



Relationship between the components of disability definition and the effectiveness of rehabilitation measures as a process

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Abstract

Introduction and Objective. The number of disabled persons is most often only estimated. The disabled require multidirectional, effective support in almost every field of functioning. There is no arbitrarily accepted definition of disability, and those currently available outline the ranges of support for which rehabilitation measures are necessary.

Objective. The aim of the review is to present the problem areas that contribute to the definition of disability and their interdependence and effectiveness in relation to rehabilitation interventions, as well as identification of the most frequent medical and social problems interdependent on the quality and feasibility of rehabilitation interventions.

Review Methods. Scientific literature in Polish and English for 1993–2023 and legal acts concerning the definition of disability, definition of rehabilitation and the problem of employment were reviewed. The following key words were used to search the NIZP-PZH, MZ, JAHEE and ISAP databases: disabled persons, definitions of disability, rehabilitation as a process, synchronization of thematic groups of disability definitions with the rehabilitation process.

Brief description of the state of knowledge. Disability is a public health problem. The actual determination of the extent, medical and social needs of people with disabilities involves methods and measures for classifying people as disabled. The effects of treatment and rehabilitation are assessed by the level of functioning of the disabled in society.

Summary. The multiplicity of characteristics included in the definitions of disability account for all problems in health and social terms. In view of the social, environmental and cultural changes, the scope of needs of people with disabilities is also changing, which can be seen in newly-developed definitions, including rehabilitation.

Key words

disabled persons, defining disability, interdependencies between the definition of disability and rehabilitation activities

INTRODUCTION

Osler's aphorism: 'Care for the individual patient rather than for the particular characteristics of the disease' (cited in: Whitty Rising [1]). In every society in the world there used to be and still is a certain group of people who, as a result of various bodily dysfunctions, form the group of disabled people. They require support or maintenance for their condition which involves an assessment of needs of a health and social nature, and ways and methods of addressing them. Specific scientific methods must be applied to these activities which will allow, as far as possible, a standardised solution to the main problems that arise from the type and degree of disability. A fundamental problem in the implementation of many projects aimed at helping the disabled is the lack of uniform definition of a disabled person, arbitrarily adopted by scientific groups [2, 3, 4]. This is associated with a need for further work on developing a definition, or defining

the disability status. The number and types of disability definitions available, particularly in the publications of experts of the world organizations (e.g. WHO) and in legal acts at various level, is so large that it has proved to be a failure in achieving a consensual definition, with the delineation of problem groups. Thus, defining disability is complicated because it is complex, dynamic, multi-dimensional and contentious.

It is currently estimated that there are approximately 1.3 billion people worldwide experiencing intractable disability. This equates to 16% of the world's population, that is, 1 in 6 persons [5]. The ongoing search for a comprehensive definition of a disabled person, and for effective recording methods, prove the fact that their number is underestimated. It turns out that the ongoing work on defining a disabled person can be considered a 'running' problem, forced mainly by rapid social and political changes and, above all, advances in medical knowledge.

Rehabilitation remains closely linked to the concept of a disabled person. Generally, Szawłowski mentions three main lines of action in the rehabilitation procedure: assessment of degrees of impairment, therapeutic improvement,

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and social integration or reintegration [6]. Appropriately selected rehabilitation content, depending on the types of dysfunction of organs, systems or the whole body, is used in all clinical specialties in medicine. Most disabled people require rehabilitation measures as a complete process encompassing therapeutic, psychological, social, and vocational rehabilitation. Rehabilitation is defined as 'a procedure that is supposed to restore physically and mentally disabled people to function in society' [7, 8]. Unfortunately, only a small percentage of disabled people have the chance to participate in all stages of the rehabilitation process that are interdependent with the definition of disability. Due to this fact, most of them, irrespective of the causes of their body dysfunction, rate their level of satisfaction with their lives as rather low.

In spite of the numerous available studies published by various specialists, there is still a need to provide evidence of the close correlation between the characteristics of the definition of disability and rehabilitation activities. Based on the actual needs of people with disabilities, high hopes can be raised to support the expected level of functioning of people with disabilities in the community, despite numerous barriers and unfair stereotypes encountered in their environment.

OBJECTIVE

The aim of this review is to present: 1) the areas (scopes) of defining disability, taking into account the causes of bodily dysfunction; 2) the types and intensity of health and social and interdependent issues; 3) to determine the needs and level of effectiveness of rehabilitation as a process, depending on the quality and purpose of the definition of disability; 4) to present the most important issues and problems of disabled persons, resulting from low effectiveness of rehabilitation, mainly of persons living in a rural environment.

MATERIALS AND METHOD

Scientific literature in Polish and English for 1993–2023 and legal acts concerning the definition of disability, disability assessment, definition of rehabilitation, and importance of taking up employment by disabled persons, were reviewed. Medical, sociological and psychological literature of a research and review nature was also reviewed. The authors also made use of many years of their own research experience in the field of disability issues through their analyses of the adopted characteristics encompassed by the title of the review. The following key words were used to search them in the databases: NIZP-PZH (Narodowy Instytut Zdrowia Publicznego – Państwowy Zakład Higieny, Polska), JAHEE (Joint Action. Health Equity Europe, UE), MZ (Ministerstwo Zdrowia, Polska), ISAP (Internetowy System Aktów Prawnych, Polska) defining disability, needs for changes in the definition of disability, rehabilitation as a process, and synchronisation of the thematic groups of the definition of disability with the process of rehabilitation.

DESCRIPTION OF THE STATE OF KNOWLEDGE

It is difficult to talk about the significance of defining disability in terms of the cooperation of its individual areas with the relevant rehabilitation activities as a process without some historical facts. This problem was interestingly presented by Marcin Garbat in his monograph, entitled *History of disability. Origins and development of rehabilitation, technical aids and support for people with disabilities* [9]. For centuries, various dysfunctions of the human body were referred to in pejorative terms, which was a kind of taboo. The terminology of the various dysfunctions of disability was quite broad, and the most commonly used terms were: invalid, crippled, handicapped, impaired, lame and deformed [10]. Such persons were discriminated against worldwide. For example, in ancient Greece, disabled people, who were regarded as punished by deities due to their defects and sins, were able to return to the 'normal' society only by making attempts at complete physical, mental and moral recovery [11]. The first attempts to define incapacity, also in Poland, date back to the time when people involved in warfare began to be cared for, treated and returned to health in an organised manner. The evolution of the concept of disability did not result in an open social debate until the turn of the 20th century, when attempts to effectively solve the most difficult problems of this group of people emerged. It was at this time that the problems were noticed in terms of health and social issues.

No less difficult was the evolution of understanding and defining the meaning and usefulness of activities defined as rehabilitation. The origins and development of rehabilitation has been a huge success on the way to modern requirements setting modern standards in many countries for the highest possible level of integration in every sphere of life [12, 13]. The difficult work on this problem is evidenced by the fact that there are at least 187 definitions of rehabilitation in the literature. Their contents deal with various problems. Some of which are used in medical practice, others for research purposes by authors from different professions, and some for reporting purposes [14].

Due to the availability of many definitions of disability, health and illness or disease in the scientific literature, only two definitions are presented here. According to the WHO expert definition, disabled persons are defined as those who are: 'unable, partly or wholly, to ensure by themselves the necessities of a normal individual and social life, as a result of a deficiency, either congenital or not, in their physical and/or mental capabilities' [15]. According to the Convention on the Rights of Persons with Disabilities: 'persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, for whom interactions with various barriers may hinder their full and effective participation in society on an equal basis with others' [2].

A number of studies show that there are plenty of problems faced by people with disabilities, but that barriers of a social nature constitute a much greater obstacle to everyday functioning than functional limitations of the body. These include: problems of discrimination, health inequalities, lack of psychological support, insufficient diagnosis of health and social needs, physical and psychological barriers, insufficient support from family members, hardly accessible or inaccessible rehabilitation in the community, and secondary disability [6, 16, 17].

Thematic structures that make up definitions of persons with disabilities.

In spite of the availability of many definitions, there is no single, arbitrarily accepted definition that defines the terms – ‘disabled person’ and ‘disability’. Defining and describing disability is very difficult, and further work on the clarification of the multifaceted criteria still requires plenty of research and discussions in the scientific field. The main reasons for this problem are: difficulty in defining a clear boundary between health and disease, between disease and disability, as well as the difficulty in constructing rules for deciding on the degree of disability, i.e. the ‘specific nature’ of the objective and subjective state of health in the somatic, physical, mental and social dimensions. Difficulties in developing specific definitions can also be associated with the fact that almost every country has its own definitions, different methods of assessing disability, and different levels of capacity to manage medical resources. For this reason, among others, descriptive definitions are increasingly more often being published, capturing as broad a spectrum of symptoms as possible, taking into account their severity, durability and extent, as well as the resulting consequences. Since the concept of disability relates to human functioning in many areas of life, the problem of disability is of great interest to many scientific disciplines. Therefore, many researchers develop definitions and terminology for their own purposes. This and many other reasons account for the fact that, in the near future, a universal definition of a disabled person and the concept of disability will not be developed. Despite the authors’ efforts to maintain the neutrality of the terms and phrases used in the available definitions, each term acquires a subjective meaning over time [18, 19]. Nonetheless, in order to avoid arbitrary interpretations of definitions and legislation, it is necessary to organise these terms, taking into account the scheme of the scope of their usefulness.

Additional difficulties are posed by the multi-dimensionality of health assessments which result from the WHO expert recommendations. Apart from the objective scopes of health assessment, self-assessment by the disabled person is very important, and often the categories of these assessments are divergent [18, 19]. This problem is accurately recognised by Kabsch, who stated that: ‘Disability is as individual a characteristic, as only a person can be an individual’ [20].

Modifying the definition of a disabled person – a need for changes arising from the necessity to broaden the scope of rehabilitation activities.

The term ‘disability’ consists of a number of characteristics taken into account in the assessment of health, on the basis of which the most important health and social needs are determined. In defining the concept of disability, it is essential to know how to define health and disease. It is important to emphasise that work on these definitions has also not been completed [21]. For reasons of universal accessibility, these definitions are not included here.

While developing definitions of disability, many researchers – mainly doctors, nurses, psychologists and sociologists, educators and lawyers – take into account the fact of emerging new phenomena in terms of health, environmental or economic, and social conditions. These include, among others, the discovery of new genetic defect syndromes, the emergence of new or recurrent diseases or new pathogens, increase in the number of people diagnosed with multimorbidity, and new or increasing social pathologies.

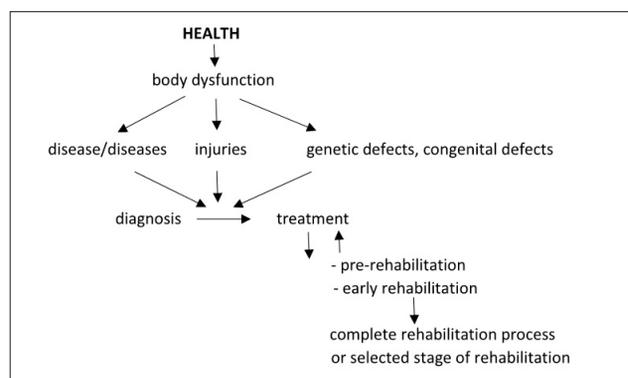


Figure 1. Co-occurrence of rehabilitation activities with the treatment process. Source: own studies

These are reasons why the definitions of disability should be enriched with new elements. With these changes, there appears a need to develop new, sensitive measures of the ‘quality’ of disability, which are essential for the assessment of the health status and identification of medical and social needs, which, in turn, will determine the scopes of rehabilitation interventions [22, 23].

A valuable scale presented by Rashid has great potential: The Comprehensive Rehabilitation Outcome Measurement Scale (CROMS), developed in compliance with the Delphi process, and takes into account the comments from various rehabilitation experts [24, 25]. The scale provides an opportunity to determine the correspondence between the therapist’s rating scale and the scale provided by the patient applying the intraclass correlation coefficient.

The Cochrane Rehabilitation Group is also involved in the search for a new definition of disability. In the project presented, this group emphasizes the difficulties in defining inclusion and exclusion criteria for interventions in rehabilitation [26].

An important contribution to the discussion on further work on defining the measurement of health and disability is the International Classification of Functioning, Disability and Health (ICF) adopted on 22 May 2001. The main objective of the ICF is to adopt, as far as possible, a uniform language allowing the description of health and health-related conditions. This Classification defines the components of health and certain health-related conditions of well-being, and are therefore divided into health domains and health-related domains. They are described from the perspective of the human body, the individual person, society, and included in two lists: 1) functions and structures of the human body and 2) activity and participation [27].

Objectives, tasks and philosophy of rehabilitation as a process.

Concepts and definitions of rehabilitation are available in the works of numerous specialists, not only in the medical field, and just like the definitions of disability, they too are variously understood and interpreted. Rehabilitation, understood as a process, was not appreciated until the 19th century. It constitutes a unique, irreplaceable support for people with disabilities. Rehabilitation (Latin *re* – again, anew, against; *habilis* – fit, proper, appropriate) has already become an indispensable component of the social development of every modern country society [28]. As a continuous process during varying lengths of time, rehabilitation offers opportunities to return, if not to full

health, but at least to maintain it at a stable level. In the absence of such opportunities, rehabilitation measures may result in the development of compensatory mechanisms which, to varying degrees, will be able to replace lost bodily functions. This process offers the possibility to restore or shape a disabled person's loss, the most important biological, family and social functions. Achieving this goal is possible through the implementation of therapeutic, vocational and social rehabilitation tasks that make up the whole rehabilitation process (Fig. 1). Such understanding makes it possible to distinguish between disease and disability. A person with a disability, especially in the period at the end of a treatment process, expects such life, social and economic opportunities in the achievement of the intended goal, the same as a non-disabled person. Rehabilitation understood in this way often enables a disabled person to return quickly to his or her family and society. An interesting, though rather broad, definition of rehabilitation was presented by Krasuski: 'Rehabilitation is understood as a continuous, ongoing social process, resulting from the activity of various self-governmental, national, charitable institutions, foundations – and its purpose is to provide such conditions so that a disabled person could return to full health, and in the absence of such a possibility, develop compensatory mechanisms that would replace the lost functions of the organism' [28].

Special emphasis ought to be placed on the importance of the Polish model of rehabilitation, which is also known as the Polish School of Rehabilitation which was developed by the eminent Polish orthopaedic surgeons Wiktor Dega and Marian Weiss. The quality of this model was appreciated not only in Poland but also worldwide. The founders of the Polish model of rehabilitation gave it four characteristic features: universal, early, comprehensive and continuous. Universal, meaning accessible to all patients in need, also refers to the concept of interdisciplinarity (all fields of medicine). Early initiation, meaning improvement of the patient both before an elective surgery (now called pre-rehabilitation) and immediately after the surgery. Early initiation also applies to patients with all other diseases, including neurological, cardiac, respiratory problems.

Comprehensiveness – rehabilitation in the form of functional treatment and also, in the case of major body dysfunctions, rehabilitation is carried out by a multi-specialist rehabilitation team. Depending on the needs, the team includes doctors of different specialties, e.g. neurologist, orthopaedist, neurosurgeon, rheumatologist, oncologist, cardiologist.

Continuity – means that rehabilitation is to be uninterrupted, with medical, occupational and social rehabilitation carried out simultaneously. The concept of continuity of rehabilitation also means continuation of rehabilitation after leaving the rehabilitation centre, that is, in the conditions of the living environment [29, 30] (Fig. 2).

As early as in 1995, Professor Witor Dega said that, 'If therapeutic rehabilitation is not closely connected with social and vocational rehabilitation, the outcome of rehabilitation will not be complete' [29]. In 1960, Dega organised the Department of Rehabilitation Medicine in Poznań, one of two departments in the world, with the other centre for Comprehensive Rehabilitation was established by Professor Howard Rusk in New York [30, 32]. These specialists were the first ever pioneers of modern medical rehabilitation. Professor Dega's professional achievements led the Polish Ministry

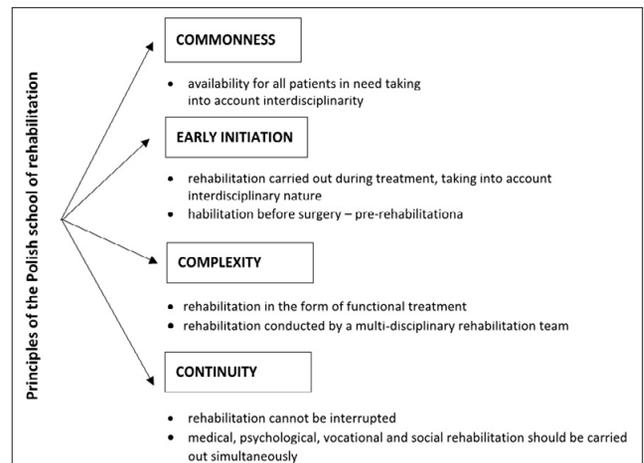


Figure 2. Four principles of the idea of the Polish School of Rehabilitation [31]

of Health to integrate rehabilitation into the framework of health care in 1969, and in 1970, the European Office of the WHO recognised a programme of comprehensive rehabilitation present at every stage of treatment as the model [33].

According to Szawłowski and other rehabilitation specialists, the philosophy and content of this School's programme are still relevant and should continue to be the foundation of activities in many other countries. Obviously, some of the aspects ought to be extended, modified and adapted to the tasks imposed by organisational changes in health care, environmental and social conditions [6].

Currently in Poland, the coordination of therapeutic, occupational and social rehabilitation and rehabilitation carried out in spa facilities is insufficient. One of the main reasons is the lack of coordination on the part of payers of public funds. This not only affects the treatment of patients (it is difficult to measure outputs and outcomes), but also makes it difficult to summarise the total expenditure on therapeutic rehabilitation. In many countries, different amounts of money are spent on rehabilitation (per patient), e.g. in Poland the resources allocated to rehabilitation (expressed in pay per room) are more than seven times lower than in France, about five times lower than in Austria and Belgium, and three times lower than in The Netherlands [34].

Another problem is the difficulty in diagnosing the real health and social needs of people with disabilities. Since this is a public health issue, the development of maps of health needs is reasonable as they can contribute to the long-term identification of problems and needs within the areas or regions of a country [17].

Rehabilitation as a method of choice for social and vocational integration. Vocational rehabilitation is one of the most crucial factors that, when implemented correctly, effectively integrates disabled people into society. This stage of rehabilitation can be applied to people with any disease, and is particularly beneficial for post-injury persons of working age. The scopes of vocational rehabilitation are used depending on the therapeutic methods of procedures and the progress of psychological rehabilitation and, therefore, the effectiveness of rehabilitation measures is linked to varying degrees to the content of the definition of disability, and the content of the definition of rehabilitation (Fig. 3).

Effective interventions, coordinated by multi-disciplinary interaction, are necessary in every field of rehabilitation, as otherwise the return to work is delayed or even impossible, which has an adverse impact not only on the health of the person with a disability, but on his or her financial stability, as well as the need to use State health services [35, 36]. Interesting results were obtained by Radford, from a study of post-stroke people, who showed that two-thirds of the subjects returned to work within 12 months after a stroke. She found that return to work was heterogeneous in nature, and might have a dramatic impact on work status, working hours and income [36].

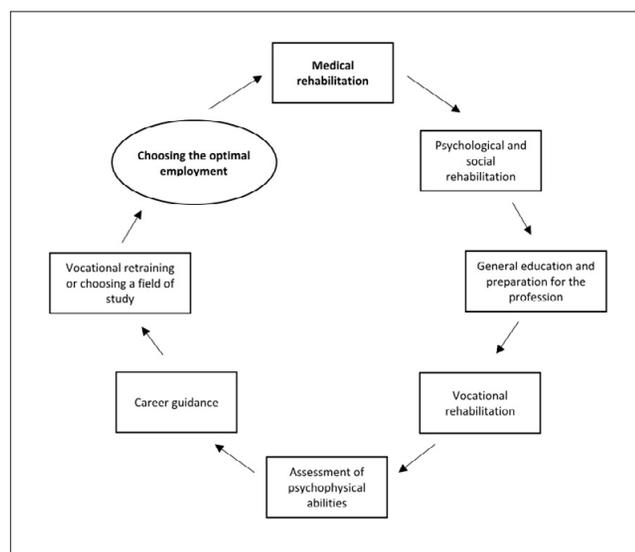


Figure 3. Factors supporting employment opportunities for people with disabilities. Source: K. Czechowski and A. Wilmowska-Pietruszyńska [37]

Poland continues to have one of the lowest employment rates of disabled people in the European Union. Less than 0.5 million out of 4.5 million disabled people of working age are employed [38]. This indicates a lack of availability or limitations to the implementation of rehabilitation measures which, after all, are supposed to ensure that disabled persons, regardless of the type of disability, can enjoy social and economic participation as much as possible, and also to be as independent as much as possible.

Nughara et al. rightly divided the scopes of research in physical medicine and rehabilitation into five areas: 1) biosciences in rehabilitation; 2) biomedical rehabilitation sciences and engineering; 3) clinical PRM sciences; 4) integrative rehabilitation sciences; and 5) human functioning sciences [22].

A disabled person will never achieve the full effects of rehabilitation without the implementation of the individual stages in the living environment. Even the best achievements in inpatient treatment and rehabilitation will be futile without its continuation in the living environment of the disabled person. These circumstances quickly lead to secondary disabilities. In this situation it is extremely difficult to achieve favourable rehabilitation effects again, particularly in people with severe body dysfunctions, mainly of the musculoskeletal system, and in older age groups. The psychological reasons are probably the biggest barrier, including discouragement, disappointed hopes and lack of prospects for successful rehabilitation resulting in an employment.

All over the world, people with disabilities have lower employment rates compared to the general population. In developing countries, between 80 – 90% of people with disabilities are unemployed [39]. The reasons for this are numerous, the vast majority of which, unfortunately, are social barriers. There is a perceived social distance in the work environment which often contributes to a biased view of the capabilities of disabled employees in such a way that people with disabilities are seen as helpless, lacking opportunities for advancement, and unable to achieve similar levels of productivity as their colleagues [27].

Multi-morbidity as a challenge for the rehabilitation process. In recent years, researchers have recognised a growing problem related to the ever-increasing numbers of people suffering from two or more diseases, which is referred to as multi-morbidity. Multi-morbidity is defined as the co-existence of one chronic disease with one or more acute/chronic diseases, or somatic or biopsychosocial problems/risk factors [40]. According to the WHO, multi-morbidity refers to the simultaneous presence of multiple chronic diseases (i.e. physical and psychological), treated with the intention of addressing all diseases in one person that may affect that person's overall health (i.e. with reference to all medical procedures, products, drugs, etc., recommended for each disease, and their potential interactions) [41].

The actual extent of multi-morbidity is extremely difficult to estimate due to the lack of uniform definitions and lack of methods of classification and qualification. Therefore, the existing evidence base is fragmentary and difficult to interpret scientifically. This also applies to persons with chronic infectious diseases, mainly hepatitis C [42, 43]. There is also little data on the effectiveness of services and health systems for patients suffering from multi-morbidity. In most countries, health care systems are meant for people with single diseases. Therefore, in the case of persons suffering from multi-morbidity, there is a huge underestimation of the needs related to rehabilitation activities [44, 45], and this is a condition that undoubtedly generates disability. For instance, the US Department of Health and Human Services (HHS) estimated that one in four Americans suffers from two or more diseases [46]. The research conducted by Sousa et al. show that in European countries there is a large variability in the occurrence of multi-morbidity in people aged 50+. An increase in the incidence was noted in Central European countries (Austria, Belgium, Czech Republic, France, Germany and Switzerland) and Spain among both genders, and in The Netherlands among men. Nevertheless, a stable situation was observed in the countries of Northern and Eastern Europe [47].

Multi-morbidity is most often associated with age, which is mainly related to demographic changes. However, available research shows that multi-morbidity is increasingly affecting people in younger age groups, and is attributed to multiple causes. This health problem is more common in people with lower socio-economic status, lower education levels, and may be affected by other variables, such as gender, ethnicity, multiple disabilities, and many health behaviours that are already known to increase the risk of single chronic diseases [48]. There is evidence that multi-morbidity is high in many populations, both in HIC (High-Income Countries) and LMIC (Low- and Middle-Income Countries) as well. So far, available evidence regarding the burden, determinants, prevention and

treatment of patients with multi-morbidities is insufficient [49]. This situation may change if doctors are trained in subspecialties in order to coordinate care for patients with several chronic diseases. This particularly concerns general practitioners, geriatricians and internal diseases specialists. There are already results from studies which indicate that, on the one hand, multi-morbidity may be a set of random individual conditions, but on the other hand, may be a series of largely predictable diseases affecting the same person, for instance, in the case of diabetes – a disease that generates many pathological multi-organ processes [50, 51].

Despite scarce epidemiological data on the most common groups of diseases, it is already known that multi-morbidity is highly heterogeneous. Patients may experience a wide range of different combinations of contributing conditions. In some persons, comorbidities may have similar treatment requirements due to a common etiology, and this state is referred to as ‘concordant multi-morbidity’. Another group of people may be affected by disharmonious multi-morbidity in which the conditions seem to be unrelated or require a different management approach [52, 53].

SUMMARY

The percentage of people with disabilities in almost all countries is defined mainly in terms of estimates. The main reason for this is the lack of uniform methods and rules for qualifying people as being disabled, despite the fact that there are about 50 definitions and descriptions of a disabled person in scientific literature, laws and other legal documents. Taking into account the lack of consensus in defining the state of disability, it is necessary to agree with the fact that there are many differences in the content of the definitions, e.g. differences in culture, quality of life, level of economic functioning, causes of disability, political conditions, and many others. It is no exaggeration to say that it is not possible to clearly define both disability and a disabled person. Therefore, as far as possible, care and support for disabled persons should be based on a reliable assessment of their health condition, medical and social needs resulting from the consequences of disability, and reference to adequate needs in rehabilitation proceedings.

It should be clearly emphasized that many achievements and solutions in the field of knowledge about disabilities are underestimated in many European countries, including Poland. It is a great pity that the programmes of the Polish school of rehabilitation have been largely abandoned. New, often inconsistent research, legislative and organizational changes in the care of disabled persons, as well as insufficient funds for rehabilitation activities, have led to stagnation in improving the quality of life of these social groups.

In the 1990s, 12 compact works were published, the issues of which can certainly constitute a basis for the development of scientific activities, taking into consideration the current political and social reality. The expert opinion edited by outstanding specialists in the field of medical and social rehabilitation – Professor Jerzy Kiwerski and Professor Antonina Ostrowska, entitled *The state of rehabilitation and rehabilitation needs of persons with particular types of disabilities* is particularly noteworthy. These included, for instance, disability caused by circulatory system diseases, severe motor disability following spinal cord injuries,

disability caused by nervous system diseases, rheumatoid dysfunctions of the motor organs, disability caused by malignant tumours, disability due to chronic lung diseases, and disability caused by deafness and blindness [54].

Rehabilitation is undoubtedly a crucial health strategy and ought to be implemented at all levels of the health care system. Scientific evidence is essential to further strengthen the significance of rehabilitation, the activities of which are integrated with the definition(s) of disability.

Harmonized activities resulting from the definition of disability and rehabilitation constitute a process (or its stage/stages) that offers great opportunities for improving the quality of life and full participation in society. Continuation of rehabilitation activities in the disabled person's living environment is often neglected, which almost always triggers the destruction of previous achievements, and results in secondary disability. This type of problem more often concerns disabled persons living in small towns and villages.

A vital and often underestimated problem is the need for greater commitment in the implementation of tasks on the part of the patient, his/her family members, and the rehabilitator and other specialists who form a special team.

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