Rehabilitation RESEARCH REVIEW™

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Issue 74 – 2026

In this issue:

Abbreviations used in this issue
ACC = Accident Compensation Corporation
HER2 = anti-human epidermal growth factor receptor 2
OR = odds ratio

Welcome to issue 74 of Rehabilitation Research Review.

We begin this issue with a qualitative Dutch study assessing system responsiveness and health literacy in return-to-work challenges for individuals with chronic low back pain and learn of four overarching themes including psychological vulnerability, seeking diagnostic and return-to-work clarity, lack of understanding and support from stakeholders, and absence of professional consensus. The authors of the study suggest that health literacy-responsive practices may help reduce health-literacy-related inequalities in this group. A Portuguese study reports that women receiving chemotherapy for early-stage breast cancer experience substantial work disruption, emphasising the need for integrated survivorship care with vocational support. We conclude this issue with a qualitative study exploring people with stroke's perceptions of digital technologies in post-stroke rehabilitation.

I hope that you find the information in this issue useful in your practice and I welcome your comments and feedback.

Kind regards,

Professor Nicola Kayes
nicolakayes@researchreview.co.nz

System responsiveness and health literacy in return-to-work challenges for individuals with chronic low back pain: A qualitative study

Authors: Frydenlund G et al.

Summary: This small, Danish, single-centre study examined how 17 individuals with chronic low back pain, all on long-term sick leave (exceeding 30 days), experienced return-to-work processes and potential improvements for the processes. Reflexive thematic analysis identified four overarching themes: psychological vulnerability; seeking diagnostic and return-to-work clarity; lack of understanding and support from stakeholders; and absence of professional consensus.

Comment: Those of you who have engaged with my commentary in Rehabilitation Research Review previously will know that I advocate for a system and institutional approach to health literacy (inspired by Palumbo et al., Health Services Management Research 2016), rather than using individual health literacy levels to apportion blame for poor outcomes to individuals. This paper distinguishes between four types of health literacy: functional; interactive; critical; and systemic health literacy. The authors explore how people living with chronic low back pain experience and navigate return to work, applying a health literacy lens to their analysis. While many of the challenges described in relation to return to work for people with chronic low back pain will be familiar to rehabilitation professionals, the application of a health literacy framework provides a valuable way of interpreting these experiences and, importantly, of generating recommendations that move beyond individual emotions and behaviour. From a health literacy perspective, the authors propose that: 1) Psychological vulnerability can limit individuals' capacity to engage with information (functional health literacy); 2) Diagnostic uncertainty can undermine their ability to understand, interpret, and apply information (interactive and critical health literacy); 3) Interactions with multiple stakeholders shape people's sense of legitimacy and their capacity to advocate for themselves (critical health literacy); and 4) Conflicting information, poor coordination and systemic barriers place an undue burden on individuals to navigate a complex, and often contradictory, system, compounding these health literacy challenges (systemic health literacy). The authors offer several health literacy responsive strategies and, importantly, call for health literacy sensitive health and return-to-work systems that are explicitly designed to be sensitive to health literacy demands. The challenge for us, as rehabilitation practitioners, providers, funders, and organisations, is: What health literacy-responsive strategies could we implement tomorrow in our own practice?; How might we collectively move towards a more health literacy-sensitive system of care and rehabilitation?

Reference: Disabil Rehabil. 2026;Jan 8 [Epub ahead of print]

Abstract

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Work reintegration after chemotherapy in patients with early-stage breast cancer: The RESTART cross-sectional survey

Authors: Silva S et al.

Summary: This Portuguese, cross-sectional, single-centre, exploratory study evaluated return-to-work outcomes and identified factors associated with sick leave and prolonged absence in 71 women (median age 52 years) 12 months after receiving chemotherapy for early-stage breast cancer. Most patients (83.1%) took sick leave and 71.2% were still on leave after chemotherapy. After 12 months, 81.4% had returned to work (median 18 months after diagnosis and a median of 13 months from end of chemotherapy); 14.6% had shifted to part-time work, 27.1% had changed roles, and 22.9% experienced income loss. Common reasons for continued leave included fatigue (82.5%), impaired cognition (72.2%), mood changes (55.6%), and inadequate adaptation of the workplace (53.1%). Facilitators of return included physical exercise (64.2%), psychological support (47.2%), and physical therapy (47.2%). Multivariate analysis suggested that persistent leave was associated with lower educational level (OR 4.67; 95% CI 1.07-20.50; p = 0.040) and high physical demands (OR 1.43; 95% CI 1.09-1.87; p = 0.009); there was a borderline association (OR 3.45; p = 0.074) with anti-HER2 therapy. While on leave, women reported poorer quality of life.

Comment: This paper positions employment and return to work as a key outcome following a cancer diagnosis and advocates for return-to-work support to be embedded within oncological pathways of care. In Aotearoa New Zealand, we are fortunate to have the Pinc and Steel Foundation (https://www.cancerrehab.org.nz/), which has played a pivotal role in putting cancer rehabilitation on the map. Through many years of sustained advocacy, the Foundation has helped make cancer rehabilitation a visible and essential component of integrated care for people affected by cancer—within what has otherwise been a largely medico-centric endeavour. I suspect we are even further from the mark when it comes to the routine provision of return-to-work support as standard practice. This context is what sparked my interest in this paper. The paper did not quite deliver what I had hoped. The findings are relatively high level and somewhat crude, and they should be interpreted with caution. The small sample size means the results are exploratory, and the cross-sectional design limits our ability to draw causal inferences. Nonetheless, the paper is useful in signalling areas that warrant further, and more indepth, investigation. Several figures are worth noting. Eighty-three percent of participants took sick leave (85% following diagnosis and 15% following chemotherapy), and 81% of those eventually returned to work. The median time to return to work was 18 months from diagnosis and 13 months from chemotherapy. Among those who did return to work, 15% shifted from full-time to part-time employment, 27% changed role or position, 23% experienced a reduction in income, and 15% moved to a new employer. Taken together, these findings paint an interesting picture. Two issues stand out as particularly salient, the prolonged time away from work, and the substantial changes in employment status among many of those who did return. To me, this highlights multiple missed opportunities for vocational support—both in supporting people with a cancer diagnosis to maintain employment, and in facilitating more timely return to work. It also raises important questions about how we can better support return to work in ways that do not compromise longer-term employment security or future earnings. Our ACC system prioritises return to work as a key outcome for people with injury. Those impacted by cancer are just one example of a group who would benefit from vocational support, but who do not have access to vocational support through ACC. How might we ensure a similar level of priority is placed on this important outcome for those who are not eligible for ACC?

Reference: Cureus 2025;17(12):e99684
Abstract

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Comparing inpatient stroke rehabilitation care and outcomes for people with and without aphasia in Australia

Authors: Stone M et al.

Summary: This Australian, observational, cross-sectional study used data from hospitals participating in the Stroke Foundation biennial National Stroke Audit – Rehabilitation Services (2016, 2018, 2020; n = 9960) to examine the differences in inpatient stroke rehabilitation care and outcomes associated with the presence of aphasia. Overall, 33% of patients (median age 75 years; 56% men) had aphasia and those patients were more likely to have a mood impairment (54% vs 44%) and were less likely to see a psychologist (40% vs 49%). Patients with aphasia were less likely to be involved in goal setting (84% vs 88%) or development of their care plans (91% vs 96%), or consulted about return to work (67% vs 74%) or driving (41% vs 45%). The median length of stay was longer in patients with aphasia (26 vs 21 days; p ≤ 0.001) and at discharge these patients were less independent (adjusted OR 0.80; 95% CI 0.71-0.90).

Comment: The findings of this paper are interesting but perhaps not unexpected given what we already know from the evidence base. However, the findings are based on a large National Stroke Audit in Australia, including 1007 admissions and 133 participating hospitals. As such, notwithstanding the limitations inherent in retrospective and cross-sectional data, the audit offers a grounded snapshot of contemporary practice. There are likely unmeasured confounders that have not been captured in this research, so the findings should be interpreted with caution. Nonetheless, three findings warrant further reflection: 1) People with aphasia were less likely to be involved in decision-making about their care; 2) They were less likely to be assessed for mood impairment, and when mood impairment was identified, they were more likely to be prescribed antidepressants rather than referred for cognitive-behavioural interventions; and 3) They were less likely to be asked about returning to driving or work. These patterns of care are concerning. They suggest that people with aphasia are being systematically excluded from person-centred rehabilitation practices, denied opportunities to access evidence-based interventions despite being at higher risk of difficulties that could be effectively managed, and less likely to receive support for key activities that are critical for successful community reintegration following stroke. I would argue that these inequities are likely less about people with aphasia accessing care, and more about the systems and professionals delivering that care. This may reflect the additional time required to meaningfully involve people with aphasia in decision-making, limited skill or confidence in using accessible communication strategies, or assumptions—conscious or unconscious—about what might be possible for people with aphasia, which in turn constrain the options that are offered. This raises an important question? Would people with aphasia accessing stroke care in Aotearoa New Zealand have a different experience, or would they encounter similar inequities in access to high-quality care? Critically reflecting on who and what we may inadvertently privilege in our rehabilitation practices is an essential step if we are to move towards more equitable, inclusive, and person-centred models of care.

Reference: Clin Rehabil. 2026;Jan 19 [Epub ahead of print]
Abstract

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Physiotherapist factors associated with the intention to deliver psychologically informed physiotherapy in persistent low back pain: An online cross-sectional vignette study

Authors: Earl C et al.

Summary: This New Zealand, cross-sectional, vignette-based online survey assessed 224 physiotherapists with respect to the intention to deliver psychologically informed physiotherapy (PIP) in two vignettes of people with non-specific low back pain. Overall, one-third of physiotherapists intended to deliver PIP for management of low back pain. Pain knowledge and attitudes were associated with the intention to deliver PIP in both the first (OR 1.05; 95% CI 1.01-1.08; p = 0.015) and second vignettes (OR 1.05; 95 % CI 1.02-1.09; p = 0.005). In one vignette, beliefs about the consequences of PIP were associated with an intention to deliver PIP (OR 2.15; 95% CI 1.12-4.11; p = 0.021).

Comment: Taking a psychologically informed approach to physiotherapy in the management of low back pain has long been advocated for; however, its routine integration into everyday physiotherapy practice has been slow. While some research has sought to understand this translation gap, the authors of this paper identify several limitations in the existing literature that they aimed to address. They used clinical vignettes to examine intention to use psychologically informed physiotherapy in Aotearoa New Zealand. It is notable that only one-third of respondents indicated an intention to deliver PIP. Higher levels of neuroscience knowledge were consistently associated with intention to deliver PIP, and more positive beliefs about the outcomes of such approaches were also associated with intention in one vignette. This paper makes a useful contribution by illuminating current intentions, knowledge, and beliefs related to PIP in Aotearoa New Zealand. Understanding how intention translates into realworld delivery is a critical next step if we are to meaningfully address this ongoing knowledge mobilisation challenge. Important questions remain about how PIP is enacted in realworld practice, particularly within the constraints, uncertainties, and relational dynamics of everyday care. Addressing these questions will be essential if PIP is to become not just an aspiration, but a routine and supported aspect of care for people living with low back pain.

Reference: Musculoskelet Sci Pract. 2026:81:103462
Abstract

Predictors of patient engagement in a care coordination program

Authors: Adejumo KL et al.

Summary: This observational analysis of data from the cluster-randomised, controlled, Vermont RETAIN phase II trial testing evidence-based stay-at-work and return-to-work strategies, sought to identify predictors of engagement in a care-coordination programme for 429 patients with work disabilities. Injury- or illness-related work absences were predictive of greater odds of engagement (OR 2.87; 95% CI 1.81-4.56), while lower engagement was predicted by unemployment (OR 0.43; 95% CI 0.27-0.63) versus an employer-based job. Less engagement was also associated with a high school education or less (OR 0.40; 95% CI 0.23-0.69), or a college education (OR 0.52; 95% CI 0.31-0.88) versus post-graduate education. Higher engagement was also predicted by self-rated poor or fair health (OR 1.87; 95% CI 1.31-2.68) and age (OR 1.02 per year; 95% CI 1.01-1.04).

Comment: The authors make several compelling points in the introduction to this paper. They argue that engagement in work disability interventions has typically been inferred from return-to-work or stay-at-work outcomes, which are often treated as proxy indicators of engagement. However, given the complexity of work disability interventions—and the multiple factors that intersect within them, including the individual, health system interactions, employer relationships, workplace context, and job demands—the authors suggest that engagement cannot be meaningfully captured in this way. They also note that engagement is likely to fluctuate over time and therefore argue for a continuum-based framework. Such a framework recognises varying levels of readiness and support needs, and positions engagement as an ongoing, dynamic process. This framing is thoughtful and persuasive, and it is what initially sparked my interest in this paper. However, this more nuanced conceptualisation of engagement does not fully carry through into the study design. Given the emphasis on engagement as dynamic and evolving, I expected the authors might adopt a longitudinal approach—capturing engagement at multiple time points and exploring how different factors influence movement along the engagement continuum over the course of the intervention. Instead, the study adopts a more conventional crosssectional approach, assessing engagement at a single point in time. Furthermore, participant engagement was assessed by the workhealth coach and was largely framed in terms of individual behaviour, with limited acknowledgement of the broader relational, organisational, and systemic contexts in which engagement is shaped and constrained. I don't wish to dismiss the findings as they may be of interest to those working in vocational rehabilitation. However, the study ultimately stopped short of delivering on the promise of its conceptual framework. Future research would benefit from designs that better align with this conceptualisation—particularly longitudinal and mixed-methods approaches that examine how engagement evolves over time and how system-, workplace-, and provider-level factors interact with individual readiness and capacity. This research is needed if we are to move beyond measuring engagement as an individual attribute and towards designing work disability interventions that actively enable and sustain engagement across the continuum of care.

Reference: Patient Prefer Adherence 2025:19:4245-4256
Abstract

INDEPENDENT COMMENTARY BY

Professor Nicola Kayes

Professor Nicola Kayes is Associate Dean of Research in the Faculty of Health and Environmental Sciences and Co-Director of the Centre for Person Centred Research at Auckland University of Technology. Nicola has a background in health psychology and as such her research predominantly explores the intersection between health psychology and rehabilitation.
For full bio CLICK HERE.

Understanding patient and staff perspectives on dignified rehabilitation care experiences

Authors: Chapman K et al.

Summary: This study used a Generative Co-design Framework for Healthcare Innovation to examine dignity in healthcare from 18 patients and 20 staff perspectives in an inpatient rehabilitation unit. Dignity was influenced by people, infrastructure, and policies. Dignity was defined by participants as being acknowledged and respected as people, or acknowledgement of personhood. Some patients reported undignified, but necessary care activities. Both staff and patients highlighted a requirement for flexibility and person-centred policies. Dignity enhancing practices included validation of patient choices, respect for privacy, and informed decision-making. Despite systemic challenges, staff had a strong commitment to dignified care.

Comment: I enjoyed this paper. Those familiar with my research interests will know that I come to it with a degree of bias—the topic is very much my cup of tea. The study explores perspectives on dignified rehabilitation care, with an explicit focus on inpatient rehabilitation settings. The authors argue that dignity is closely linked to a range of downstream outcomes, and that people in hospital are particularly vulnerable to breaches of dignity. They position inpatient rehabilitation as a setting where such violations are especially likely to occur. Interestingly, while participants were able to describe concrete moments of care that felt both dignified and undignified, they found it more challenging to articulate a clear definition of dignity itself. What was evident though, was a shared understanding that dignity was fundamentally about recognising every person as fully human and valuing them for "who they are, as they are". At its core, dignity was framed as an acknowledgement of personhood. Both staff and patient participants acknowledged that some care processes are inherently undignified, yet unavoidable, intimate personal care being a clear example. However, while a degree of indignity may be inevitable in such situations, how these care processes are carried out was described as deeply important. The paper highlights, for example, the value of offering choice and control over when and how care is delivered. Enabling people to express their preferences, and acknowledging and valuing those preferences, even when they cannot be fully accommodated, was seen as a key mechanism for preserving dignity. The authors also emphasise the importance of respecting privacy, particularly in inpatient settings where privacy can be easily and routinely compromised. It was encouraging to read that staff participants expressed a clear commitment to the delivery of dignified care. However, unsurprisingly, staff also reflected on the many organisational and system-level demands that compete with this intent in their everyday practice. In response, the authors argue for the development of responsive care interfaces in which dignity is deliberately built in by design. Although more research is needed to understand how dignity-by-design approaches can be embedded and sustained, this study provides a helpful foundation for thinking differently about inpatient rehabilitation as a setting where dignity is actively supported.

Reference: Disabil Rehabil. 2026;48(1):84-93
Abstract

Barriers to early rehabilitation and support needs among elderly hip fracture patients with kinesiophobia: A qualitative study

Authors: Ma Y et al.

Summary: This phenomenological qualitative study assessed early rehabilitation experiences among 15 elderly Chinese patients with post-operative kinesiophobia recruited 2-7 days after surgery for hip fracture. Five major themes were identified along with five sub-themes: fear is a barrier to rehabilitation progress (fear of falling, poor recovery, or reinjury); frustration and anxiety result from a gap between expectations and reality; progress is impeded by a lack of knowledge (limited awareness of early rehabilitation, low rehabilitation literacy in caregivers); recovery is impeded by loneliness and insufficient social support; and a need exists for rehabilitation continuity after discharge to achieve recovery.

Comment: This study explored the perspectives of older adults experiencing kinesiophobia within the first week following surgery for hip fracture. The research was conducted in China, where the authors note that rehabilitation policy, workforce capacity, and practice models are still evolving. Nonetheless, the issues identified are unlikely to be culturally specific and will likely resonate with clinicians working with this population in other contexts. The findings paint a complex picture. Fear of re-injury, coupled with a limited understanding of the purpose and benefits of early mobilisation, constrained participants' engagement in rehabilitation. These challenges were further compounded by loneliness, limited social support, and poor continuity of care following discharge, all of which undermined confidence and reduced willingness to actively participate in post-operative rehabilitation. These findings challenge us to respond more deliberately to the emotional, informational, and social dimensions of early rehabilitation after hip fracture. Addressing kinesiophobia requires clear, consistent, and timely communication about the safety and value of mobilisation, alongside relational approaches that build trust and confidence in the immediate post-operative period. Furthermore, continuity of care and social support appear critical, particularly for older adults navigating recovery in isolation.

Reference: Disabil Rehabil. 2026;48(1):187-196
Abstract

Stakeholder perspectives on a return-to-work cognitive intervention after stroke

Authors: Chen NYC et al.

Summary: This Singaporean study used in-depth semi-structured interviews to investigate 20 stakeholders' experiences (stroke survivors n = 7; caregivers n = 4; healthcare professionals n = 5; and employers n = 4) of return to work after stroke, and co-design preferences for a return-to-work cognitive intervention. Three core themes were identified: barriers to return to work (including subthemes of lack of resource awareness, support scheme ineligibility, and lack of workplace understanding); intervention content (subthemes of awareness, acceptance and adjustment, goal setting, self-management strategies, and navigating the return-to-work journey); and intervention delivery (subthemes of programme structure, social support, format and accessibility).

Comment: This paper reports on a qualitative study that sought to capture the perspectives of stroke survivors, primary caregivers, employers, and health professionals to inform the design of a return-to-work cognitive intervention. I support the intent and purpose of the work; ideally, we would engage those people likely to be impacted by and benefit from an intervention in the design of that intervention more routinely. Overall, I enjoyed the paper, and some interesting insights were offered, some of which are likely particular to the research setting (Singapore) and their broader socio-political context. That said, I was struck by a set of contradictions that were evident to me, but largely unacknowledged by the authors. While the research engaged multiple stakeholder groups and identified barriers that clearly sit with health providers, employers, and disability systems, the authors framed the work as the codesign of an intervention targeted primarily at stroke survivors. This raises an important question about where responsibility for successful return-to-work interventions is ultimately located. If barriers are distributed across individuals, workplaces, health services, and systems, then interventions that are positioned as being "for" stroke survivors alone risk reinforcing an individualised framing of what is, in reality, a shared and relational challenge. This paper makes a valuable contribution by surfacing the perspectives of multiple stakeholders; the next step may be to more explicitly reflect this complexity in how interventions are conceptualised, targeted, and evaluated so that responsibility for change does not rest disproportionately with those already navigating the consequences of stroke.

Reference: Clin Rehabil. 2026:Jan 18 [Epub ahead of print]
Abstract

Evaluating in-reach rehabilitation: A parallel model of multidisciplinary rehabilitation delivered alongside acute hospital care

Authors: Shiner CT et al.

Summary: This Australian study assessed an emerging model (in-reach rehabilitation) for delivery of early, multidisciplinary rehabilitation alongside acute specialist medical care in 967 participants between 2015 and 2023. In-reach rehabilitation was delivered over a median of 11 days over a range of diagnoses including reconditioning (31.3%), cardiopulmonary transplant (22.1%), and neurological impairment (20.1%). Multivariate analysis indicated that scores for Functional Independence Measures increased with rehabilitation (mean gain 24.0 points; 95% CI 22.9-25.1), younger age, earlier in-reach rehabilitation initiation and certain diagnoses. In-reach goals focused on activities and participation and high rates of goal attainment were observed (90.5%).

Comment: This paper focuses on in-reach rehabilitation, an emerging model of care gaining traction in Australia that aims to deliver early rehabilitation within acute hospital settings. The authors describe in-reach rehabilitation as involving "the delivery of coordinated, multidisciplinary rehabilitation programmes to patients in an acute hospital setting in parallel to disease-specific acute medical and/or surgical care […] typically delivered *via* 'mobile' teams of specialist rehabilitation professionals". At face value, this model makes intuitive sense. However, the authors note that there is currently limited research examining in-reach models and their outcomes. This gap is attributed, at least in part, to the methodological challenges inherent in evaluating complex rehabilitation interventions. As with many models of rehabilitation care, conventional randomised controlled trial designs are poorly suited to capturing the effects of in-reach rehabilitation. To address this gap, this research is a naturalistic evaluation of in-reach rehabilitation conducted at a public hospital. In brief, in-reach rehabilitation comprised weekday, multidisciplinary rehabilitation delivered alongside acute care, coordinated by a rehabilitation physician and reviewed weekly via case conference. The paper reports several figures that help ground the delivery of in-reach rehabilitation in practice. Rehabilitation commenced a median of 21 days after hospital admission and typically lasted 11 days, although nearly 18% of programmes extended beyond three weeks. Around 16% of participants experienced a medical interruption, with just over half able to resume and complete rehabilitation after stabilisation. The authors make a strong argument for in-reach rehabilitation in circumstances where medical events do not require transfer, enabling rehabilitation to proceed without waiting for complete medical stability. Almost half of participants were ultimately transferred to subacute inpatient rehabilitation, while 40% were discharged directly home. I would be interested to understand how these patterns differ from care pathways where in-reach rehabilitation is not available. Overall, participants undertaking in-reach rehabilitation demonstrated high rates of goal attainment and gains in functional independence. While it is difficult to directly attribute these improvements to in-reach rehabilitation alone—given that some degree of recovery would be expected with acute care in the absence of in-reach rehabilitation—the findings tentatively suggest that in-reach rehabilitation may contribute additional benefit. Overall, the findings suggest that in-reach rehabilitation is a promising approach with important implications for how rehabilitation is integrated into acute care in Aotearoa New Zealand.

Reference: Disabil Rehabil. 2026;48(1):209-222
Abstract

Exploring people with stroke's perceptions of digital technologies in post-stroke rehabilitation – A qualitative study

Authors: Hestetun-Mandrup AM et al.

Summary: This Norwegian qualitative study explored how 17 people with stroke perceived the usage of post-stroke rehabilitation using digital technologies. Reflexive thematic analysis identified two themes: "Still digitally connected" - digitalisation impact on everyday life and rehabilitation; and "To bring people closer"- personal contact and responsibility. Participants used digital technologies for rehabilitation and considered digital self-management tools beneficial for exercising and gaining information. Using various technologies they stayed connected to a rehabilitation network using video-consultations, apps and exergaming.

Comment: This study explored how people with stroke perceive the use of digital technologies in their rehabilitation. As health professionals, we often make assumptions about individuals' willingness, openness, readiness, or capacity to engage with digital technologies in rehabilitation. There is a risk, however, that these assumptions simply reflect our own willingness, openness, readiness, or capacity to use digital technologies in practice. Engaging directly with people who access and participate in rehabilitation services is an important way of testing these assumptions—and this paper did exactly that for me. We often talk about the uptake of digital technologies in rehabilitation as though we are asking people to engage with something entirely unfamiliar. In contrast, this research found that many people with stroke routinely used digital technologies in their everyday lives and when accessing health services prior to their stroke. As a result, the use of digital technologies in rehabilitation was experienced as a continuation rather than a departure. Some participants did describe becoming more "digitally aware" following stroke, adjusting how and when they used technology in response to changes in their capacities. This highlights the importance of not assuming either capability or incapability, but instead supporting flexible, adaptive use of digital technologies that aligns with people's preferences, contexts, and changing needs during recovery. Importantly, participants viewed digital technology as a key mechanism for getting "100% out of the rehabilitation" and as integral to self-management following stroke. In Aotearoa New Zealand, where there is an increasing shift towards early supported discharge, long waiting times for community-based rehabilitation, and variable access to services to address longer-term impacts, digital technologies may play an important role in supporting ongoing rehabilitation and recovery. That said, participants also made visible the conditions under which digital technologies are most likely to work well as part of their rehabilitation process. These included the integration of meaningful personal contact—both with health professionals and with peers—alongside digital tools that were tailored to the individual's situation, needs, and preferences. Crucially, the authors make visible the importance of supported self-management, distinguishing between digital technologies that are used to support and extend rehabilitation, and those that feel like a deferral of responsibility by health services. Overall, people with stroke described digital technologies as a valuable support for rehabilitation, particularly when they complement, rather than substitute for, person-centred and relational care.

Reference: Disabil Rehabil. 2026;48(2):359-368
Abstract