - this may include the use of appropriate touch and non-touch when communicating and respecting the individual's need for physical space  • Be able to communicate cross-culturally, which may mean the involvement of interpreters or people in the community.  Focusing on what is important to the individual and what their goals are transcends all cultures. |

TEAMWORK

Rehabilitation, because of its complex nature, cannot be achieved by one professional group alone. Rehabilitation has become synonymous with teamwork. A review of the literature on trends in rehabilitation policy highlighted the need for rehabilitation to be centered on the most important aspects of an individual's life with the involvement of service users. To enable this to be achieved rehabilitation needs to involve a group of professionals all working with the same purpose of meeting the individual's goals. This process must involve the individual and their family. One definition of rehabilitation: 'a process aiming to restore personal autonomy in those aspects of daily living considered most relevant by patients or service users, and their family carers' also highlights the need for a multiprofessional approach to rehabilitation.

* This definition also focuses on individual-centered care, emphasizing what service users and their carers, not the professionals, see as important. The five main principles of individual-centered care can be identified as being
  + empowerment of individuals,
  + enhancement of staff,
  + multidisciplinary integrated pathways,
  + multidisciplinary teamwork and
  + Restructuring and decentralization of services.

One could argue that truly individual-centered care requires interdisciplinary teamwork in which there is not only a shared philosophy and collaboration but also blurring of professional roles in order to meet the individual's goals.

* This use of terminology brings into question the different terms used when talking about rehabilitation. Terms such as multi professional, inter professional, Trans professional, multidisciplinary, interdisciplinary and Trans disciplinary are often used interchangeably. What is the difference between professional and disciplinary? Between multi- and inter-?

Table1.2 gives some dictionary definitions. 'Multi-' implies that there are a number of different professional groups working together, whereas 'inter-'implies that there are a number of different professionals working together towards a common purpose and that there is some blurring of boundaries. 'Professional' can be taken to mean the different professional groups whereas 'disciplinary' can be taken to refer to the knowledge and skills underlying different professional roles.

Table 1.2 Definitions of team types

Term ProfessionaI

Disciplinary

MultiInter

Definitions of Team Types (Oxford Paperback Dictionary1998) Someone who belongs to aprofession, which isanoccupation that involves knowledge and trainig at an advanced level of learning Oforfor adiscipline, which isdescribed astraining that produces aparticular skill;orabranch of learning orinstruction Involving many Between oramong

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This is supported by Payne (2000), who distinguishes between'professional'and'disciplinary'by suggestingthat'professional' is concerned with the functions and activities associated with the different professional groups, whereas 'disciplinary' is concerned with the knowledge and skills required for different professional roles. Norrefalk (2003) takes on the challengeof trying to make sense of the different terminology and identifies that: • Amultidisciplinary team • Involves the efforts of individualsfrom a numberof disciplines • Isusedto describe a team consistingof manydifferentprofessions workingin rehabilitation • In an interdisciplinary team • Members notonly require the skills of their own disciplinesbut also have the added responsibility of the group effort on behalfof the activity or individualinvolved • The skills necessary for group interactionare required, and the knowledgeof howto transfer integrated group activities into a result thatis greater than the simplesumof the activities of each individual discipline • The group activity is synergistic • In a transdisciplinary team • Allborders arebroken betweenthe individualprofessionals.One member ofthe team actsasa primarytherapist, being supportedby therestofthe team.Thisprimarytherapistmay bea health-eare assistantwith specificrehabilitationtraining (jackson& Davies1995). The terms 'discipline'and'professional'can beidentified ashavingmore or less the same meaning. Norrefalk (2003) makes the point that it is importantthat rehabilitationprofessionals nationally and internationally use the same terminologywiththe same meaning. He makes the suggestion that 'multiprofessional team' is used rather than 'multidisciplinary team'. As the team consists of different professionals, this does perhaps make sense. However, there can still be seen to be a difference between 'multi-'and 'inter-', with the interprofessional team truly workingacross boundariesinordertomeetthe goals thatare importantto the individual and havebeen identified by them. This fits in with the view of McGrath & Davis (1992), who consider the distinction between multidisciplinary and interdisciplinary to be their focus, with 'multidisciplinary' being focused on the levelofactivity and'interdisciplinary'focused on the level of participation. It is the level of participation that enables goals to be more realisticfor the individual.In rehabilitation,professionalsshouldbe working towards goals thatare importantto the individual.

Collaboration Collaboration is the key to effective team workingand can be described as the process of working towardsacommongoal with sharedplanning

Figure 1.1 Concepts related to collaboration

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andaction. The team has joint responsibilityfor the outcome(Lindeke & Block1998). Interdisciplinary collaborative care differs from multidisciplinary collaborative care in that it involves joint decision making, shared responsibility andshared authority (Lindeke & Block1998).Professionals work together and cooperatively to achieve an agreed individual-centred goal. Transdisciplinary care takes this way of working onestep furtherinthat thereisacompleteblurringofgoals withone person being responsible for ensuring that the individual's needs are met (Hutchings et al 2003). Although collaboration is the ultimate aim in practice it isnot always easy to achieve. Freemanet al (2000), as a result oflooking atcasestudiesofsixteams, identifiedthatdifficulties in developingcollaborative practicecan be identified at the levels of the organisation, the groupandthe individual.There are anumberofconceptsthat affectall these levels, whichneed to be taken into account for collaboration to occur. Figure 1.1 identifies concepts related to collaboration, which are the basis fora taughtmoduleon collaborationat the Schoolof Health andSocialCare, Oxford BrookesUniversity. Althoughteam workingisseen asbeingcentral to rehabilitation there islittle publishedevidencefor its effectiveness (Embling 1995,Waters & Luker 1996,Proctor-ChildsetaI1998).There isevidenceat aclinicallevel fromprofessionalswhohavechangedfrom one approachtoanotherthat it does have an effect on individuals (McGrath & Davis 1992). Using acasestudyapproach,Proctor-Childset al(1998) explored the realities of multi- and interdisciplinary teamwork. Although this was a small study using only two case studies,both from a neurorehabilitation setting, the findings support the work of McGrath & Davis (1992). Proctor-Childs