Realities of Reablement

The central theme in the 'transformation of social care' proposed in Haringey Council's 'draft corporate plan' and in the linked 'three year plan and budget consultation', both entitled Building a stronger Haringey together, is its adoption of a 'reablement approach'. (Haringey 2014, 2014a) This entails closing residential and day care facilities (thereby abandoning a 'buildings-based day care' model), cutting home-care packages (the target of 'intensive reablement') and encouraging 'customers' to 'access community-based activities'. But is the 'reablement model' appropriate across the range of adult social care – including for people with learning disabilities and other complex needs – and will it save money (the over-riding objective of the proposed measures)?

The term 'reablement' appears to have come into fashion because of the stigma attaching to the more familiar concept of 'rehabilitation', perhaps because of its association with treatment of alcohol and drug dependency. It has been adopted in the sphere of health and social care to describe an approach to tackling problems of disability, particularly among elderly people, often on discharge from hospital following stroke or fracture. (Scie 2012) The emphasis is on restoring physical abilities and re-learning skills (while recognising psychological and social factors in recovery). Reablement programmes typically have a short-term ('six weeks' is the standard duration) and intensive character. No doubt there are considerable advantages of this approach for people with limited physical disabilities or temporary incapacity. But this does not mean that it can readily be extended for use with people with autism and learning disabilities and those with other complex needs.

There are few enough studies of the cost-effectiveness of reablement in relation to people with physical disabilities – but none of its application in the sphere of autism and learning disabilities. This is not surprising because people with autism typically do not lack physical abilities (though some with severe learning disabilities may also have associated physical disabilities). In general, people with autism and learning disabilities have not lost skills that can be readily 're-learned'. They may have limited social and communication skills, and varying degrees of cognitive impairment, but these deficits are not likely to be addressed in a six week period. They may experience problems of anxiety, sensitivity to environmental factors and behavioural difficulties that necessitate long-term structured programmes of care and activity, with skilled, experienced and familiar support staff. Given that eligibility for services currently available in residential and day care facilities is restricted to those who experience the most severe disabilities (typically meeting 'Fair Access to Care Services' criteria for 'substantial' or 'critical' needs), the reablement approach is particularly inappropriate for this population.

Despite the lack of research evidence, there have been attempts to implement a reablement approach in relation to people with learning disabilities (though not autism) in a number of local authorities. A guide 'for frontline staff' on reablement policy in general produced by the NHS in the North East includes some reference to the potential of this approach in relation to people with learning disabilities. (Department of Health 2010) However, these guidelines also indicate that one mode of service delivery – the 'intake and assessment model' –

‘screens out’ people with learning disabilities (together with those needing ‘end of life’ care and those with severe dementia) from reablement services. The guidelines suggest residential care homes and day centres as possible locations for the implementation of reablement programmes – options that will not be available in Haringey if these are closed down.

The NHS North East guidelines insist that the reablement service should be ‘time-limited’ (to the familiar ‘6 or 8 weeks’), as the second of ‘several essential elements’. By contrast, one of the few accounts of the implementation of a reablement approach for people with learning disabilities (in a small pilot project in Oldham) declares as the first of its ‘eight key principles’, that ‘reablement is a journey rather than a service and it is not limited to 6 or 8 weeks’. (Pitts, J. et al 2013) The fact that, in trying to extend this approach to a wider population, it is found necessary at the outset to abandon what most authorities seem to consider a cardinal feature of reablement suggests the limitations of this concept in practice. It is also striking that the case studies presented in this report suggest that the reablement programme may be helpful for individuals who would meet FACS criteria for ‘low’ or ‘moderate’ needs – who would not be considered eligible for any council services in Haringey (or indeed in many councils). When Haringey Council indicates that it plans to use reablement ‘with a view to promoting full independence’ or to enable ‘access to supported employment’, this suggests a lack of awareness of the level of disability (‘critical’ or ‘substantial’ in the FACS framework) of the vast majority of those currently receiving council services.

In common with other local authorities, Haringey seems to be extending the limited concept of ‘homecare reablement’ to reablement programmes of longer duration, implemented in some institutional context, such as residential care (despite its wider commitment to abandon a ‘buildings-based’ approach). This would appear to be the significance of the distinction between the terms ‘reablement’ and ‘enablement’ (particularly in relation to people with mental health problems) as they are used in the Council’s budget proposals. The limited research evidence relating to ‘homecare reablement’ programmes cannot legitimately be invoked in relation to these wider developments of the concept.

There have been some attempts to implement a reablement approach in relation to adults with dementia. (Scie 2013) But even enthusiasts for this approach acknowledge the dearth of evidence concerning its efficacy. Given that this approach demands a highly skilled specialist team, with workers receiving additional training in dementia as well as in reablement, there are further doubts about its cost-effectiveness. However, it is worth noting that its advocates emphasise that ‘it is crucial that local services are available to provide ongoing support, appropriate to people living with dementia’ – exactly the local services that are being withdrawn in Haringey.

Only one study – conducted at the York Social Policy Research Unit – has undertaken a formal cost-effectiveness analysis of reablement (specifically ‘homecare reablement’ and largely in relation to elderly people with physical disabilities). (Glendinning, C., et al, 2010) It found that reablement requires higher upfront investment than conventional home care, although it also identified savings of up to 60 per cent in the costs of subsequent social care

provision among the reablement group. The study also found evidence that reablement did not reduce health care costs, although this may be attributable to weaknesses in data collection. Its, widely quoted, conclusion was that, from a social care perspective, there was 'a high probability that reablement is cost-effective'. However, the authors conceded that the results were less convincing when health care costs were included, but still concluded that the intervention was 'more likely than not' to be cost-effective. One of the 'key messages' emerging from a review of reablement by Scie in 2011 was that 'there is currently little evidence to suggest that it reduces health care costs'. (Francis, J. et al, 2011)

Though there is little evidence of the value of reablement and few examples of good practice, it may well have some role for people with mild or moderate learning disabilities. The experience of its use in relation to physical disabilities suggests that success depends upon careful assessment and implementation by an experienced multidisciplinary team with appropriate leadership, training and skills. Such a team is likely to take some time to establish, and is not likely to be cheap: there is little sign of any such team emerging in Haringey, at a time when many experienced workers in this field are threatened with redundancy.

It is clear that the impetus for the reablement approach comes from politicians, civil servants and economists determined to curb public expenditure in all areas of health and social care. It has been seized upon by local councils as a means of curtailing their spending – while allowing them to indulge in the rhetoric of innovation, transformation, empowerment, enabling, etc. A combination of wishful thinking and cynicism permeates Haringey's promotion of reablement. The burden of this fantasy is likely to be borne by people with disabilities and their families.

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