

**Prospects and contributions
of extending future rehabilitation
practices to urban green spaces and
community-based rehabilitation:**

Experiences and perceptions of people with
disabilities and health professionals

PhD dissertation

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PhD dissertation

2021, Louise Sofia Madsen

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Financial support

Aarhus University

Folkesundhed I Midten

Familien Hede Nielsens Fond

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Thanks to
Photographer Thomas A. Christensen
for providing the cover image.

Acknowledgements

My sincere gratitude goes to the people who have made this work possible.

My most grateful thanks go to all the persons participating in rehabilitation and their health professionals who kindly spent valuable time participating in my studies and generously sharing your personal considerations, experiences perceptions and individual stories during my fieldwork and interviews. I would also like to thank the management at the Orthopaedic Rehabilitation Centre, Neurological Rehabilitation Centre and Dementia Activity and Rehabilitation Centre, who invited me into their clinical settings.

I owe a special appreciation and grateful thanks to my main supervisor Professor Claus Vinther Nielsen and my co-supervisor Associate Professor Charlotte Handberg. You have shown great trust in the importance of my work and my ability to accomplish it. You have continuously challenged me to keep developing through rewarding and constructive discussions and feedback. Lastly, you have been an invaluable support and inspiration throughout the whole process and I appreciate all the fun memories we have shared.

I wish to thank Professor Sonya L. Jakubec for hosting me at an inspiring research stay at the Mount Royal University, Calgary, Alberta, Canada, and for introducing me to the inspiring people engaged in the practice field in the town of Canmore. I appreciate your great, commitment and interest in my research and your participation as a co-author. I look very much forward to hopefully returning to Canmore and continuing our fruitful discussion and friendship.

Thanks to John L. Oliffe at University of British Columbia, Vancouver, Canada, for inspiring feedback and rewarding discussions on the study in which he participated as a co-author.

A special thank goes to lecturer Dorthe V. Poulsen for inspiring dialogues and collaboration and for the constructive contributions to the study in which she participated as a co-author.

I owe a very special thanks to my dear colleagues at DEFACTUM, MarselisborgCentret. It has been an incredibly inspiring and fun working environment for me throughout my PhD. You have all contributed in a very special way with rewarding discussions and endless fun. A special thanks to my office colleagues and great friends Birgitte and Louise. It has been invaluable to share all the aspects and joys that comes with doing a PhD study.

I owe a very warm thank you to the interpretive description journal club network based in Aarhus for rewarding discussion and your amazing company.

I would like to express a sincere thanks to my family and friends for their curiosity towards my project and never ending encouragement. A special heartfelt thank you to my possibly

biggest cheerers of all, Camilla, Charlotte, and Maya for your caring nature and for being on the sideline over the past three years.

I would like to thank my parents, my big brother and sister-in-law and my grandmother and granddad for always being understanding, showing great love, and unconditional support as well as interest in my work throughout this PhD.

With my deepest love and respect, I thank Mathias for the understanding, endless support and cheers for the last three years. Thank you for giving me the best possible conditions for accomplishing this PhD, surrounded by the calming nature and our loving dogs. To everybody who knows me, it is a necessity to thank Bente, my beloved four-legged friend, who have been by my side all the way.

This PhD dissertation is based on the following articles

- Article I. **Community-based rehabilitation approaches in outdoor settings: a systematic review of people with disabilities' and professionals' experiences and perceptions.**
Madsen, L.S.; Handberg, C.; Jensen, C.M.; Nielsen C.V.
Published in: Disability & Society. 2020, June 26.
doi: 10.1080/09687599.2020.1783206
- Article II. **Navigating a Middle Ground - Exploring Health Professionals' Experiences and Perceptions of Providing Rehabilitation in Outdoor Community Settings.**
Madsen, L.S.; Nielsen C.V.; Oliffe J.L.; Handberg, C.
Published in: Qualitative Health Research. 2020 September 3; 31(1), pp. 41–53. doi: 10.1177/1049732320951771
- Article III. **The potential of outdoor contexts within community-based rehabilitation to empower people with disabilities in their rehabilitation.**
Madsen, L.S.; Jakubec, S.L.; Nielsen C.V.; Handberg, C.
Published in: Disability and Rehabilitation. 2021 March 21.
doi:10.1080/09638288.2021.1897887
- Article IV. **“It Was Definitely an Eye-Opener to Me”—People with Disabilities' and Health Professionals' Perceptions on Combining Traditional Indoor Rehabilitation Practice with an Urban Green Rehabilitation Context.**
Madsen, L.S.; Poulsen, D.V.; Nielsen C.V.; Handberg, C.
Published in: International Journal of Environmental Research and Public Health, 2021 June 3; 18(11).
doi.org/10.3390/ijerph18115994

The articles are provided in Appendices 1-4.

Abbreviations

CBR	Community-based rehabilitation
HPs	Health professionals
ID	Interpretive description
MC	MarselisborgCentret
PWDs	People with disabilities
SPARK	Sound Park Activities, Rehabilitation & Climate
WHO	World Health Organization

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1.0 Motivation for the PhD

Rehabilitation for people with disabilities (PWDs) has traditionally been a primarily hospital-based subspecialty of medicine or an allied health intervention with an expert-driven approach (1-3). In economically privileged countries, rehabilitation typically takes place in indoor facilities designed for clinical purposes, using state-of-the-art equipment, exercises, activities and measures to ensure effectiveness (4). However, including urban green spaces and community resources in the rehabilitation process has become an area of growing interest; one that supports diversity in disability experiences by being integrated with everyday life situations (5-10).

In recent decades, research on the association between human health and green spaces has increased and grown into an interdisciplinary research field (5, 11-13). Research on the link between human health and green spaces points to positive impacts such as improvement of mental health (14-17), increased level of physical activity (18, 19), strengthened social connections (20, 21), increased quality of life (17, 22), and improved cognitive as well as immune responses (13, 23). Current research also suggests a positive impact in terms of enabling empowering experiences of PWDs (24-26) and experiencing a sense of belonging and equality (13, 17). Hence, there has been a growth in rehabilitation and other health services for PWDs utilising green spaces as a health promoting context to improve or maintain functioning (6, 7, 27).

Half of the world's population including PWDs live in urban areas (28, 29). Rehabilitation based in urban green spaces and public parks thus plays an important role (19, 30-32). There is focus on creating enabling environments (17, 19) for PWDs to benefit from outdoor experiences, which may include inclusive community development for this population (9). Including urban green spaces (13, 33) and community-based rehabilitation (CBR) strategies (9, 34) offers additional avenues to rehabilitation, that may challenge longstanding practices, but paves the way for new possibilities in future rehabilitation practice. This dissertation examines the prospects and possible contributions of urban green spaces and CBR in the future rehabilitation for PWDs.

My personal motivation and research interest driving the work of this dissertation are centred on a sincere wish to make a difference for persons who experience their life situation is disrupted because of a temporary or long-term change to their health condition. My perspective and engagement in the field of public health and rehabilitation is founded on a strength-based approach, exploring facilitators and resources to support a meaningful life.

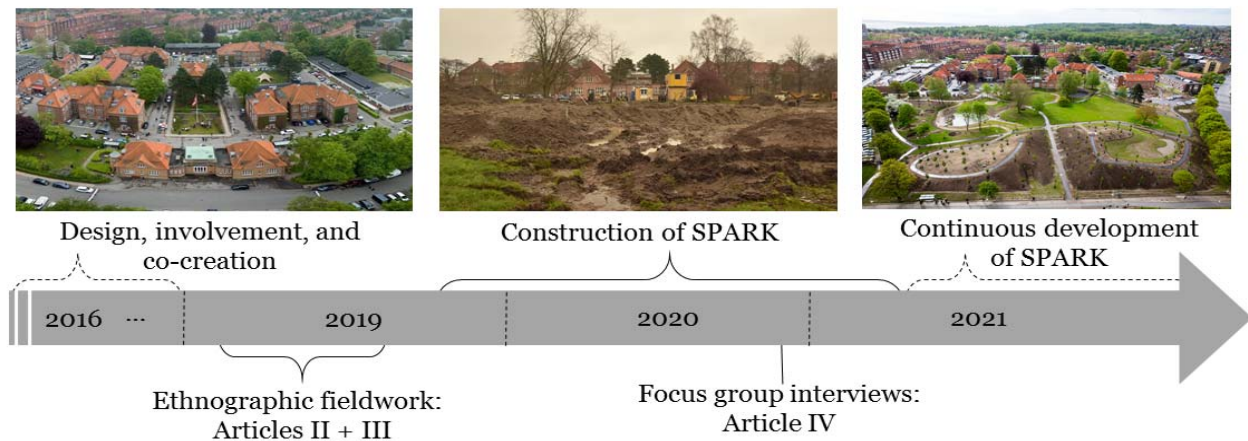
Before the introduction section, I will present and clarify the context of my analysis and this dissertation; the SPARK (Sound Park Activities, Rehabilitation and Climate) park.

1.1. Study context and clarification

The planning of this dissertation began in 2016, when my co-supervisor Associate professor Charlotte Handberg introduced me to the SPARK park project (35), which became the starting point of this PhD. SPARK serves as a demonstration project providing a possible rehabilitation context for an innovative example of an urban green space intervention: *actions that significantly modify the quality, quantity and accessibility of urban green spaces* (31, 34). At that time, the establishing of the SPARK park was settled (including the financing of approx. EUR 6 million) and the actual design phase was in progress (Figure 1).

Figure 1. Timeline of the MarselisborgCentrets transformation into the SPARK park and parallel data generation.

Photo credit: Thomas A "Christensen



The SPARK park is a 7.2-hectare urban green rehabilitation area currently under development in the outdoor surroundings of the National Rehabilitation Marselisborg-Centret (MC), Aarhus, Denmark (34). The MC is a collaboration between Aarhus Municipality and Central Denmark Region regarding rehabilitation services and is organised as a cluster organisation consisting of approximately 22 different facilities working with rehabilitation e.g., an orthopaedic rehabilitation centre, a neurological rehabilitation centre and a dementia activity and rehabilitation centre (35).

Construction of the SPARK park is a transformation of the current environment surrounding the MC into an innovative arena reflecting the varying social and physical contexts of everyday and societal life by combining rehabilitation, a public city park and climate adaptation solutions (34). Based on an extensive involvement process (34), the construction is aimed at providing a place which is socially cohesive and promotes social solidarity through development of a physical and socially inclusive urban green space, facilitating equal participation opportunities for PWDs.

Based on principles of CBR; the World Health Organization's (WHO) strategy for inclusive community development (9) and urban green space interventions (31), the SPARK park has the contextual surroundings to be a potentially unique example of innovative rehabilitation

solutions. Rather than providing a fixed intervention model, the idea behind SPARK is to encourage participation and rehabilitation in new ways relevant to users of the park, such as PWDs and health professionals (HPs), and to contribute to establishing a park community together with local residents. According to the original plan, this PhD dissertation intended to run parallel to the construction process of the SPARK park (2018-2019) and subsequently to follow how SPARK may be integrated into applied rehabilitation practices (2020-2021). As the construction of the SPARK park was delayed two years (2020-2021), this dissertation provides knowledge established throughout the ongoing development and construction of the SPARK park. Thus, it was not possible within the framework of this PhD to specifically examine how SPARK could be integrated into rehabilitation practices for PWDs.

Meanwhile, an action plan on urban green space interventions provided by WHO stresses that early detection of potential challenges and constraints is an important part of the development and planning process to maximise use and possible social and health benefits (36). Ongoing involvement of future key users in the development process is described as an essential part of this work (36). Accordingly, the experiences and perceptions of PWDs and HPs provide important insights into both individual and shared views on what should be considered for the future work of rehabilitation practice development and implementation of urban green spaces such as the SPARK park.

1.2 Knowledge gaps addressed in this dissertation

To gain an in-depth understanding of the prospects and contributions of urban green spaces and CBR in the future rehabilitation for PWDs, it is central to gain knowledge in the following areas covered by the four articles in this dissertation:

1. A growing body of literature points towards rehabilitation in outdoor environments and CBR initiatives as important on the continuum of rehabilitation to support diversity in the disability experience and underpin the rights of PWDs to equally engage in outdoor and community life. Knowledge is scarce on the perspectives of PWDs and HPs on rehabilitation in outdoor settings combined with CBR. The article provides an overview of potentials, opportunities and challenges in linking outdoor settings and CBR approaches as a resource in rehabilitation for PWDs.

Published in Disability and Society, Madsen et al. 2020, June (37).

2. Outdoor-based rehabilitation and CBR have demonstrated potentials for advancing rehabilitation outcomes for PWDs. HPs are the pillars in these initiatives with a strong potential to endorse or dismiss such new practices. Literature addressing the perspective of HPs regarding rehabilitation in urban green spaces and CBR is limited. Urban green spaces as a resource for promoting inclusive development of PWDs is unaddressed. There is a dearth of knowledge on HPs' experiences and perceptions on providing rehabilitation in an urban green context as well as literature on opportunities and challenges of extending conventional indoor rehabilitation practices.

Published in Qualitative Health Research, Madsen et al. 2020, September (38).

3. In the literature, CBR with integrated outdoor experiences, is suggested to provide opportunities for PWDs to learn how to overcome challenges of everyday life. Still, research is lacking on insights into the underlying mechanisms at stake when extending rehabilitation practices for PWDs. This served as an inspiration to gain knowledge on urban green spaces and CBR as a potential resource for promoting empowering experiences of PWDs in their rehabilitation.

Published in Disability and Rehabilitation, Madsen et al. 2021, March (39).

4. More studies describe the complexity of including urban green spaces in established health system services. An understanding of the challenges related to rehabilitation in urban green spaces remains unaddressed. This inspired me to explore knowledge sharing among PWDs and HPs to contribute to new mutual understandings and important practice insights to guide future practice development of rehabilitation in urban green spaces.

Published in, International Journal of Environmental Research and Public Health, Madsen et al. 2021, June (40).

2.0 Introduction

2.1 Rehabilitation for people with disabilities

During the course of life, most people are likely to experience some form of disability, temporarily or permanently, following an injury, illness, disease or because of age-related decline in functioning (28, 41). According to WHO, 15 % of the world's population are estimated to live with a variety of disability (28). To support PWDs (arising from any cause) to obtain optimal functioning in all aspects of life, rehabilitation can be an important and crucial factor (3, 28). Globally, the number of individuals with conditions that would benefit from rehabilitation is estimated to have been increased by 63% from 1990 to 2019 (3). According to WHO rehabilitation is defined as:

“A set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment” (42).

Due to an increase in political focus and interest in rehabilitation, a general Danish definition of rehabilitation was published in 2004 (43), in a White Paper on the concept of rehabilitation:

“A goal-oriented cooperative process involving a member of the public, his/her relatives and professionals over a certain period of time. The aim of this process is to ensure that the person in question who has, or is at risk of having, seriously diminished physical, mental, and social functions can achieve independence and a meaningful life. Rehabilitation takes account of the person's situation as a whole and decisions he or she must make and comprises co-ordinated, coherent, and knowledge-based measures” (43).

In this dissertation, I used a combination of the above definitions. Both definitions focus on improvements or maintenance in the individual's functioning. In Denmark and abroad, rehabilitation is increasingly prioritised as a concept and area of welfare. Additional to the White Paper in 2004 (43), an important report has influenced the political agenda on rehabilitation in Denmark, “Guidance to rehabilitation in the municipalities” (44). In 2011, the Ministry of Economy, the Ministry of the Interior and Health, the Ministry of Social Affairs and the Ministry of Education published a guideline for rehabilitation in the municipalities (44), which has later become integrated in Danish law within each administrative area. Within the Danish Health Legislation, the 2015 Declaration on rehabilitation plans and patient's choice of rehabilitation following discharge from hospital, deals with training plans and physical rehabilitation (45). Physical rehabilitation is an essential part of rehabilitation. However, a holistic approach is the aim applying a variety of initiatives within a biopsychosocial approach (46-50).

Rehabilitation from the perspective of PWDs may best be described as a change process; a processing of and adaptation to a person's life circumstances that closely relates to changes

in everyday life (51). Rehabilitation is set out to support the resources, personal autonomy and opportunities of PWDs to e.g., be a parent, a partner, have a connection to the labour market as well as participating in leisure activities or other social contexts (3, 52). The type of support needed vary considerably depending on the cause of disability and the surrounding environment. To best support the person in need of rehabilitation, a realistic professional assessment is essential of interventions, practices and measures available and needed (43, 53). This assessment should be based on a close dialogue with the person in need of rehabilitation.

2.2 Rehabilitation – practices and initiatives

The starting point for rehabilitation is that a person has or is at risk of having significant limitations in functioning and everyday life due to health conditions or social circumstances (3, 28, 43). Rehabilitation has been shown to be effective and needed across diagnoses, ages, settings and extend of disability (3, 28, 53, 54). Rehabilitation can help to reduce, manage or prevent complications associated with many health conditions, such as stroke (55), musculoskeletal injury (3) or dementia (56, 57). Specifically, rehabilitation after discharge from hospital has been shown to be effective (53).

Rehabilitation is a complex concept (53, 58). There is no consensus on how to describe different levels, phases, or forms of practices in rehabilitation as it depends on a person's functioning, values, resources, environment of daily living and society's opportunities to meet individual needs (43, 47). Further, specific diagnostic initiatives e.g., strategic programmes, structural priorities and legal requirements in the field of rehabilitation impact on specific practices (43, 47). Interventions in rehabilitation can be considered as an arena with different forms of practices - evidence-based and practice-based initiatives (47). Wade (53) highlighted that the interventions mentioned most frequently in reviews on rehabilitation and with the best effect are exercise, education and self-management as well as psychosocial support. Rehabilitation is typically delivered by HPs belonging to the professions of physiotherapy, occupational therapy, nursing, psychology, general practitioners and social workers but also by e.g., prosthetists, speech and language therapists and audiologists (42). The setting of delivery of rehabilitation may vary from inpatient or outpatient hospital settings to private clinics, community settings such as municipal rehabilitation centres or the home of PWDs (43, 53).

In Denmark, rehabilitation is provided free of charge as part of a tax-financed welfare system. The majority of rehabilitation is carried out within the municipalities by specialised rehabilitation professionals or teams (44). The overall effort must be directed towards the person's entire life situation and both current and future goals based on a collaborative process between PWDs and HPs with ongoing adjustments using a problem-solving approach (43). Often rehabilitation is an interdisciplinary effort combining physical exercises, psychosocial and pedagogical components, typically lasting 8-12 weeks (44). Solid evidence underpins the effectiveness of physical exercise across different groups (53, 59). Strong evidence has been found for task-oriented and task-specific training after stroke

with improved performance of a specific function such as walking (60). Most activities are delivered in an indoor training facility or gym setting, enabling continuous assessment and documentation of performance and progression of body functioning (61). The psychosocial component often takes the form of education, self-management, cognitive therapy, mastering of psychological and emotional reactions, peer-support or practicing of mindfulness and is typically delivered in an indoor setting with confined external social stimuli (47, 53, 62). Evidence in this area is not as solid, but the varying social context may challenge rigour of structured research designs (53). In rehabilitation, documentation is a considerable element in the creation of a coordinated and transparent course of the rehabilitation process, including documenting and evaluating if quality standards and goals are met (43).

2.3 Community-based rehabilitation

Traditional rehabilitation is intended to support the individual person and does not address and remove barriers at society level (28). Yet, in WHO's Global Disability Action Plan 2014-2021 (63), CBR is suggested as an essential strategy to complement existing rehabilitation initiatives and optimise support of diversity in the disability experience. CBR is WHO's strategy for inclusive community development of PWDs (9). A CBR strategy employs a rights-based approach, including five main components: health, education, livelihood, social equity, and empowerment (9). To improve participation opportunities of PWDs, the barriers causing restrictions to daily living should ideally be addressed. Therefore, CBR is increasingly considered an important part of the continuum of rehabilitation to support inpatient care and rehabilitation services in general (28, 64).

Originally, CBR was developed as a strategy for use in low- and middle-income countries to improve access to rehabilitation services for PWDs through use of local resources (9). The early years of CBR placed much emphasis on individual-focused services, medical and surgical therapies, education, and vocational training (65). Prior to the development of the CBR guidelines in 2010 (9), CBR has grown and evolved into a global multi sectoral strategy to address the broader needs of PWDs, ensuring participation and inclusion in society and optimising quality of life (9). CBR is based on a "twin-track" approach addressing individual needs of PWDs on the one hand and promoting enabling environments on the other (65). The CBR approach is thought to optimise physical and mental outcomes, personal agency, accessibility to resources and opportunities for participation; however, the approach varies across cultural contexts (1, 66, 67). While application of CBR strategies in low- and middle-income countries is well established (68), the inclusive CBR strategy does not fit naturally into already well-established and highly specialised health systems in economically privileged countries (1,69). Thus, to achieve inclusive development for PWDs, new pathways, and opportunities must be explored (1, 67).

2.4 Rehabilitation in a green space context

To support diversity in the disability experience and include everyday life situations, rehabilitation practice has started to rethink use of natural and urban green spaces as a resource in and context for rehabilitation for PWDs (6, 7, 27). Outdoor adaptive activities in rehabilitation are suggested to support PWDs to adjust to the potentially drastic life changes caused by disability and to provide new life opportunities (37). Extending the rehabilitation context may move attention away from the limitations of disability and motivate participants to strive to improve functioning and learn new strategies (37). By facilitating a variety of physical and social contexts with different levels of difficulty, outdoor and urban green spaces may enable PWDs to overcome challenges of community engagement (19, 39), build empowering experiences (24, 25, 37) and even encourage more physical activity (18, 19).

Emerging research suggests that PWDs benefit from including green spaces in their rehabilitation process (5, 6, 37). Current trends of utilising urban and natural green spaces as restorative and health promoting settings may be viewed as modern interpretations of original views of the relationship between humans and nature (30, 32). Building on scholars such as Shafer and Meitz (70) and later Ulrich (71, 72) and Kaplan and Kaplan (14), research exploring and documenting the impact of green spaces on health and well-being has increased substantially (7, 11-13). As a result, there has been an increasing number of interventions and actions using green spaces as a resource for health promotion and disability support (7, 8, 73). To obtain an overview of the diversity in the field, a description of the empirical knowledge and potential evidence for targeted groups will be presented and followed by type of intervention.

PWDs make up a large heterogeneous group (28). Among a broad range of targeted groups, the strongest evidence of health benefits from natural environments is found in populations with stress-related illness or depression (14, 22, 71, 74, 75). Further, positive effects for specific groups have been identified, including people with dementia (76, 77), cancer survivors (78), people with physical impairments (5, 79, 80), people with Parkinson's disease (81, 82), people recovering from spinal cord injury (83, 84), and people with acquired brain injury (6, 79, 85). Jakubec et al. (17) have shown beneficial trends in quality of life for people with disabilities as a group. Active engagement as well as passive exposure to natural environments have been shown to have potentially positive effects (32).

The types of interventions involving green spaces demonstrating an effect can be divided into directions, although more can be found to overlap. Nature-based/assisted therapy/rehabilitation has evolved as a well-described and well-established concept in Scandinavia (16, 24, 75). Nature-based interventions are developed from Aesthetic Affective Theory (71) and Attentive Restoration Theory (14) and use nature as a restorative element in the treatment and rehabilitation of people with depression or stress-related illnesses (16, 24, 75). A systematic review of randomised controlled and observational studies on nature-assisted therapy showed that a small but reliable evidence base supports the effectiveness of nature-assisted therapy as a relevant resource in public health (7). Related interventions are

horticultural therapy (73, 86), and wilderness/adventure therapy (87, 88). In Japan and China and in other parts of the world, the concept of forest bathing has become a widespread approach, showing reductions in heart rate and blood pressure and improvement in stress-related conditions (27).

Green exercise, including green prescription programmes, refers to physical outdoor activities in natural environments (including outdoor gym settings) and has been shown to provide improvements in mental health (89-91). Further, a substantial health effect has been demonstrated from being physically active in a natural environment compared with being physically active indoors such as in a gym (18). Another direction is outdoor recreation for PWDs, which focuses on providing inclusive outdoor experiences through adaptive activities of for instance, hiking, skiing and kayaking, often including family members and volunteers (17, 26, 84, 92). Participation in outdoor recreational activities has been associated with improvements in mental well-being and a feeling a sense of equality (17, 26). Nevertheless, severe impairment, serious pain, or co-morbidity may result in negative experiences when engaging in outdoor recreational activities despite adaptations (79, 84). Lastly, the concept of green care farms, including animal-assisted therapy, is a growing trend combining health and green environments with activities related to agricultural production (25, 93). The green care farm initiatives have been acknowledged to serve as an innovative nursing home for people with dementia, as it provides an attractive, homelike environment with activities that positively influence engagement and social interaction (93). Green care farming interventions have been shown to improve quality of life across diagnoses (25).

2.4.1 Urban green spaces and community-based rehabilitation

The extensive literature documenting positive links between human health and green spaces, supports the important role of urban green spaces and public parks as half of the world's population, including PWDs, live in urban areas (19, 30, 31, 36). Supported by global disability inclusion documents (9, 28, 94), increasing attention has been drawn to improving accessibility for PWDs to different environments, including urban green contexts (5, 17). Environments, physical, social, and attitudinal, can either be disabling or foster the participation and inclusion of PWDs (28). Barriers are common for accessibility to outdoor and urban green spaces (5, 37). Even if physical barriers are removed, social exclusion and negative attitudes can still produce barriers for social and community engagement (5, 37). To enable PWDs to benefit from outdoor experiences also for rehabilitation purposes, supportive environments, both physically and socially, need to be offered and improved (17, 19, 37).

Extending rehabilitation to urban green spaces including a CBR strategy may help PWDs to build confidence in own capabilities and move personal boundaries as well as strengthen the ability to overcome challenges of everyday life (37). This confidence has been suggested to extend to other aspects of life such as family, friends, and job opportunities (26). Outdoor inclusive environments and adaptive activities may serve as a social gathering point, where people can share experiences and be equally included in social communities

(17, 37, 95). Still, specific contributions to the way rehabilitation practices may be influenced in urban green contexts, including CBR, remain unaddressed.

2.5 People with disabilities

According to WHO disability is:

“The outcome of the interaction between individuals with a health condition (e.g. cerebral palsy, down syndrome or depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social supports)(41).”

The WHO’s definition is used in this dissertation and takes its point of departure in the International Classification of Functioning, Disability and Health framework (50). In this framework, functioning and disability are understood as a dynamic interaction between health conditions and contextual factors, both personal and environmental (50). The definition of disability as an interaction defocuses disability as an attribute to the individual person (9, 28). Contemporary views have adopted a biopsychosocial approach to disability; a balanced understanding that people may be disabled by environmental factors as well as by bodily functions (28, 50).

Disability can impact considerably on daily living of PWDs and disrupt the life pattern of both PWDs and relatives (28). To some, this process can be managed on their own, while others need to be supported and learn how to adapt to the changed life circumstances (28, 51). For instance, persons who are influenced on the musculoskeletal system, caused by e.g. low back pain or a knee injury may experience temporary or long-term loss in functioning, and are most often offered physical rehabilitation (3). The persons who are affected by cognitive impairments after e.g. acquired brain injury or stroke often experience their functioning to be affected in more areas, and may need rehabilitation support in more areas, such as physical function, the performance of everyday activities and in relation to social participation (55). Whereas persons with an illness such as dementia may be in need of professional rehabilitation support for maintaining or slowing down loss in functioning (56).

In the literature, it has been suggested that there may be a lack of coherence between rehabilitation initiatives and the subsequent everyday life of PWDs (47, 51, 96, 97). A report examining rehabilitation practices in Denmark based on 72 empirical case studies indicated that the experience of coherence in everyday life is by many perceived as lacking (98). Nunnerley et al. (96) examined the experience of community (re)integration of persons after spinal cord injury. They found that a focus on physical rehabilitation in particular may have reduced the participants' possibility to participate in other forms of community reintegration such as leisure and work activities. Furthermore, unmet needs have been reported among PWDs in the period following rehabilitation; this stage is experienced as a hard transitional period for some without the support of HPs (96, 97). The fact that people live longer but with potentially more disability requires new standards for the content of

rehabilitation services in close connection to the everyday lives of the persons participating in rehabilitation (3, 28). In the literature, outdoor-based rehabilitation and CBR are suggested to provide opportunities for PWDs to learn how to overcome challenges in everyday life (37). Still, research is lacking on insights into the way rehabilitation for PWDs may be influenced by including urban green spaces and CBR.

2.6 The role of health professionals

The complexity of rehabilitation leads to difficulties for HPs as there is no complete manual (53). Research points to the health benefits of rehabilitation in urban green spaces including a CBR strategy (37). Complexities related to including outdoor contexts and CBR into established health systems in a western context have been indicated (1, 99, 100). HPs play a central role in these initiatives as they have a strong potential to endorse or dismiss such innovative ways of conducting rehabilitation (101). In a qualitative study by McCluskey and Middleton (99), more HPs did not perceive outdoor-based rehabilitation to be part of 'real professional practice', and therefore took on a role as gate keepers. Moreover, HPs have been shown to struggle to build confidence to deliver rehabilitation outside the traditional centre-based setting (26, 79, 99).

HPs apply different competencies and contributions to the rehabilitation course of PWDs (42). For instance, the role of occupational therapists can be characterised by the goal of enabling an active way of life for the individual person through a focus on activity and participation (102). The work of an occupational therapist often involves conversation as an important tool supplemented by specific investigations on the level of body functions (102). Professional competencies of physiotherapist cover movement, training, exercises and communication with a focus on bodily learning, control, movement experience and reflection (42, 103). The role of HPs in a modern health organisation and in holistic rehabilitation is also to contribute to the shared interdisciplinary work in a person's course of rehabilitation to achieve the best possible result (103). Besides being experts within their special disciplinary field, they are expected to be attentive to the body functions of PWDs as well as social roles and concerns of the individual (42). Core values of HPs will most often build on a broad understanding of what is important for the individual person attending rehabilitation in relation to his or her everyday life situation. Nevertheless, this set of values may be challenged when the HPs' practice is set within an organisational frame where the fundamental task may be more focused (103). HPs are known to play a key role to ensure safety and provide social support, but the literature is sparse on the HP perspective on opportunities, challenges and motives of extending rehabilitation into urban green spaces and CBR (37).

3.0 Aims

The overall aim of this PhD dissertation was to explore the experiences and perceptions of PWDs and HPs on extending rehabilitation practices and establish a practice-based understanding of the prospects and contributions of urban green spaces and CBR for future rehabilitation.

This PhD project consists of four substudies and the individual aims addressed are specified below:

1. To examine and synthesise qualitative knowledge of PWDs' and HPs' experiences and perceptions regarding facilitators and barriers to CBR approaches in outdoor settings (37).
2. To examine HPs' experiences and perceptions of providing rehabilitation in urban green spaces. The purpose is to use these experiences to generate practice-based knowledge of using green spaces as a means to guide CBR (38).
3. To examine the potential of CBR in urban green spaces to empower PWDs in their rehabilitation (39).
4. To describe and analyse PWDs' and HPs' perceptions on combining traditional indoor rehabilitation practices with an urban green rehabilitation context (40).

4.0 Methods

In this chapter, I outline the foundation of this dissertation elaborating on the methodology, theories, methods and analyses. Given the nature of the project aims, a qualitative research approach was applied. Qualitative methods are considered appropriate when research is focused on the meanings and content of social phenomena as experienced by individuals in a natural context (104, 105). In particular, qualitative methods are considered applicable to understand a person's experience of participating as a part of the health care system such as attending rehabilitation, and to describe experiences and practices of HPs (106). Considerations regarding methodology, epistemology, ontology, and methods are appropriate in conducting qualitative research (104, 107). Interpretive description (ID) was chosen as the research methodology, which I will unfold as a starting point. The distinctive features of ID are used to structure the chapter, where I specify how these elements are implemented into this dissertation (104, 108):

- 1) *Scaffolding of the study, including a literature review and forming the theoretical forestructure.* First, the methods of the literature review will be presented in brief. Next, I will describe and elaborate on ID, the overall research methodology in this dissertation, including the theoretical framework which combines social practice theory and organisational culture theory.
- 2) *Framing of the study design, including sampling and data sources.* Sampling and strategising of a credible study will be unfolded and represented by the PWDs and HPs included in the empirical studies. I will unfold the setting of data generation. Next, the ethnographic fieldwork and selection of specific data sources with examples from the data construction will be presented: participant observation, photovoice and interview.
- 3) *Entering the field.* In this section, my considerations on my own positioning in the field and the decisions made prior to and during data construction will be unfolded.
- 4) *Data analysis; transforming patterns into findings.* The unfolding of the four-step analytical process of ID, leading to the final findings related to the overall aim of this dissertation.

To illustrate the chronology of the work process for the four articles of this dissertation Figure 2 is provided.

Figure 2. Chronology of the four articles of the dissertation.

	2018	2019	2020	2021
Article I	Review			
Article II	Ongoing analysis	Empirical		
Article III	Ongoing analysis	Empirical		
Article IV	Ongoing analysis	Empirical		

4.1 Methodology – interpretive description

This PhD draws upon the applied research methodology ID (104, 109), informed by social practice theory (110) and accompanied by organisational culture theory (111).

In this dissertation, I have engaged in the enquiry to establish a practice-based understanding of the prospects and contributions of urban green spaces and CBR for future rehabilitation of PWDs. I seek knowledge on the reinforcing and limiting factors for including urban green spaces and CBR into the continuum of potential actions for rehabilitation of PWDs. I sought to gain insights into the potentials, opportunities and challenges of extending rehabilitation to urban green spaces and CBR, how it is perceived by the HPs and PWDs - the future key-users - and if it makes sense in current rehabilitation practices. Hopefully, knowledge drawn from the individual and shared perspectives of PWDs and HPs can provide a research-based choice for initiating actions in rehabilitation practices for PWDs. This dissertation seeks to contribute with knowledge to create a solid foundation for further development of urban green spaces and CBR as resources in rehabilitation.

A main purpose in ID is to create new insight, understanding and knowledge, which can be applied in practice to improve and qualify healthcare system services (104). ID originally derived from a gap in applied research within a nursing tradition, although not reserved for nursing research (104, 112). ID may be considered ‘the new kid on the block’, but the methodology has already developed into a multidisciplinary approach within applied health research, sociology and anthropology (109).

ID was chosen as the methodology of this dissertation for several reasons:

1. To provide an organising logic throughout the different study phases (104). Conducting practice-based research is a main driver in my work with this dissertation. ID provides the opportunity to accomplish that, through offering an organising logic for constructing knowledge for and in practice (104). In ID, the basic premises are that knowledge is there to be useful in the sense of the applied practice world (104). To plan an ID study in a trustworthy and credible manner, appropriately aligned with the applied research aim, it is important to consider and continuously reconsider the many pieces of a design decision-making process (104). To plan for relevance in applied practice, I developed a predetermined sample strategy and choice of data sources as well as a main idea of the relevant theoretical frameworks, which provided a foundation for obtaining deep and rich knowledge (104). This plan was developed in cooperation with practice and my supervisors, but with an inherent flexibility for adjustments as the project unfolded.
2. To provide a frame within applied health research practice knowledge (104). In ID, the type of knowledge constructed concerns individuals in contexts, knowing what is particular to the subjective experience of an individual person. Attention is explicitly drawn to the value of subjective and experiential knowledge as one of the fundamental sources of applied practice insight. In ID, knowledge is not expected or considered to be

factual or fixed (104). Rather, relevant understandings will be processual, systematic, flexible, infinitely and adaptive. My choice of ID was to guide and inform disciplinary thoughts on extending rehabilitation to urban green spaces and CBR.

3. To apply an inductive and interpretive analytical approach (104). ID is an inductive research methodology, seeking a coherent conceptual description and in-depth interpretation of the relations and patterns within the phenomenon in question (104). The type of qualitative research conducted within the frame of ID draws on an interpretive explanation of the data material, similar to phenomenology, grounded theory and ethnography (104). To provide new insights, Thorne advocates for the need to go beyond the descriptive level to answer the “so what” of the research enquiry (104). Within this dissertation, ID provides direction in the creation of an interpretive account, which is generated on the basis of informed questioning, using techniques of reflective, critical examination (104). ID provides a contextual framework for developing a conceptual understanding in which all parts interact and are meaningful to one another configuring the wholes and parts of the data material. The engagement with data through ID processes enabled my analyses to move beyond obvious comprehensions and gave rise to new insights and relations (104).
4. To borrow relevant parts across different established methodologies disciplines and theories (104). ID challenges the idea of “following the rules” based on the assumption that in the human world things are not straight forward (104, 109). By being flexible both on the input and output, ID distinguishes itself from other methodologies by drawing on several already known research traditions such as ethnography, phenomenology and grounded theory (109). In this way, the idea of “methodological rigidity or orthodoxy” is dismissed. My inspiration for applying ID may be best described by this illustrative saying by Thorne (104), which symbolically explains how ID differs from other methodologies: *When the only tool you have is a hammer, all problems resemble nails*. In this dissertation, I apply elements borrowed from sociology, organisational psychology, landscape architecture and nursing science to best cover the research enquiry of this dissertation, although I am not formally educated within these disciplines.

Although ID is argued not to be a step-by-step methodology providing a ‘recipe’ for the research process, some distinctive features are applied in the research process to meet the principles of an ID study (108). These include scaffolding and framing of the study design as well as data construction, entering the field and data analysis.

4.2 Scaffolding of the study

The scaffolding of a study constitutes a distinctive feature of ID (104) and was a significant element throughout this dissertation, because it constituted the basis of the initial study design. Two critical elements of scaffolding were involved; first, a review of literature regarding “state of the science”, what is known and what remains unaddressed in relation to the study aim. Secondly, a clarification of the theoretical forestructure, where I position

myself and what I bring into the study as a researcher (104). I will specify the content of the two elements of scaffolding in the following sections.

4.3 Systematic literature review

To create a knowledge base and a starting point for this dissertation, a systematic literature review was conducted (37). To help avoid unplanned duplication and to enable comparison of reported review methods, the review was registered at inception and published in the International Prospective Register of Systematic Reviews, PROSPERO database (Registration number: CRD42018109844).

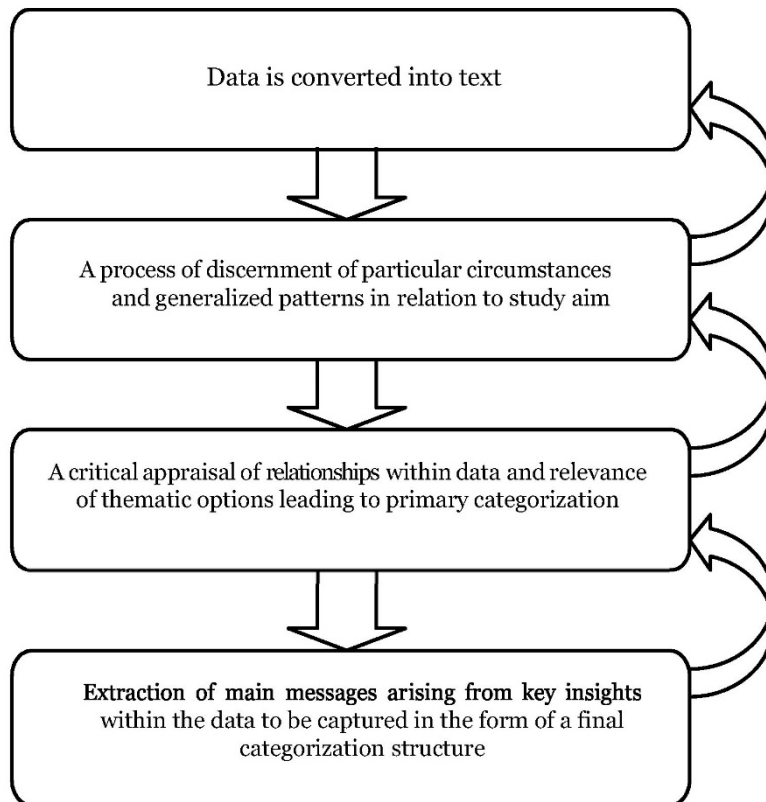
Seeking knowledge on human and social experiences and perceptions (105), I aimed to centralise my focus methodologically, including only articles applying qualitative methodologies (113). I acknowledge current efforts to identify or prescribe a standardised health and nature interaction reported through the use of quantitative methods (114). Inclusion of knowledge deriving from quantitative methods would have strengthened the breadth of the knowledge reported in the review. I was particularly interested in gaining in-depth insights into the individual experiences and perceptions of PWDs and HPs to create an overview of potentials, opportunities and challenges of linking outdoor settings and CBR approaches as a resource in rehabilitation for PWDs. This research enquiry also includes an understanding of the critical aspects of an alternative rehabilitation approach; which mechanisms are at stake constituting either facilitators or barriers for supporting PWDs in their rehabilitation (105). Meanwhile, generalisability of qualitative research is low (115); however, conducting a review cutting across and synthesising existing knowledge enhances the transferability and cogency of qualitative research.

The search strategy was developed and conducted in consultation with a health science librarian. Through initial pilot searches we experienced the broad variation and often implicit way of describing the outdoor context. Thus, I chose for this 'outdoor-element' to be integrated into the exclusion criteria in the screening of full text articles, to capture a broad search and avoid excluding articles of relevance at the initial stage. A systematic search for peer reviewed studies was performed in the electronic databases PubMed, Cochrane Library, CINAHL, PsycINFO, Embase and Scopus.

The Critical Appraisal Skills Programme (CASP) checklist for qualitative articles (116) was used for assessing the rigour of the nine articles included. The assessment included structural critical appraisal of the aim, methodology, research design, recruitment strategy, data collection, relationship between researcher and participants, ethical issues, analysis, findings and value of the research (37). All included articles were thoroughly read, analysed and synthesised through subsequent critical discussions with the research team to qualify interpretations and content. In situations of disagreement or ambiguity regarding the original content and the extraction, syntheses and interpretations were discussed by going back and forth to the original sources until consensus was reached (37).

Based on the study aim and set within the qualitative ID methodology, the synthesis and analysis were conducted inspired by a four-step analytical approach, leading to the synthesised findings, cf. Figure 3. (104, 109).

Figure 3. A data analysis model inspired by the ID methodology (109, 117).



The findings from this review provided an initial overview of where knowledge in the field is complete and where gaps exist, constituting a solid foundation for the planning and conducting of the field work, used to focus the observations and inform the development of interview guides.

4.3.1 Theoretical forestructure

Clarification of the theoretical forestructure is critical as the researcher using ID is considered an instrument whose actions and thinking play a significant role in shaping the nature and results of the enquiry (104). In other words, the theoretical forestructure accounts for ‘how is it known?’ ID allows using ‘the best of all worlds’, but with care, consideration and respect for implications and interplay of disciplines (104). It is thus elementary that I as the researcher am able to objectify my understandings, thoughts, and feelings by making them objects of reflection and thereby creating transparency for the knowledge constructed. The theoretical forestructure is described as containing three linked elements: locating theoretical allegiances, locating disciplinary orientation, and positioning the researcher within the ideas (104). I will describe the distinctive features of the three elements related to this dissertation in the following.

4.3.1.1 Locating theoretical allegiances

The element of locating the theoretical allegiances concerns how I as a researcher place myself within the scientific theoretical landscape in relation to this dissertation, including my the epistemological (104). In ID, the study can be positioned within a theory to guide the framing of the design, construction of data and analytical interpretations, though not a prerequisite (109). Social scientific approaches were originally designed with the primary purpose of theorising, whereas the primary purpose of ID is action in practice, thus using theory as a tool and not as the ultimate purpose (104).

Although ID cannot be placed within one single scientific theoretical tradition or epistemology, the main directions of ID are set within a continuum between social constructivism and critical realism (109). Drawing from a social constructionist thinking, ID acknowledges an inseparable interaction between “the knower and the known” (104). ID acknowledges a socially “constructed” element to human experience that cannot be meaningfully separated from its essential nature (104). Whereas the stance of critical realism provides an alternative to the hermeneutic and postmodern approach represented by social constructivism and to a positivist tradition at the other end of the spectrum (109, 118). Figure 4 illustrates my interpretation of the ID continuum of critical realism and social constructivism. The Figure 4 illustrates only three theoretical scientific positions and should thus be understood as an excerpt of the directions available. Critical realism assumes that there are three levels of reality including three ontological domains: the empirical, the actual, and the real domain (119). Critical realism recognises the complexity of phenomena and centres on explaining what works under specific conditions or in specific contexts and thus appeals to how health and healthcare-related problems are approached (119).

Applying ID as the methodology, it is a prerequisite that my epistemological standpoint and choice of theories is placed within this continuum between social constructionist and critical realist traditions (Figure 4). To produce empirically and theoretically grounded knowledge in this dissertation, I chose social practice theory (110) as the main theoretical lens, accompanied by an organisational culture theoretical approach (111), cf. Figure 5. Tenets from social practice theory guided the framing of the design and construction of data such as the development of interview guides (Appendix 5-6), while the analytical interpretations were informed by social practice theory (Articles II-III) and organisational culture theory (Article IV) respectively.

Figure 4. The epistemological continuum of the PhD

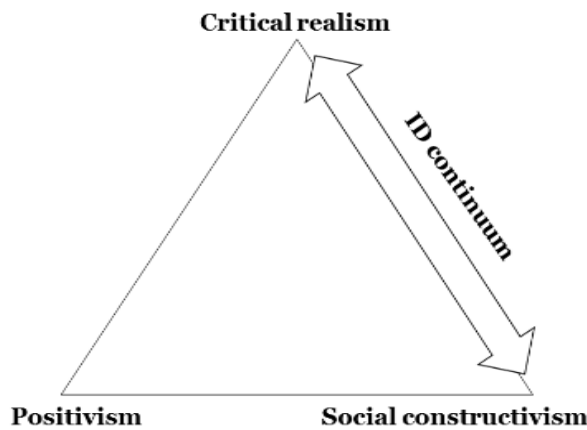
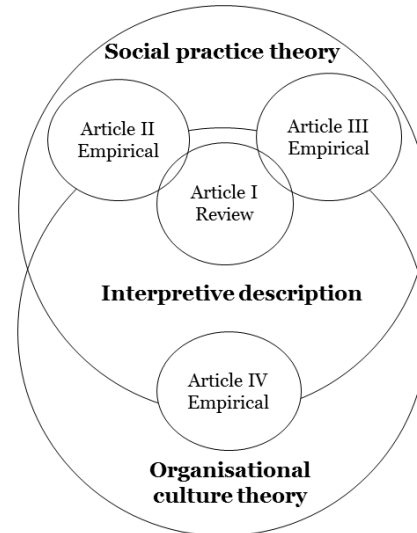


Figure 5. Methodology and theoretical lenses in the four articles



Social practice theory

Social practice theory is developed as a response within the field of sociology, seeking to change the unit of analysis away from the long-contested dualism between individual behaviour and structures of society to understand social action (120). Traditionally, sociological perspectives are split into two main directions at their extremes: First, functionalism where the underlying assumption is that the actor appears as determined by structures in society; second, is the 'action sociologies' with an underlying assumption that individuals' actions define structures of society (120). These main directions are traditionally considered a dualism and as conflicting. The social practice theory approach reframes the question of attention, as practices and how they change over time become the unit of analysis. Rather than focusing on the individual and their motivations, desires and capacities (micro levels of a phenomenon) or considering structural and economic factors (macro levels of a phenomenon), micro and macro levels are viewed in cooperation (120).

One of the reasons for choosing social practice theory was that it has been recognised as a relevant theory to gain understanding of diversity in disability experiences and potential social issues implied (121). Further, a social practice approach have been suggested to provide a beneficial frame for gaining insights into outdoor environments and human health connections, adding to the medical 'dose-response' approaches (114, 122). While some relational configurations may be therapeutic or enabling others may be unsettling, exclusionary, or even disabling. A social practice approach allows insights into this complexity, including diversity in individual health, disability, and nature experiences. Applying a social practice approach in this dissertation amends my analytical focus towards understanding how the PWDs and HPs conceptualise, embody, and interpret the extension of rehabilitation to urban green spaces for the future rehabilitation practices of PWDs. Social practice theory is represented with different developers and perspectives and not a homogeneous approach (120). In this dissertation, I have primarily drawn on the work of

one of the main figures within social practice theory Anthony Giddens (110). Giddens' structuration theory served as the main theoretical lens (110).

Social practice and the structuration theory – distinctive features

Giddens' major contribution is a re-evaluation of the classic theories, including functionalism, structuralism, action sociology and Marxism (120). The core element of the structuration theory is to overstep the duality between agency and structure in traditional scholars (110). Thus, structuration is a contraction of structure + action - a reconstruction where action and structure are merged. The structuration theory is a move away from analysis of action and structure dualism to exceed the tension between individuals and societal structures. Hence, the relation between the individual and society depends on the individual's dependency on existing structures and their ability to act autonomously. The distinctive elements of the structuration theory are elaborated in the following; agents, agency, structure and social practice (110).

Agents and agency involve the framing of individuals as agents who are knowledgeable and thus able to make informed decisions (agency). A person is perceived as a reflective agent with the ability to reflect, not only on own behaviour but on everyone else's behaviour as well, and make choices based on what the person perceives. Agency refers to the capability of acting the way one chooses: the power to intervene, to influence and to abdicate choice. To monitor and respond to oneself and to others, the agent is considered to have knowledgeability; a person's awareness of own behaviour which occurs on three levels: a) unconscious knowledgeability where the agent is unaware of own motivation for acting in a sudden way (habits), b) practical knowledgeability where the agent is aware and make choices but are not able to verbalise them to others (routines), c) discursive knowledgeability where the agent is able to explain to others and discuss why they do what they do (intentional consciousness). Learning processes are often concerned with agents' movement from discursive to practical knowledgeability.

Structure is the rules and resources the agents draw upon in everyday actions and cooperation. Structures can enable or limit future actions and are created through and with the agent, who draw on structural characteristics when they act. The properties of the structure are explained through 'rules' and 'resources', which are said to have both structural and individual qualities. Rules are each person's understanding of how things should work and compose the learnings throughout life and refer to structural qualities. Disability changes the rules and thus one may need to re-establish his or her way of living. Resources are the things or capacities that can help agents to 'get stuff done'. Knowledgeable individuals can use the resources available to change policies, standards, or norms that the structure imposes on them. Like for instance, HPs and PWDs use of urban green spaces and CBR as a resource in future rehabilitation.

Social practices refer to recognisable activities performed routinely over time. A social practice approach enables examination of the daily routines around rehabilitation with an eye to the particular 'rules and resources' that constitute the distinctive way of practice. Development of new social practices often emerge because routines are broken, such as transforming the outdoor surroundings of the MC into an urban green rehabilitation context

- SPARK. To understand social practices, we need to look at the potentials (resources) of a given action, such as extending rehabilitation to urban green spaces and CBR. Seeking to understand the prospects and contributions of urban green spaces and CBR for the future rehabilitation of PWDs, the social practices constitute the source of explanation to account for regards potential challenges or particular behaviours and not the individual persons.

By applying a social practice approach, I gained insights into the relational configurations, complexity and diversity of individual experience of HPs and PWDs on extending rehabilitation to include urban green spaces. Meanwhile, the analytical focus on how the PWDs and HPs come to conceptualise, embody, and interpret the prospects of urban green spaces and CBR for the future rehabilitation of PWDs, outlined a discrepancy in perceptions. This inspired me to add an organisational culture approach to the analytical process (Article IV) to gain insights at a cultural level (111).

Organisational culture theory – distinctive features

Organisational culture theory originating from the field of organisational psychology has been shown as beneficial to understand change processes within health practices (123). I draw on the work of Edgar Schein, who is known as the most prominent figure within the humanistic direction of organisational psychology, operating within a notion of planned change (111). In this dissertation, the research enquiry revolves around the extension of rehabilitation to include urban green spaces drawing on the experiences and perceptions of PWDs and HPs, which potentially involves practice change at some point. According to Schein planned change (such as the development of the SPARK park) cannot be understood without considering culture (111).

Schein's work revolves around macro cultures and is developed from the historical context of anthropological culture work (124). Schein applies a dynamic definition of culture focused on the general process of how any culture is learned and will evolve but within a somewhat stable structure. According to Schein, *The concept of culture implies structural stability, depth, breadth, and patterning or integration that results from the fact that culture is for the group a learned phenomenon just as personality and character are for individuals' learned phenomena* (111). Schein's organisational culture approach mainly draws on a functionalist tradition, because he believes that culture develops as a responsive system in relation to the organisation. This cultural understanding from a functionalist approach implies that culture is an expression of values and assumptions that have worked in the past, and that rapid change often causes challenges.

Schein's overall contribution is the Organizational Culture Triangle, which is a dynamic model of learning and group dynamics (111). Schein draws very explicitly on the interest in how people form and develop in groups as well as how individuals learn through explicit and implicit assumptions defined as stated values taken for granted. According to Schein, culture can be analysed at different levels. By levels he refers to the degree to which the cultural phenomenon is visible to the participant or observer (111). Three major levels are involved:

Artefacts and behaviours, espoused beliefs and values as well as basic underlying assumptions.

Artefacts and behaviours is the visible and feelable level of culture and provides a first impression when you encounter a new culture. Artefacts compose objects, verbal expressions, and activities which constitute the constructed physical and social environment of an organisation. Like for instance the physical environments that PWDs meet when attending rehabilitation in an indoor gym, a consultation room or an urban green rehabilitation context. This level has been recognised to be easy to observe and describe but difficult to decipher the meaning it has to the group. The artefacts are often the result of values and basic assumptions and its creation, use and meaning will change over time.

Espoused values are norms and rules of behaviour and is a less visible part of the culture. The espoused values are often manifested in mission statements that for instance unfold a rehabilitation centre's core mission and values driving the goals of future work and direction. The values of a group or organisation have been developed to be able to cope with problems of external adaptation and internal integration. At this level, discrepancies between the desired behaviour and the actual behaviour can be unfolded.

Basic underlying assumptions is a deeply embedded and unconscious level of culture determining behaviour, perception, thought, and feeling. This level composes the essence of a culture although the level is often taken for granted. The basic assumptions represents the structural stability in a group and is also the most difficult to relearn and change, because it provides meaning and predictability to the group. If a basic assumption is strongly held in a group, members will find behaviours based within another premise - like for instance extending rehabilitation to urban green spaces and CBR - to be challenging or inconceivable.

According to Schein all three levels of culture should be analysed to gain an in-depth understanding of how the culture of a group or organisation works (111). By considering all three levels of culture, I can gain insights into the obvious and underlying dynamics affecting the perceptions of PWDs and HPs when combining traditional indoor rehabilitation practice with an urban green rehabilitation context. This insight can provide a deeper understanding of the discrepancies a stake and which mechanisms to consider for the future work of practice development and implementation.

4.3.1.2 Locating disciplinary orientation

In ID, it is stressed that one cannot enter the field and conduct research “as a blank slate” (104). The disciplinary orientation inevitably shapes the thinking, enacting and making of a research product. As a researcher, I am influenced by anthropology as my basic disciplinary orientation accompanied by a public health science orientation.

My disciplinary background within the humanities shapes my orientation towards qualitative research enquiry and the immersion into the field through creating thick descriptions (125). Basically, anthropology is presented as the study of man in its social and cultural contexts drawing attention to social relationships, societal structures and how people live and perceive the world” (126). I bring with me a curiosity and critical approach towards understanding the field in all its complexity through a holistic approach. I am shaped by my inherent anthropological curiosity and creativity to open new perspectives and ways to understand the world.

My interest within health research is shaped by my will to make a positive difference to other people. Although my experience is not extensive, I have experienced a tendency among anthropologists to keep within our own tradition and not mingle with other disciplines. Quite opposite, I seek with this dissertation to be open and bring my anthropological background into play in a field with a different set of “rules”. I am shaped by a strong methodical and analytic orientation from anthropology, whereas the applied approach and the disciplinary ambition of providing practice implications based on the research results is acquired from qualitative health research, particularly ID. Thus, throughout the research process my goal was to conduct research that could contribute to improve rehabilitation practice for PWDs.

4.3.1.3 Positioning the researcher within the ideas

This element outlines distinctive personal features of me as a researcher engaging with the field of rehabilitation research. Being mindful of one’s personal role in and impact on the research construction enables removing oneself from impacting the results in an unconscious or non-transparent way (104). I have no individual experiences with participating in rehabilitation, living with disability, or providing health services. However, in my previous research, I have been involved with people in need of rehabilitation due to disability and gained insight into how their way of everyday living and family relations can be disrupted, and thus the central role that rehabilitation and HPs comes to play. This insight served as a personal motivation for conducting this dissertation. I have an inherent and sincere curiosity and will to understand and put forward the voices of PWDs and I hope to make a difference to some persons at least. The opportunity for learning something new every day in a persistent search for personal, professional and academic development was also an essential part in my motivation.

4.4 Framing of the study design

To enhance on the internal integrity and strategizing a credible study, a detailed plan was mapped out before entering the field and initiating data construction and analysis (104). Framing of the study design is an essential step in ID, where a wide range of options for design decisions can be enacted.

Prior to entering the field, I designed an overall research plan (Figure 6). Inspired by patient public involvement principles (127), I involved two PWDs and four HPs to give input on and discuss the overall study aim, choice of methods and details on how to recruit and inform about the interviews. The PWDs helped qualify the idea of conducting individual walking interviews, and the HPs elaborated on the idea and use of photovoice and provided the idea for conducting focus group interviews (FGIs) in a way that corresponds to the multiple category design (128). Based on these inputs I decided on the order in which the different data sources for the field work should be carried out in advance (Appendix 7). Still, I emphasised flexibility during data generation in terms of specific use of and approaches to the different data sources as recommended for an ID study (104). Thus, details of the study design and decisions about how best to obtain data, from whom to obtain data, and length of data generation evolved as the project unfolded. I planned to generate data for the field work in 2019 and then I planned on letting the analyses and interpretations influence the subsequent data generation in 2020.

Figure 6. Fieldwork and data construction at the three rehabilitation centres.

	Fourth quarter 2018	First quarter 2019	Second quarter 2019	Third quarter 2019	...	Fourth quarter 2020
	Articles II+III					Article IV
Information/involvement/planning/correspondence/presentation of study etc. *Rehabilitation Centres; A, B, C. 01.12.2018 – 01.03.2019 / 15.11-15.12 2020						
Participant observation *Rehabilitation Centres; A, B, C. 01.03 – 31.06 2019						
Photovoice HPs 01.04 – 31.05 2019						
Individual walking interviews PWDs 01.06 – 31.07 2019						
Focus group interviews HPs / HPs & PWDs 01.04-31.05 2019 / 15.11-15.12 2020						

*A) Orthopaedic Rehabilitation Centre, B) Neurological Rehabilitation Centre, C) Dementia Activity and Rehabilitation Centre.

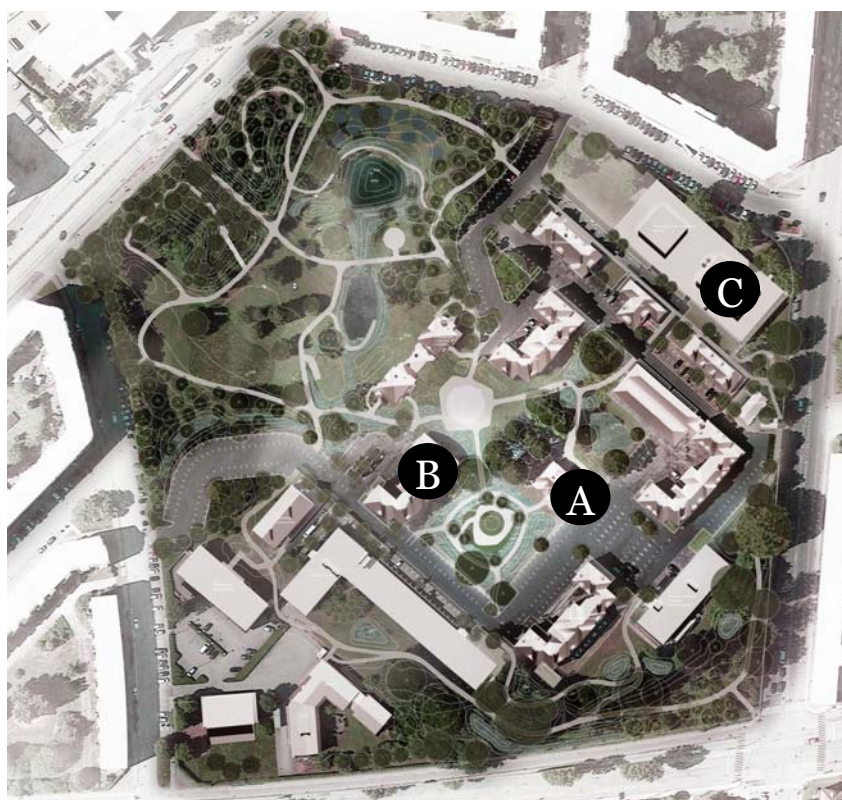
Before arriving at my decisions about sampling strategy as well as data sources and data construction, I will present the setting where data for this PhD were constructed (104).

4.4.1 Setting – The SPARK park

The SPARK park transforms the 7.2-hectare urban park space surrounding the MC (Figure 1) into an innovative arena that reflects the varying social and physical contexts of everyday life by combining rehabilitation, a public city park and climate adaption solutions (34, 35). The overall approach of SPARK was to create multifunctional solutions and utilise opportunities embedded in the natural elements in innovative ways. For instance, a “meadow of motor function” representing natural play equipment and moving on the slopes, wooden constructions to encourage and motivate movement and working together outdoors, “the tingle area”, awakening the senses through biodiversity and “the meeting place”, creating a roofed area for use all year round. Further, the SPARK park will provide a landscape of accessible paths around the park (Figure 7).

Figure 7. Architectural layout of SPARK including the cooperating rehabilitation centres (39)

Credit: Kristine Jensens Tegnesteue



Data were constructed in cooperation with: A) Orthopaedic Rehabilitation Centre, B) Neurological Rehabilitation Centre, and C) Dementia Activity and Rehabilitation Centre (Table 1). The three rehabilitation centres are affiliated to the MC and among the key users of the SPARK project. The naturalistic setting of the three rehabilitation centres formed the study context for conducting the ethnographic fieldwork.

SPARK is a demonstration project, providing a shared park context that links people (in need of rehabilitation or not), culture and health with the environment. SPARK is aimed to be a place that provides the basis for the development of practice of CBR (9, 34), by providing a possible context for facilitating equal participation opportunities for PWDs in the surroundings of the rehabilitation centres affiliated to the MC. No professionals were educated or guided to use the outdoor facilities in connection with this study and rehabilitation in conventional indoor settings was the norm. However, outdoor-based rehabilitation was an opportunity using varying approaches. Orthopaedic Rehabilitation Centre is the only facility of the three delivering outdoor-based rehabilitation all year round. Table 1. Characteristics of the included rehabilitation centres (39).

Centre	Conventional indoor rehabilitation services	Rehabilitation in outdoor contexts	Types of disabilities handled
A. Orthopaedic Rehabilitation Centre: <i>A multidisciplinary service for people with musculoskeletal injuries</i>	<ul style="list-style-type: none"> - Individual consultations - Back training programmes in teams (physical training and patient education) - Leg training in teams - Training of walking with a leg prosthesis - Heated basin training - Fitness self-training 	Nature training programmes in teams delivered outside during all seasons of the year. Additionally, some individual consultations and team programmes are performed outside during the summer season.	<ul style="list-style-type: none"> - Back pains - Back injuries (surgically treated) - Leg amputations - Knee injuries - Achilles injuries - Hip fractures - Shoulder and neck injuries - Hand and wrist injuries - Elbow injuries
B. Neurological Rehabilitation Centre: <i>A multidisciplinary service for people with acquired brain injury or related neurological injuries</i>	<ul style="list-style-type: none"> - Individual consultations - Fitness training in teams - Balance training in teams - Stress relief in teams - Patient education about the brain in teams - Energy management training in teams - Home visits 	Balance training in teams are often performed outside during the summer season. Additionally, some individual consultations and home visits are performed outside in the garden or in the local community.	<ul style="list-style-type: none"> - Apoplexy/Stroke - Dysphagia - Cerebral Palsy - Head and neck cancer - Meningitis
C. Dementia Activity and Rehabilitation Centre: <i>A day and activity service for community-dwelling elderly with dementia or related issues</i>	<ul style="list-style-type: none"> - Socialising around the dinner table - Cognitive stimulation - Playing games - Physical and balance training and gymnastics - Community singing 	Strolls in the park in suitable weather conditions. Weekly excursions to nearby communities and nature parks.	<ul style="list-style-type: none"> - Dementia - Alzheimer's - Socially marginalised populations

4.4.2 Sampling and recruitment

The strategising of a creditable ID study encompasses explicit and concrete decisions related to sampling techniques and decisions on sample sizes (104). Applying the ID methodology, it is essential that the study is conducted based on a transparent and thoughtful sampling

logic (104). To gain knowledge on PWDs' and HPs' experiences and perceptions on extending rehabilitation practices to include urban green spaces, my choice of sampling strategy was guided by research in the field and the empirical study context.

The sampling of the participants was a combination of a convenience sampling for participant observations and a purposive sampling strategy for the interviews (104). The sample was composed of PWDs attending rehabilitation or HPs employed at one of the three rehabilitation centres. The three centres were purposefully selected based on following reasoning: they represent future key users of the SPARK park, they provide rehabilitation for diverse target groups with motor or cognitive disabilities (cf. Table 1), and they offer rehabilitation for target groups where conventional indoor and outdoor rehabilitation to some extent have been found to be effective.

Participants

Inclusion criteria for HPs encompassed a variation of disciplinary and experiential backgrounds working as a frontline HP at one of the three centres included. Twenty-seven HPs were purposefully selected for FGIs (Table 2), of which 10 HPs were purposefully included for photovoice and an additional FGI (Article II).

Table 2. Participant characteristics of HPs (38).

Participants	n=27
Profession	
Physiotherapist	n=15
Occupational Therapist	n=10
Health Assistant	n=2
Gender	
Female	n=23
Male	n=4
Age	
< 40	n=8
40-50	n=8
> 50	n=11
Professional experience	
< 10 years	n=6
10-20 years	n=14
> 20 years	n=7
Affiliation	
Centre of Orthopaedic Rehabilitation	n=15
Centre of Neurorehabilitation	n=8
Dementia Activity and Rehabilitation Centre	n=4

Of the larger group of participants, nine HPs were purposefully selected for FGIs at a later stage, including a newly enrolled HP (Article IV). In total, data generation of HPs included 28 participants.

Inclusion criteria for PWDs were: PWDs living at home and attending outpatient municipal rehabilitation, > 20 years, experiencing loss of functioning affecting their everyday life (physically, mentally, cognitively, socially), and at least one exposure to rehabilitation in an outdoor context as part of their rehabilitation course (Article III). A total of 115 PWDs attending rehabilitation at one of the three rehabilitation centres were included for participant observation based on a convenience sample strategy (Table 3).

I included PWDs who were present in the rehabilitation centres and attended rehabilitation either as individual consultations or as a part of a team. Everyone I met at the rehabilitation centres was informed of who I was, the purpose of the study and the fact that I was generating data.

Table 3. Participant characteristics of PWDs (39).

Participants	N=115
Gender: - Men - Women	n=60 n=55
Age: - 20 – 39 - 40 – 59 - 60 – 79 - 80 – 99	n=29 n=28 n=37 n=21
Attendance: - Orthopaedic Rehabilitation Centre - Neurological Rehabilitation Centre - Dementia Activity and Rehabilitation Centre	n=77 n=13 n=25
Mobility Status - Ambulant - Non-ambulant	n=108 n=7
Participants (interviews)*	n=15
Gender: - Men - Women	n=8 n=7
Age: - 20 – 39 - 40 – 59 - 60 – 79 - 80 – 99 Average age: - 63 years	n=2 n=3 n=6 n=4
Attendance: - Orthopaedic Rehabilitation Centre - Neurological Rehabilitation Centre - Dementia Activity and Rehabilitation Centre	n=5 n=5 n=5
Mobility Status - Ambulant - Non-ambulant	n=15 n=0

*Participants included in the walking interviews were recruited from the total sample (N=115).

Most participants included in interviews I had observed and spoken to while few were newly enrolled in a rehabilitation course or appointed by the centre; this reflected a variety of experience in the data. Participants were at different stages of the rehabilitation process; some were newly enrolled, and others were approaching the end of their formal rehabilitation course. This variety gave me a chance to follow the PWDs throughout their rehabilitation while I also gained insights into their reflections about the transitional stage at the end of rehabilitation. By following the same participants attending rehabilitation over

a longer period, I had the opportunity to observe the different types of interventions or initiatives in their course of rehabilitation (Table 1).

Of the larger group of participants, 15 PWDs were purposefully selected for individual walking interviews; three of these were purposefully included in FGIs at a later stage of data generation, including a newly enrolled person attending rehabilitation (Article IV). In total, data generation included 116 PWDs.

The sample size was decided on drawing on inspiration from the concept of information power. Engagement in the field continued until I deemed to have the information power for being able to obtain research findings within the field of enquiry, though well aware that there is always more relevant variation (129). A broad sample was sought, but with awareness that in ID, maximal variation and representation at best serves as a broad ideal (104). I assume that the sample of this dissertation is not representative, but rather represents a particular perspective set within a context transferrable to other practices and research settings (104).

4.4.3 Data sources and data construction

My decision on choice of data sources was guided by an assumption about what would most likely produce meaningful answers to the research enquiry. The fact that the SPARK project was a research context under development, and the knowledge produced would be based on PWDs and HPs current experiences and perceptions on the future rehabilitation, impacted on my choice of methods. Field work was chosen as the overall frame for data construction to get to know the field through the experiences of the PWDs and HPs. I decided on visual methods to enhance the tangibility for the participants including photovoice (130) and individual walking interviews (131). The intention was that the visual part in the form of photographs or physical outdoor environments should support the PWDs and HPs to reflect on what could be perceived as an abstract topic of conversation. In addition, I chose participant observation (132) and FGIs (128) to gain in-depth insights into the field (Figure 8). Data were generated holistically and divided between articles II-IV (Table 4). The data construction took place between March and July 2019 and between November and December 2020, with ongoing analyses throughout the period (Figure 6).

Figure 8. Constitution of data sources.

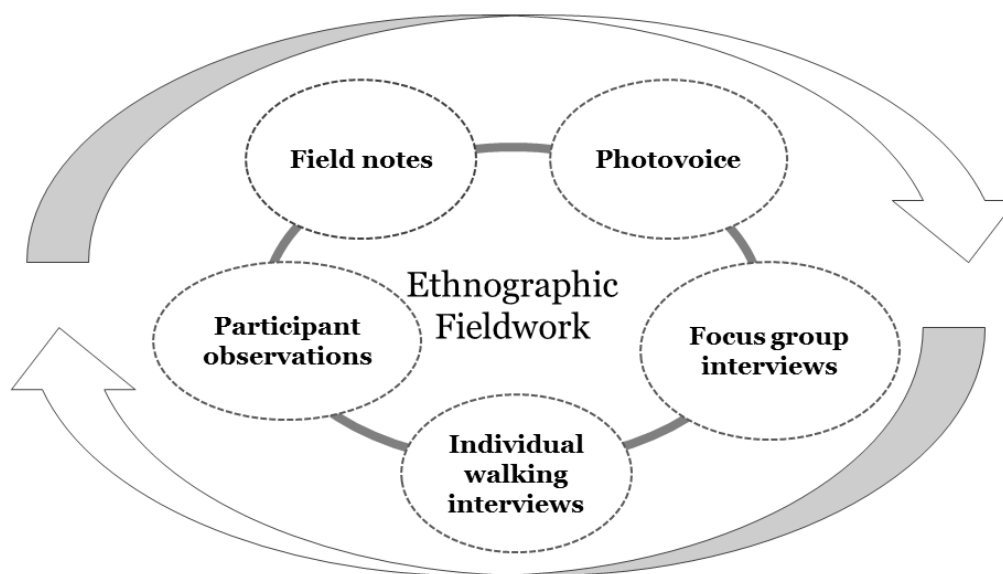


Table 4. Data for articles II-IV

	Article II	Article III	Article IV
Participants	N=115 (n=15) PWDs	N=27 HPs	n=4 PWDs – n=10 HPs
Data sources	Participant observations Field notes 15 Individual walking interviews	Participant observations Field notes Photovoice 5 FGIs	3 online FGIs

4.4.3.1 Ethnographic fieldwork

Applying ethnography in an ID methodological frame, means that I have used and considered ethnography as a method and tool for providing an in-depth approach to the data generation through thick description based on multiple data sources (104). The ethnographic fieldwork is suitable for examining how people seek to create meaning in their lives and at the same time be a part of a collective whole that constitutes the terms for their possibility for social action (132). “My being there” provided a window into understanding the complexity within PWDs’ and HPs’ experiences and perceptions and the logic of social organisation regarding rehabilitation for PWDs at the three rehabilitation centres.

I carried out the field work during a five-month immersion between March and July 2019 (Figure 6). The natural settings of everyday rehabilitation practice at the Orthopaedic Rehabilitation Centre, The Neurological Rehabilitation Centre and Dementia Activity and Rehabilitation Centre was the context of my field work (Table 1). The field work was well planned and it was unproblematic to get access to data (104). Prior to entering the field, I

gained knowledge about the weekly schedules of each of the centres and mapped out when and where to participate estimating the specific activities relevant for participant observations (Appendix 8). During the field work I made sure to participate in all the different activities offered by the three rehabilitation centres, respectively (Table 1). Thus, my schedule was continuously revised in a dialogue with each of the centres. I had a contact person for coordination and general communication at each centre.

4.4.3.2 Participant observations and field notes

Participant observation was chosen to contribute to in-depth insights of daily routines, tacit knowledge and create an overview of “what is going on” (132). I chose participant observation to produce a qualified perception and overview of current rehabilitation practices for PWDs and establish a practice-based understanding of the prospects and contributions of urban green spaces and CBR for the future rehabilitation of PWDs.

To grasp the variety of the rehabilitation practice fields, I chose to use a different range of approaches with a more or less active role: a) “direct observation” of peoples’ actions (133) such as participating in staff meetings or client consultations, b) participation while observing which could be during physical training or mindfulness on the same terms as the persons attending rehabilitation (134), c) informal conversation to get access into PWDs’ and HPs’ insider views (132), and d) deep hanging out, being in the field observing daily practices and routines without an immediately defined goal, which opens for a sensory experience and unsystematic reflections and observations of unplanned events and spontaneous small talk (132, 135). Observing PWDs’ and HPs’ social practices allowed me to focus on social interactions and how the social life of the participants organised within the rehabilitation context. I started my participant observations with a wide focus, which was later supplemented by focused and selected observations and guided by continuous critical reflection and challenging of own perceptions (132, 135).

I used a field notebook to document what I observed during the field work and to trace development in my reflections and preoccupations, which evolved during the fieldwork. The texting of my observations was a part of the ongoing analysis concurrent to data generation. A variety of field notes was produced concurrently (Table 5). *Sketchy superficial notes* or ‘thin’ descriptions of people, places and situations (105). This type of notes I typically jotted down during the day. *Thick descriptions are composed of notes* of “what is going on” (132). To create thick descriptions, I sought inspiration from Spradley’s core elements of field note taking - space, actors, activities, objects, single actions, events, time, goals and feelings (135). I finished a day of participant observation by developing thick descriptions. *Analytical notes* were made of ongoing development of analytical perspectives. At least once a week during the field work I developed my analytical thinking and explored new potential pathways through continuous analytical writing (104). *Reflexive notes* were taken on personal experiences, feelings, wonders etc. (136), which helped me separate personal dilemmas, feelings and values from my field observations and analytical thinking and formed an ongoing dialogue with myself on my position in the field (104).

Table 5. Empirical examples of note types

Sketchy notes
<p><i>Today, I participated in team activities in a gym. We made different exercises on the floor. In the end, I joined a talk with two female participants. One who had her last day at the course, and one who had her first day. They were asked to talk about what they had planned to do on their own between the trainings or when finished. What they wanted to do. The female who was to end the course today said that she thought she was doing too little on her own. She did not get those exercises done at home. But that she walked and biked a lot. The other female commented on this saying that “everyday training” should also be accounted for. Finally, they talked about how the female ending the course hoped that the professionals could refer her to some other kind of course, because she would not go to a fitness centre, and she did not get the exercises done at home. And she did not really know what else to do to continue with her development on her own.</i></p>
Thick description
<p><i>... After walking on the curb, he paused by leaning against a tree. Next, the therapist suggested that they could walk over to the tree trunks on the ground to balance, just as they did last time. He said last time he was not particularly happy about this activity because he felt his body was being pressured. He walked up on a tree trunk, found his balance, and walked slowly forward. The therapist walked next to him and supported him around the hip to ensure a little extra support when he staggered. He tried to put one leg in front of the other, but was very wobbly. The therapist suggested that he might be able to walk sideways instead. He started walking sideways and expressed that it felt better, and that he felt much more comfortable this way. Similarly, he walked on some pieces of tree that lay at some distance. Some tilted slightly. He was a bit cautious at first, but experienced to do well. He suggested that he could do it one more time. And after that, one more time. With a little effort, he came down from the piece of tree and paused on the large beam next to it.</i></p>
Analytical notes
<p><i>A central part in the professionals’ work, revolves around active/passive positioning and who and when to take responsibility. For instance, when a citizen complains that the exercises from last week’s training caused exhaustion or pain in the days after, then the professionals often respond with questions like: did you remember to listen to what your body was telling you? what have you learned from it? What should you do instead? In this way, the citizens are given the responsibility to reflect upon the cause and possible solutions. This focus is not reserved for a specific setting. However, based on the approaches to the training and rehabilitation activities in the urban green space, it seems to be more natural for the citizens to reflect upon their actions and take on a more active role in their rehabilitation.</i></p>
Reflexive notes
<p><i>Reflective notes, 18.03.2019: I can feel that the dual position challenges me a bit. On the one the hand I participate as a citizen, but at the same time I talk with the professionals in other ways than participants do. Also, the fact that the physical surroundings in the centres are divided into more floors influences my position, as I have access to both floors and the citizens do not. Maybe I should try to be more active in my positioning towards the citizens.</i></p> <p><i>Reflective notes, 19.03.2019: Today, I have tried something different concerning my position, which I actually thought worked well. Or, that depends on what knowledge I want to obtain? But today I gained more insights from the citizens’ perspective. It seems that it is clearly the best to gain insights from the citizens if they have met me more than once, and that I participate in the same way as they do. For example, I participated in a team activity today, where I have participated once before. I arrived at the same time as the rehabilitation participants to warm up on the fitness bikes, and small talk about what had been going on since the last time. Previously, I have arrived together with the professionals, which has caused a bit of confusion about my role.</i></p>

4.4.3.3 Photovoice

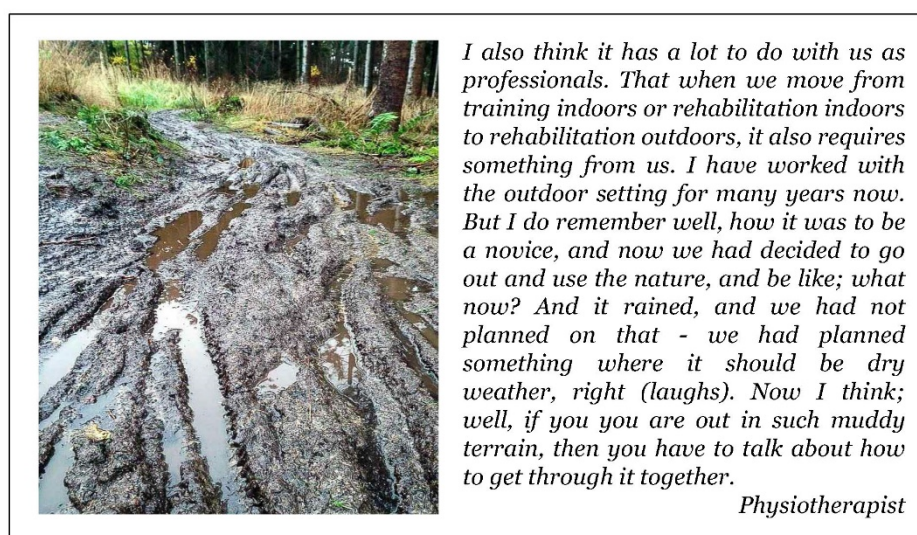
To empower the HPs' voices and interpretations, I chose to apply a photovoice strategy (130). Within photovoice research, the photos have been recognised as external symbols of what is going on inside peoples' mind (137). I chose participant-produced photographs to provide an inductive and participatory approach to the data generation (130). With the photovoice approach, the photographs were also included as data sources and analysed similarly to the texted material.

Figure 9. Example of participant photographs provided by the HPs



Ten key informants were required to take four photographs in advance of the interview (cf. Figure 9) by iphone or ipad. This helped prepare participants for group discussions, helped concentrate attention to the topic of interest, and helped recall experiences and perceptions, which may otherwise have been overlooked or missed. The HPs were asked to take a photograph related to extending rehabilitation practice to urban green spaces: two represented the opportunities entailed and two represented the challenges connected. During FGIs, key informants were asked to share with the group what caused them to take these photos, creating a narrative. In Figure 10 below, is an example of a participant photography and associated narrative from a FGI with the HPs:

Figure 10. Example of participant photograph and narrative provided by the HPs



Using photographs as data and starting point for discussions could serve as an anchor in time where discussions of current rehabilitation practices, opportunities and challenges of extending rehabilitation to include urban green space and CBR could unfold (138). Further, the photographs created a natural opening for the other participants to ask questions or agree/disagree and argue for their opinion. Another reason for choosing photographs is the strengthening of a creative form of communication compared to texted material.

4.4.3.4 Interviews

Additional to participant observations the empirical material in this dissertation is generated from interviews as a central empirical research method (139). I chose to conduct interviews to produce rich and nuanced data that provide depth and closeness regarding the perspectives, attitudes and experiences of PWDs and HPs. The method enables informants to communicate their life situation through their own perspectives and words, which was purposeful and desirable for this dissertation (139). I decided on semi-structured individual walking interviews (131), and two different formats of FGIs (128).

Individual walking interviews

I chose to conduct individual walking interviews with the PWDs to integrate the outdoor setting actively into the data production and to be able to relate the participants' verbal accounts to their practices in a concrete context (131, 140, 141). Further, the walking interview format was chosen to provide a strategy for empowering the participants who were cognitively challenged to participate in the interviews. The surroundings helped stimulate their reflection and memory regarding their engagement with the outdoor-based rehabilitation context. I chose a format inspired by Anderson's (131) concept 'bimbling', where the act of 'talking whilst walking' is the main purpose. The talking during interviews flows more naturally because the pressure of a face to face interview has been removed. This interview format clearly helped reduce the power imbalance between me as the interviewer and the interviewees (140, 141). The participants were invited for a walk around the surroundings of the MC buildings, parking lots and green spaces as the walking interviews were conducted prior to the transformation of the surroundings into the SPARK park (cf. Figure 1). Below is an example of a citation from a walking interview with a PWD.

Interviewer: Now I have only participated in one of the sessions that you have had outdoors with your therapist. Can you try to describe what it is that you do?

Participant: I can go over and show it to you?

(we walk towards the tree trunks next to our walking route)

Participant: Something like this [he walks up on a piece of tree]. And then just move around slowly. Then the therapist would encourage me to walk up the tree trunks to balance. And then move past some of the trees for support. And then we beat against the different surfaces, to stimulate my hand. I know it looks like...in a way it might seem quite trivial, but it really isn't. Because it stimulates your balance. And it also means that your body uses some of its explosiveness, instead of feeling all wobbly. It actually gives some support for when I walk. And the unpredictable aspects that it [the tree trunk] can move a little and that you might actually fall, that forces you to be present and consider what you can and cannot do.

As demonstrated in the example, the interview form allowed for engagement with the surroundings during the interview. If needed, breaks were taken along the way on a bench depending on the participants' walking abilities. A semi-structured interview guide was used with open questions, encouraging spontaneous, surprising and varying answers (Appendix 6) (139).

Focus group interviews

I chose FGIs because data produced at group level provide insight into basic social processes and practices which are not available from individual interviews (128). I used FGIs to further understand group behaviours and dynamics regarding the topic of extending rehabilitation to urban green spaces and possibly including a CBR strategy. A FGI approach is suitable for examining social group interpretations, interactions, and norms as they play out in different contexts, for instance regarding indoor and urban green rehabilitation contexts. Two different approaches were used for data generation through FGIs; utilising a multiple category approach (128) and drawing on inspiration from the Mutual Innovation and Learning Platform (MILP) approach (142).

Focus group interview - a multiple category approach

Applying a multiple category approach to conducting FGIs was decided on because this approach allowed data to be generated by comparing and contrasting knowledge across different type of groups (128). In all, five FGIs were carried out in two phases:

1. I conducted three internal FGIs with HPs employed at the same rehabilitation centre (Table 2). These group discussions were conducted to achieve a wide and varied insight into their experiences and perceptions. A semi-structured questioning route was developed based on field notes and the study aim (Appendix 5). Further participant photographs from photovoice was used as the starting point of discussion.
2. I conducted two mixed FGIs with professionals across the three rehabilitation centres. To provide new understandings, patterns and depth in the data material, initial analytical interpretations from phase 1 were compared, contrasted and challenged through discussions with the HPs in the mixed groups. A semi-structured questioning

route was developed (Appendix 5), based on initial analysis of transcripts from first phase of FGIs and field notes.

If I had only conducted the FGIs, I would have assumed that extending rehabilitation to urban green spaces and CBR was already an integrated part of applied practice based on the participant dynamics. But the insights from participant observations were congruent and the different data sources thus contributed with rich and nuanced data.

Focus group interviews – a mutual learning approach

To gain insight into the shared views of PWDs and HPs on what needs to be considered as a part of the future work of practice development on extending rehabilitation to include urban green spaces, I drew on inspiration from the MILP approach (142). The MILP is an emerging alternative approach to knowledge production based on principles of mutual learning and increased collaboration through knowledge exchange between researchers, practitioners and possibly persons from the target group involved. The relation in the MILP is reciprocal, which furthers the production of knowledge of considerable use for the everyday practice of HPs (142). As the researcher, I initiated the shared discussion based on, though not determined by, knowledge from the field of research. My interpretation of the MILP approach was to draw on analytical perspectives from article II and article III as a starting point for critical discussions between PWDs, HPs and me as the researcher and moderator (Appendix 10). By drawing on inspiration from the MILP approach, I was able to create the space for knowledge exchange and mutual perceptions on combining conventional indoor rehabilitation practice with an urban green rehabilitation context. Below is an example of a citation from a FGI and shared discussion.

HP (Id 6): But hear me out id 7. I also think we should call for revolution in relation to the demands that everything should be measurable and assessed. And then make room for the sensual experiences as well.

PWD (Id 7): That is why I started out by talking about the senses. Just remember to consider how we as human beings are equipped with so many senses. And that is what you will be able to use that park [SPARK] for. It can open up all your senses.

Interviewer: And the revolution mentioned here, what does that entail?

HP (Id 6): (laughs) I guess that some of it happens automatically, you could say. But we are also just assigned to a lot of things that comes from above [municipal management].

PWD (Id 7): The revolution id 6, will be just out the door, you just have to start using it.

The FGIs were conducted online and video-recorded using the TEAMS application platform, and an assistant moderator attended the FGIs asked follow-up questions (128). A semi-structured interview guide was applied with open-ended questions for both PWDs and HPs (Appendix 9).

4.5 Entering the field

Entering the field revolves around the researcher's role and positioning as it evolved throughout data generation (104). I documented my subjective and analytical reflections on how my position changed, any new and interesting paths to follow as well as my feelings and dilemmas of engaging in the field.

A core element in entering the field according to ID is reflection on how to engage with study participants during data generation. Being an anthropologist observing and participating in rehabilitation practice fields, I mainly took on an outsider researcher positioning (132, 143). I realise that my position as a stranger necessarily implies a distance to the social phenomenon being studied, as I am not familiar with the standard routines and social roles (132, 144). Representing an 'outside' perspective, I experienced to initially being assigned a kind of evaluator or advisory role by the HPs, who implicitly expected me to provide constructive feedback regarding my observations of a specific situation. To be able to build trustful relations, I was careful to be explicit about my role and reason for being present through elaborating on my positioning as an observer and participant to describe "what is going on" and not to evaluate and explain from my subjective point of view.

Concurrently with my increasing insights into the field and building relations with the PWDs and HPs, I experienced that my position was slowly created by virtue of adopting a dynamic responsiveness to the field (145). By occupying shifts in roles and statuses at various stages in the research process, I built a moveable position on the continuum evolving. Personal ongoing and critical reflections as exemplified in Table 5, served as an essential part of the ongoing analysis parallel to data generation (104). Further, such reflective notes form a kind of audit trail where I am able to follow and trace how I, as a person and a researcher, impact on the data generated.

During fieldwork, I wore my own clothes, though considering if the outfit was practical for me to participate actively in physically demanding exercises on same terms as PWDs and without being mistaken for a HP. Being a female conducting the fieldwork did not seem to impact on my engagement with the PWDs and HPs. My relatively young age may have played a role, as I experienced that especially the HPs were very considerate. I assume that this consideration helped me build equal and trustful relations as I did not experience a hierarchy with me being in a researcher position.

Central to the integrity of the study, my PhD office is centrally placed within the MC. Thus, by looking out the window, receiving newsletters about the MC partners and development of SPARK park as well as collaboration with the SPARK management, I could (to some extent) follow "what was going on", before and after the field work period. This position and extended immersion as a part of the SPARK activities, might have impacted on my pre-understandings, questions and curiosities as well as my choices in seeking knowledge (104).

4.5.1 Ethical considerations

This PhD dissertation was approved by The Data Protection Agency of Central Denmark Region [identification no. 1-16-02-293-18] (Appendix 11), and complied with the World

Medical Association Declaration of Helsinki. We notified the Central Denmark Region Committee on Health Research Ethics of the study, but this type of research does not require ethics approval according to Danish law (law no. 1083 of 15 September 2017).

As an important ethical rule of thumb when obtaining informed consent, both written and oral, it is emphasised in the literature that research participants must know what they participate in (104, 146). Plans for the study and written cooperation agreements were made with the three rehabilitation centres. During data generation, information letters were distributed to all staff members at the three rehabilitation centres (Appendix 12). Prior to, during and at the end of the data generation, I presented the project details, described the methods and next steps to the staff and management at the rehabilitation centres.

As the field work progressed, I continuously informed about my presence, purpose of the research, who I was and how data were conducted as well as confidentiality and anonymity. I had no experiences with participants (PWDs and HPs) expressing negative feelings about my presence.

The PWDs and HPs recruited for interviews were provided with an information letter handed out in person by me, or sent by email. The information letter and informal conversation constituted the base for the participants' decisions to participate. In the information letter for my potential informants, I presented myself, my professional starting point, the research purpose, the methods I intended to use, and the role they would play in the data generation. The persons with dementia attending rehabilitation were recruited for interview in cooperation with their HPs, who assisted explaining the terms and conditions for participating in an interview. In addition, I explained the purpose and format of the study and interview to the participants in person to ensure their consent was informed.

Prior to participation in the interviews, all participants (PWDs and HPs) provided a written informed consent (Appendix 13). Before starting the interviews, I summarised the content of the consent formula and it was made clear that they had the right to withdraw their consent at any time. Further considerations of confidentiality were explained, and permission to audio record the interviews was obtained. A debriefing was conducted at the end of the interviews. I asked participants if they had anything to add about the topic of extending rehabilitation into urban green spaces, if they had any questions about the method, the further work or if they had anything to share regarding participation in the interview. None of the participants expressed to have negative experiences with participating in an interview. For photos and videos, the participants signed a specific written consent form (Appendix 13). To comply with the requirements for anonymity, participants (PWDs and HPs) were referred to by identification numbers. Person-specific information, places as well as exact age were left out.

I am very aware that PWDs may be a fragile group to involve. One of the biggest ethical challenges was to ensure equal participation of the persons attending rehabilitation who were cognitively challenged due to acquired brain injury or dementia. These ethical considerations were worked into the choice of methods, such as the individual walking

interviews, as the inputs from the surroundings helped stimulate their memory and mediate the pressure of providing well-formulated sentences. This strategy, however, gave rise to other ethical issues of the persons with walking difficulties, but were solved by including pauses on a bench on the walk if needed.

4.6 Data analysis

ID emphasises a way of understanding the world by going beyond pure descriptions (104, 109), which is also the case in terms of the social practice theory (110) and organisational culture theory (111), serving as the analytical interpretive lenses. Using both description and interpretation as core elements in the analysis creates a high level of data transformation, moving beyond the self-evident (104).

In ID analysis, no singular technique is prescribed, but there are some basic principles of the inductive analysis and thought processes that an applied qualitative ID researcher engages in (104, 109). In the attempt to transform pieces into patterns and thematic observations into meaningful findings, four overlapping iterative analytical steps is offered in ID to guide the analyses (Figure 3) (109, 117).

1. All data were transcribed, read, and re-read to explore all variations and prepare the process of breaking data into manageable units for systematic analysis. All data were uploaded to the qualitative software programme NVivo 11™, to organise and compare data across sources. At this stage, initial analysis coding was made (Figure 11). I organised the data segments together in clusters or meaning units that seemed to reflect similar properties. The codes were refined in shared discussion with co-authors as the analytical process progressed.
2. Moving Beyond the Self-Evident. An ID analysis goes beyond presentation of raw data or retelling of stories as findings. At this stage, fractured coded data were subsumed under descriptive labels, increasingly arranging the data in patterns. At this point, I found a need to engage with the text in a tactile manner, so all initial codes were printed to enhance mobility and expanding the associations in the data. While reading them, I jotted down marginal memos, highlighted parts of the text and created mind maps expanding on associations and diversities in the material. The co-authors were included for joint discussion based on illustrative quotes and mind maps.
3. At this stage, I engaged the mechanisms of interpretation and critical appraisal of relationships within data. My engagement was to create an understanding of the meaning system within data and interpret it. Initial themes and patterns were identified and tested through interpretation to process the 'hidden'. I drafted memos of each theme and interrelations, which were tested by the co-authors through written and verbal input.
4. Finally, I extracted main messages from the key insights and envisioned the research findings, their hierarchies and correlations. By reducing the words and elevating the meaning, initial themes were subsumed into a coherent narrative. I condensed and

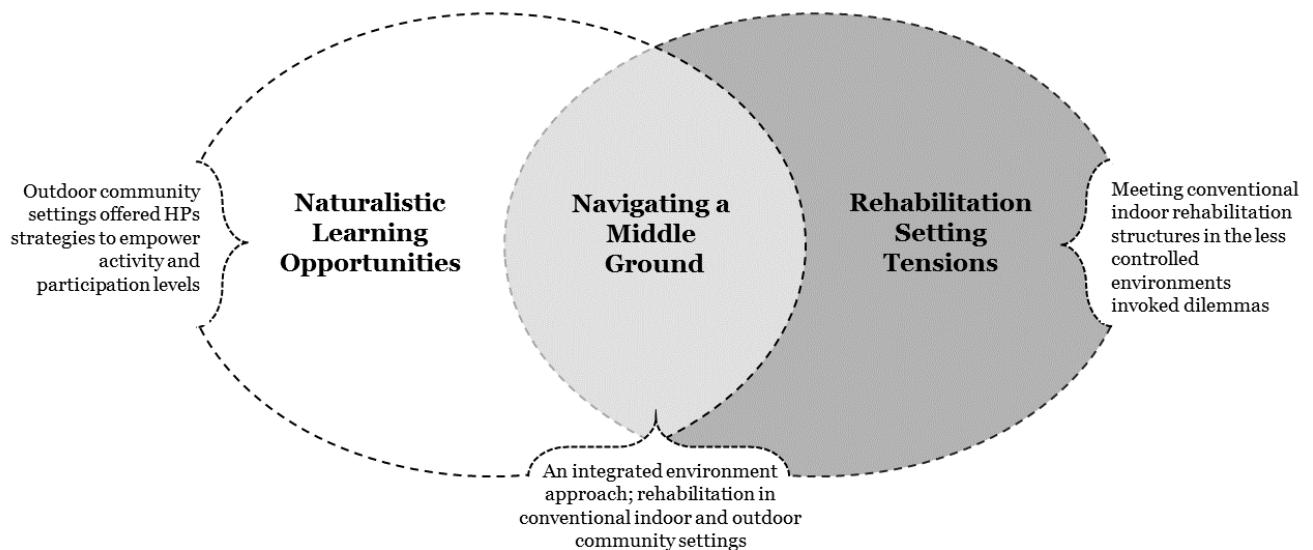
drafted the findings, which were qualified by the co-authors through joint critical discussions of interpretations and relationships within the thematic findings (Figure 12).

Figure 11. provides an example of the analytical process (38). The coding strategy of ID analysis enables coding in larger ‘units’ and across different types of data sources such as field notes, transcripts and visual images. I worked systematically with the principles of analysis in the different articles to enhance transparency (Figure 11). In the actual analysis process, these components operated more concurrently, going back and forth in the raw data material. In accordance with the ID methodology, I have applied an inductive approach, so that my analytical interpretations and theoretical concepts spring from the empirical raw material. Analysis and coding were supported by shared and critical discussions with co-authors at each step.

Figure 11. Analytical example from article II illustrating how the codes and themes subsumed (38).

Step 1 <i>Initial coding in NVivo</i>	Transferability	Social Relations	Practical Circumstances	Facing Challenges	Thinking Differently
Step 2 <i>Fractured coded data were subsumed</i>	Parallel to Everyday Life	Face Inner Concerns	A Challenge for the Professional Approach	Change in Rehabilitation Opportunities	
Step 3 <i>Initial themes and patterns were identified</i>	Natural Learning Environment	Inner Dilemmas	Contrasted Representations	Extended Rehabilitation Opportunities	
Step 4 <i>Envisioning thematic findings</i>	Naturalistic Learning Opportunities		Rehabilitation Setting Tensions	Navigating a Middle Ground	

Figure 12. Analytical model from article II illustrating the thematic findings: *Providing rehabilitation in outdoor community settings induced naturalistic learning opportunities and yet invoked rehabilitation setting tensions, involving navigating a middle ground* (38).



5.0 Findings

This section presents the overall findings. The four articles each represent significant parts of the dissertation. Further elaboration and examples of participant quotes are offered in articles I, II, III and IV.

Article I: Community-based rehabilitation approaches in outdoor settings: a systematic review of people with disabilities' and professionals' experiences and perceptions

The aim of this review was to examine and synthesise qualitative knowledge on PWDs' and professionals' experiences and perceptions regarding facilitators and barriers to CBR approaches in outdoor settings (37).

The literature search was performed in October 2018, and identified a total of 4029 items (37). Nine articles met the inclusion criteria (26, 34, 79, 84, 85, 95, 99, 147, 148). Across the nine articles, the three main characteristics were: 1) all articles were based in economically privileged countries, 2) Overall, the articles applied a community-based approach to rehabilitation, but only one was based on the WHO definition, and 3) the rehabilitation activities differed between outdoor recreational activities in nature parks and activities related to everyday life in urban green or outdoor settings.

The synthesis showed four central interdependent themes: *Ability to overcome challenges*, *Outdoor adaptive activities* and *Inclusive social communities* related in a mutual synergy that translated into a *Culture of Reciprocal Interaction* (Figure 13).

Figure 13. An integrative model of PWDs' and HPs' experiences and perceptions on facilitators and barriers to CBR approaches in outdoor settings (37).



Ability to overcome challenges

This theme involved an internal psychological process where outdoor and social aspects provided opportunities to deal with ‘real-life’ issues and thereby PWDs ability to build up confidence in own abilities. Nevertheless, barriers persisted as severe disability was an issue in a nature park context and professionals struggled to build up confidence in how to deliver a good quality service in the outdoor setting.

Outdoor adaptive activities

This theme involved recreational activities in natural environments and activities of everyday life in urban green settings. Adaption was an essential element and obtained through professional support, assistive devices, and volunteers. Among PWDs, fun and excitement were key experiences and the outdoor activities worked as social gathering points. The financial aspect of providing the adaptations seemed to constitute a barrier together with barriers of transportation and finding accessible outdoor spaces.

Inclusive social communities

The development of inclusive social communities seemed to be embedded in a person-first philosophy and appeared a natural rehabilitation approach across articles. Focus was on doing things together, rather than on disability. The creation of opportunities for being a part of social communities of interest and establish shared experiences was a core concern in the initiatives. Meanwhile, family members were barriers not trusting the professionals to deliver safety and not trusting the PWDs to be able to participate.

Culture of reciprocal interaction

Achievement of a positive synergy between participants’ ability to overcome challenges and outdoor adaptive activities interrelated with inclusive social communities seemed to provide a foundation for developing a culture of reciprocal interaction. The reciprocal aspect was found in the interdependency naturally embedded in the interactions emerging in the context of CBR in outdoor settings. An enabling context with equal interaction emerging between participants with and without disability and their surrounding environments were obtained. To expand beyond programme contexts into society, there is a need for inclusive community development as PWDs still experienced physical, social and financial barriers including misconceptions about their abilities.

Article II: Navigating a Middle Ground - Exploring Health Professionals’ Experiences and Perceptions of Providing Rehabilitation in Outdoor Community Settings

The aim was to examine HPs’ experiences and perceptions of providing rehabilitation in outdoor community settings. The purpose was to use these experiences to generate practice-based knowledge in using the outdoor settings as a means to guide CBR (38).

The findings can be summarised in the following three interrelated themes (Figure 12 illustrates the interrelations):

Naturalistic learning opportunities

Inclusion of urban green spaces in rehabilitation provided the HPs with natural opportunities to learn about the PWDs' functioning and coping strategies in a challenging environment with diverse physical and social inputs. With green spaces as the frame, rehabilitation was not planned based on scheduled exercises, specific equipment and formal tests. Rather, the rehabilitation was based on social activities, varying terrain and with greater flexibility regarding the changing needs and preferences of PWDs during the rehabilitation process.

Rehabilitation setting tensions

Urban green spaces as a frame for rehabilitation appeared to induce a dilemma to the HPs by challenging the structural requirements for documentation, goal-setting and assessment, which have traditionally been developed for use in indoor controlled environments. The HPs expressed enhanced opportunities to recognise and realise the relevance of including urban green spaces in the rehabilitation through outdoor engagement. Yet, they also expressed personal experiences of uncertainty and doubt about creating a safe environment, and ensuring a high quality that could meet the conventional rehabilitation standards.

Navigating a middle ground

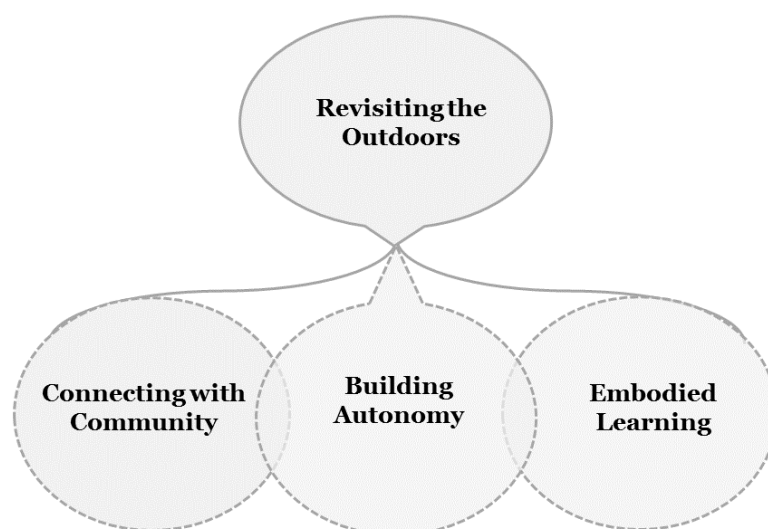
Delivering rehabilitation in urban green spaces and including local communities required that the HPs they could "think out of the box" and navigate a middle ground between structural requirements and initiatives adapted to the PWDs' everyday life. Urban green space as a frame for rehabilitation made it possible to challenge current functioning of the PWDs and thus expand the scope of existing efforts. At the same time, it also challenged conventional approaches deeply rooted in the professional identities of HPs.

Article III: The potential of outdoor contexts within community-based rehabilitation to empower people with disabilities in their rehabilitation

The aim was to examine the potential of outdoor contexts within CBR to empower PWDs in their rehabilitation (39).

The analysis revealed four overlapping themes: *Revisiting the outdoors*, *Building autonomy*, *Connecting with community* and *Embodied learning*. Figure 14 was developed to illustrate the interrelation between the themes.

Figure 14. The potential of outdoor contexts within CBR to empower PWDs.



Revisiting the outdoors

By expanding the frame of conventional rehabilitation, the PWDs had the opportunity to be reintroduced to nature and local areas as well as to rediscover their significance in their changed life situation. In addition, participants were supported in developing strategies adapted to everyday challenges such as creating social contacts, navigating the local area in varying terrain and weather conditions, as well as other similar situations that to many were associated with insecurity and fear and thus a potential barrier to participation.

Building autonomy

The urban green rehabilitation context induced the PWDs to gradually show increased independence and follow one's own intuition. By enabling the PWDs to take on a more active role in their rehabilitation, it seemed as though the awareness of their own responsibility for sustained rehabilitation increased, as well as their confidence in assessing own capabilities and limitations.

Connecting with community

Rehabilitation in an urban green space was highlighted as an important step on the way to connect or reconnect with the community in an otherwise vulnerable period with many hours in the home. To that end, the participants experienced that the inclusion of nature and local communities in rehabilitation contributed to bringing their whole life situation into play.

Embodied learning

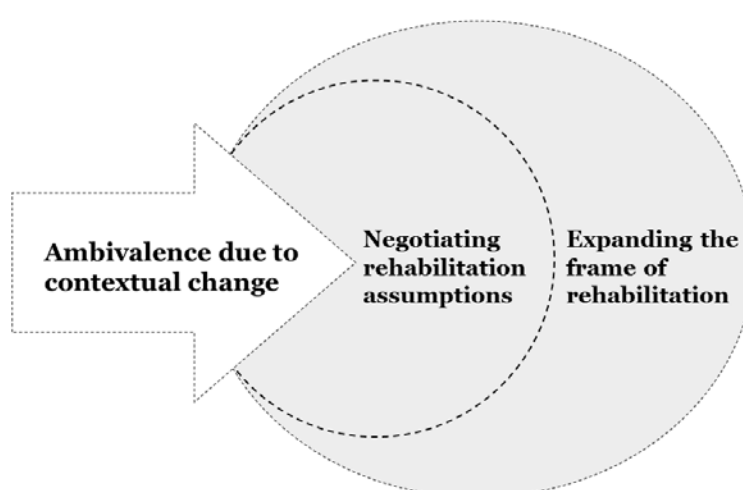
Inclusion of varying nature and local areas into the rehabilitation context provided the opportunity for the PWDs to learn through their own bodily experiences. Participants were able to translate the learning they had obtained through the rehabilitation process into concrete actions in the outdoor space, which provided a direct link to the participants' everyday lives.

Article IV: “It Was Definitely an Eye-Opener to Me”—People with Disabilities’ and Health Professionals’ Perceptions on Combining Traditional Indoor Rehabilitation Practice with an Urban Green Rehabilitation Context

The aim was to describe and analyse PWDs’ and HPs’ perceptions on combining traditional indoor rehabilitation practices with an urban green rehabilitation context (40).

The analysis revealed three interrelated themes: *Ambivalence due to contextual change*, *Negotiating rehabilitation assumptions* and *Expanding the frame of rehabilitation* (Figure 15).

Figure 15. Understanding PWDs’ and HPs’ perceptions on combining traditional indoor rehabilitation practices with an urban green rehabilitation context.



Ambivalence due to contextual change

The transformative surroundings of the SPARK park seemed to contribute to ambivalence among participants. Especially among HPs, a certain ambivalence in relation to adapting rehabilitation practices to the new SPARK park facilities was noted, challenging the current rehabilitation practice culture. At the same time, the PWDs expressed rehabilitation initiatives in urban green spaces to be an opportunity for guidance on how to proceed with daily life and thus a valuable addition to the specific rehabilitation support due to their injury or illness. Yet, the HPs raised concerns of compromising the quality of rehabilitation practices, which appeared to be rooted in an artefact level of reasoning.

Negotiating rehabilitation assumptions

In this theme, an underlying divergence in rehabilitation assumptions between PWDs and HPs was exposed. The PWDs related to rehabilitation based on their everyday experiences and complex life situations, whereas the HPs mainly related rehabilitation to health structures and conventional disciplinary reasoning. Negotiating underlying basic assumptions of PWDs and HPs appeared to be a central step in creating shared perceptions and converting the ambivalence into possible actions for use for future rehabilitation.

Expanding the frame of rehabilitation

Expanding the modes of rehabilitation practices to encompass urban green spaces may pave the way for enhancing compatibility of rehabilitation initiatives to the everyday lives of PWDs, yet still complying with structural quality standards for rehabilitation. The combination of traditional indoor rehabilitation practices with an urban green rehabilitation context seemed to enable an increased focus to the rehabilitation work within four basic elements: 1) engaging the whole life situation, 2) influencing role development, 3) enhancing everyday relations, and 4) building inclusive social communities.

6.0 Discussion of findings

This dissertation includes four articles exploring PWDs and HPs and their experiences and perceptions of extending rehabilitation practice and expand the prospects and contributions of urban green spaces and CBR in future rehabilitation. Together, these insights composed a nuanced interpretive description of applied rehabilitation practice. First, I will summarise how the findings of the four articles interrelate, proposing a discrepancy in the perceptions of PWDs and HPs as well as a suggested combined approach, which outlines prospects of urban green spaces and CBR in future rehabilitation. Second, this foundation will be the point of departure for discussing the findings in the context of existing literature on the continuum of rehabilitation for PWDs. Finally, I will discuss the possibilities of parks like SPARK and the dependency on HPs as initiators of rehabilitation interventions, including a suggested intermediate step in the future rehabilitation for PWDs.

6.1 Urban green spaces and community-based rehabilitation in future rehabilitation

The empirical articles based on the field work data, were divided into separate analyses of perspectives of HPs (38) and PWDs (39), respectively. Some of these findings (38, 39) were similar to the findings of the literature review (37). The review theme *Ability to overcome challenges* related to the PWDs' experiences of *Building autonomy* (39). It diverged from the HPs' experiences of *Rehabilitation setting tensions* (38) as they struggled to build confidence delivering rehabilitation in an urban green context. The review theme *Outdoor adaptive activities* and the essential role of the HPs were reflected in the HPs' experiences of *Navigating a middle ground* (38) and PWDs' experiences of *Revisiting the outdoors* (39). However, in the analyses of the empirical study findings, these aspects appeared in a much elaborated and redefined form where focus was narrowed from a broad outdoor context to an urban green context.

During and after conducting the analyses in article II (38) and article III (39), it was apparent to me that there may be a discrepancy between the experiences and perceptions of PWDs and HPs. This discrepancy may constitute a limiting factor to the prospect of urban green spaces and CBR in the future rehabilitation for PWDs. Moreover, the choice of fragmenting and dividing the two perspectives was a deliberate and strategic choice to conduct two substantial studies. The division of the two analyses may have helped understanding the underlying mechanisms at stake among the PWDs and the HPs, and subsequently eased the assembling of them, redefined as one unit in the conduct of article IV (40). Cutting across the three empirical articles, a suggested combined approach utilising diversities in conventional indoor and urban green rehabilitation contexts appears as a reinforcing factor to the prospects of urban green spaces and CBR for future rehabilitation.

6.1.1 A suggested discrepancy in the perceptions of PWDs and HPs

Based on the analyses in the empirical studies (38-40), an underlying discrepancy was apparent in the PWDs' and HPs' experiences and perceptions regarding the extension of rehabilitation practices. On the one hand, the HPs acknowledged the naturalistic learning opportunities inherent in the urban green rehabilitation context due to a variety in social and physical inputs. Initiators among the HPs strategically utilised the capacities attributed to the urban green context to reinforce empowering experiences among PWDs. In this way, the HPs confirmed the PWDs' experiences and perceptions of the benefits from *revisiting the outdoor setting* as an integrated extension of conventional indoor rehabilitation. The potential benefits for the PWDs included *building autonomy*, *connecting with community* and *learning from embodied experiences* (Figure 14) (39). On the other hand, extending rehabilitation practices to include urban green spaces and CBR was found to constitute considerations of quality standards and significant challenges to the work routines of the HPs (38). The change in rehabilitation context involved a more explorative, creative and playful approach to rehabilitation, as the urban green context was not defined and characterised by programmed exercises, specific equipment, and objective tests. Some HPs experienced delivery of rehabilitation in urban green spaces as natural, while others were ambivalent *due to the impact of contextual change*.

As PWDs were most often not aware that it was even an opportunity to include the urban green spaces and community engagement into a rehabilitation course, they rarely took the initiative and suggested it themselves. Meanwhile, the HPs seemingly assumed that the PWDs preferred traditional indoor rehabilitation practices, because the PWDs did not explicitly express a need for or goals related to outdoor and community life. Extending rehabilitation to urban green spaces and CBR seemed to give the HPs the responsibility to predict and continuously re-evaluate whether the individual person would benefit from revisiting the outdoor settings and to assess which terms of engagement would be relevant. If these underlying assumptions of who is responsible and how outdoor-based rehabilitation and CBR are initiated are not addressed, barriers may continue to obstruct further rehabilitation practice development.

6.1.2 A suggested combined approach

Analyses of the empirical studies (38-40) further concluded that a combined approach utilising diversities in conventional indoor and urban green rehabilitation contexts may benefit future rehabilitation for PWDs. The PWDs appeared to perceive the indoor and urban green rehabilitation contexts as integrated therapeutic environments. Whereas, more of the HPs seemed to perceive the inherent differences of contexts as contradictory, to an extent that was constraining. The findings emphasise the importance of adopting a combined approach. The strength lay in the diversities of rehabilitation practices as a complementary approach, rather than contradictory or viewed as an extension rather than a deselection.

The prospect of extending rehabilitation to include urban green spaces and CBR is not a simple matter of moving recreational activities from a conventional indoor centre-based context to an urban green context. The combined approach suggested encompasses

multiple and related aspects: a) a relational aspect, where the terms of engagement and way of utilising different indoor and urban green rehabilitation contexts are aligned with varying individual needs, preferences and progression throughout the rehabilitation course, b) a cultural aspect, where the HPs' underlying rehabilitation assumptions based on structural demands and professional evaluation are balanced with the rehabilitation assumptions of PWDs rooted in everyday life situations through including urban green spaces and CBR, c) a twin-track aspect, with a strategy of supporting individuals in physically and socially varied and challenging surroundings parallel to a strategy of creating physical and social environments inclusive of PWDs. Applying a combined approach, expanding the frame of rehabilitation to an urban green context and CBR, may provide a basis for enhancing on the everyday life aspects of PWDs while still accommodating structural quality standards of professional rehabilitation practices.

6.2 Prospects of the SPARK park

The developing SPARK park constitutes an important contextualisation of the findings of this dissertation. Based on principles of urban green space interventions (31), and CBR (9), the SPARK park has the contextual surroundings to be a potentially unique example of innovative rehabilitation solutions (Figure 1).

The prospects of urban parks like SPARK are placed within the global agendas of combining public health and environmental health (36, 149). WHO provides a comprehensive and important work as a part of this global movement of urban green space interventions through development of a global action plan (13, 31, 36). Furthermore, the European Commission developed a research and innovation agenda on nature-based blue-green solutions to face contemporary challenges concerning human health and well-being and global agendas such as climate change (149). Urban green space projects like SPARK are considered long-term public health and social investment in improved health, well-being and quality of life (150, 151). Besides mitigating impacts from extreme weather conditions, decreased noise pollution and improved air quality, urban green spaces have a great potential to support and facilitate health and well-being by enabling stress alleviation and relaxation, promoting physical activity, and improving social interaction and community cohesiveness (31).

This public and environmental health agenda also applies to the field of rehabilitation where a growing body of literature suggests the importance of urban green spaces and CBR on the continuum of rehabilitation to support diversity in the disability experience and underpin the rights of PWDs to equally engage in outdoor and community life (5-10). Nevertheless, barriers are common in PWDs' interaction with urban green spaces and the creation of physically and socially accessible environments are thus in demand (5, 19, 152). Inaccessible urban parks have been suggested to contribute to health inequities for PWDs, which ultimately may contravene human rights principles (19, 152).

In the light of the discoveries, parks like SPARK has the potential to provide platforms for facilitating equal participation opportunities for PWDs, through building on principles of inclusive community development. Still, the findings of this dissertation capitalise on the complexity and inherent dilemmas of extending existing rehabilitation practices to urban green spaces and including CBR strategies. The application of an inclusive CBR strategy has been suggested to be a poor fit in well-established and highly specialised health systems like the Danish and other similar systems (public or private) (1, 69). Still, the accomplishment of relating rehabilitation in urban green spaces to an agenda of CBR requires further analysis and more engagement at a structural level, e.g. health legislation, social initiatives, volunteer regulations, urban masterplans, and sustainability as well as biodiversity strategies.

Based on the insights obtained by exploring the developing process of SPARK, it may be suggested that the finding of *revisiting the outdoor* as an integrated part of rehabilitation practices could serve as a first phase and create a platform for development of a CBR strategy at a later stage. Utilising a combined approach, may enable PWDs and HPs to negotiate and engage with the norms and social structures that are present in and outside the centre-based rehabilitation context. The prospects of extending rehabilitation and utilising capacities of parks like SPARK certainly depends on long-term strategies, investments and sustained explorations.

6.3 Dependency on HPs as initiators

Based on the combined findings, the prospects of urban green spaces and CBR in future rehabilitation appear to be dependent on the HPs taking on the role as initiators. To enable PWDs to revisit the outdoor setting and possibly gain empowering experiences, they depend on the HPs for introductory support and facilitation. Although that PWDs stating the need for HP facilitation and support in the rehabilitation process may not be surprising or new knowledge in a rehabilitation context (101), it appears to be a central aspect to the prospects of extending rehabilitation (38-40). For the HPs to take on a role as initiators, two main aspects seemed to be at stake and constitute limitations to actions in practice: personal uncertainty and meeting structural demands.

In the findings, the HPs generally showed interest in and acknowledged the potential benefits of a combined approach utilising diversities in conventional indoor and urban green rehabilitation contexts. However, in line with other studies, HPs reported to struggle to build confidence to deliver rehabilitation outside the conventional centre-based setting (26, 79, 99). The fact that most HPs work within already well-established evidence- or knowledge-based rehabilitation practices (based in conventional indoor environments), may inhibit the motivation for experimenting with extending rehabilitation practices to urban green spaces (1, 99, 100). On the one hand, the HPs will be co-creators of potentially new and advanced services for future rehabilitation of PWDs, which seemed to motivate HPs. On the other hand, extending rehabilitation to urban green spaces and CBR may disrupt service flow and

existing rehabilitation structures, which most HPs seemed to be strongly attached to and familiar with. In a survey by Wolsko et al (100) exploring HPs' (n = 231) employment of the restorative capacity of nature for patients with mental health issues, HPs were concerned that outdoor-based activities would cause a too personal relationship and result in lost professional objectivity within the traditional therapeutic frame. The findings in this dissertation indicate that the structural demands of effective pathways, documentation practices and disciplinary reasoning in many cases seem to outweigh the motivations for and contributions to extending rehabilitation. Thus, the organising structures of current rehabilitation practice appear as a crucial factor restricting the HPs' perceptions of the prospects of urban green spaces and CBR in future rehabilitation.

The current COVID-19 pandemic and associated research, provides different terms and conditions and new aspects for understanding and discussing the findings of this dissertation. The pandemic is documented to have changed the usage and perception of urban green spaces and local environments in the general population (153, 154). Further, governments utilised urban green spaces as an important public health tool (153, 154). With many indoor and recreational spaces closed due to COVID-19 restrictions, populations were encouraged to socialise, exercise and work outdoors (155).

Understanding the role of public green spaces to public health was amplified by the pandemic (151, 153). This also applies to the reshaping of rehabilitation services for COVID-19, where urban green spaces and forest areas have been shown to play a key role (152, 156). The acute and drastic change in conditions due to the pandemic has made HPs responsible for building new practice experiences and to think 'outside the box' to work around the challenging circumstances and still be able to provide rehabilitation services (154). Although not yet documented, most municipalities in Denmark used green spaces as settings for rehabilitation during the pandemic across target groups, including the three rehabilitation centres included in this dissertation but also e.g. within cancer and cardiac rehabilitation (157). The experiences and learnings reported by practice have mainly been positive, and may possibly influence the way of future rehabilitation. Based on this context and conduct, some of the structural barriers (e.g. effective pathways, documentation practices and disciplinary reasoning perceived by the HPs in the findings of this dissertation), have potentially been addressed during the pandemic and brought sustainable solutions for future application. These new practice experiences may have impacted positively on the readiness of HPs to learn, and/or re-learn practice skills and competencies related to utilising green spaces and community engagement as resources in the rehabilitation work.

Due to the pandemic, the prospects and contributions of urban green spaces and CBR in future rehabilitation may be amplified. More studies document that many people have rediscovered an urge for nature engagement and have experienced the health benefits of nature during this period (153, 158). In a case study of urban green space use during the COVID-19 pandemic in Brisbane, Australia it was found that 45% of the previous non-users of urban green spaces began using these for the first time during the pandemic (154). Although it has not yet been possible to measure whether this behavioural change is

sustained, it is suggested in the literature that peoples' connection to urban green spaces and natural environments has been fundamentally changed (154). In the literature prior to the pandemic, differing needs and perceptions were expressed by PWDs, who on the one hand had been found to encourage more creative and innovative rehabilitation solutions outdoors (79, 85, 148) and on the other hand expected traditional indoor centre-based interventions (85, 99). This difference may have decreased and then possibly amplified the PWDs' wishes to also engage in urban green space rehabilitation contexts.

To support the HPs taking on the role as initiators in future rehabilitation, skills and competence development are central to reinforcing practice development and distilling the restorative and health promoting benefits of outdoor environments and community engagement (1, 99). Regarding CBR, the inconsistent use of terms and practices identified in the literature (37), may complicate development of CBR in contexts like SPARK (1). One avenue towards a practice of combining indoor/urban green environments and community resources in rehabilitation, is to include training of undergraduate HPs in outdoor and community practices, which is currently inadequate and in demand (1, 100). In accordance with recommendations of Kendall et al. (1), I consider it a central component to address the role of educational institutions to take on a responsibility and respond to the growing demands of integrating urban and natural green spaces, and inclusion of the wider community in future rehabilitation. Moreover, it seems fair to assume that management support is required to develop a sustained practice strategy and culture in future rehabilitation practices (111, 159).

6.3.1 A suggested intermediate step in the future rehabilitation for PWDs

The aggregated findings suggest that extending rehabilitation to urban green spaces offers an intermediate step towards supporting and guiding PWDs in everyday life circumstances in addition to the specific support they need due to their injury or illness. In the literature, different pathways of human health and nature relations are suggested (160). According to Ugolini et al., (151) the way people perceive and relate to nature is believed to be either inherent (e.g. evolutionary theories such as "biophilia" by Wilson (161), or Attention Restoration Theory by Kaplan and Kaplan (14)), or learned (e.g. shaped by social, cultural and personal characteristics (162)). Another aspect is provided by Levinger et al. (152), who suggest that the underlying mechanisms of exposure to natural environments include biopsychosocial pathways including harm reduction, restoring and building capacities (163). Considering the findings of this dissertation, it mainly aligns with the learned approach, although the specific contributions of each of the ways of approaching human and nature relations should be considered as equally worthy. The findings highlight potentials of PWDs' learning from embodied experiences in varied urban green contexts and engaging with the community as enablers of a certain kind of mastery; a sense of personal agency for rehabilitation, being empowered to move rehabilitation outside the formal centre-based context. According to Sit et al. (164) health empowerment is a process of enhancing patients' self-belief, which makes them willing and able to play an active role in managing their own health and well-being through events that affect their lives during rehabilitation (164). To

reinforce empowering experiences among PWDs, the extension of rehabilitation practices to urban green spaces and CBR is suggested to provide an intermediate step for PWDs to develop new routines for ongoing rehabilitation, transferrable to their everyday context.

In the literature, the setting for delivery of rehabilitation has primarily been concerned with the different ways of organising rehabilitation into health systems, e.g. inpatient or outpatient hospital settings, private clinics, community settings such as municipal rehabilitation centres or the home of PWDs (43, 53). Nevertheless, the solid documentation for urban and natural green spaces as restorative and health promoting contexts (5, 11-13), and the contribution of the findings of this PhD, demonstrates urban and natural green spaces as important settings to consider for delivery of rehabilitation for PWDs. Evidence is strongest regarding mental health issues (14, 22, 71, 74, 75) and promotion of physical activity (18, 19). The findings of this dissertation contribute to the understandings of urban green spaces as having strong potentials for providing empowering experiences for PWDs. Similarly, a study by Palsdottir et al. (24) documented how nature-based rehabilitation for patients with mental health problems seeking return to work was specifically empowering for patients towards the end of their rehabilitation course. Through facilitating naturalistic and varying contexts and with different levels of difficulty, urban green spaces can challenge and assist PWDs to improve or maintain their functioning in ways that are different from what is offered by indoor-based activities (15,17,18).

In future rehabilitation for PWDs, adopting a combined approach may enable HPs to support the PWDs to proceed with their everyday lives and tailor the rehabilitation course to shifting needs and preferences throughout the process. Holistic assessment is called for with different values brought into play, as focus shifts between body functions and advancing levels of empowering experiences, activity and participation.

6.4 Discussion - methodological considerations

In this section, I outline my critical considerations regarding the quality and adequacy of the research process in this dissertation. I reflect upon and discuss how my decisions throughout the research process have impacted on the overall findings of the PhD. Assessment of quality within qualitative research is a long-contested area (165, 166). Though, some agreement has been reached concerning concepts such as validity, and generalisability being inadequate for evaluating the rigour of qualitative enquiries (104, 167). Both general principles and specific evaluation criteria are involved to critically consider ID research (104). First, I will discuss the relevance of engaging in the research on extending rehabilitation for PWDs to include urban green spaces and CBR, as well as elaborate on my methodological considerations of the review. Second, I will discuss the credibility of the dissertation including a sound critique of the ID approach, based on the evaluation criteria provided by ID: epistemological integrity, representative credibility, analytical logic and interpretive authority including reflexivity of the research process (104).

6.5 Relevance

To the best of my knowledge, this is the first study to establish a practice-based understanding of the prospects and contributions of urban green spaces and CBR for future rehabilitation drawing on the experiences and perceptions of both PWDs and HPs. Before conducting the PhD, growing evidence pointed to a positive link between human health and nature (11, 12), and a need for inclusive community development for PWDs (63). As a result, contemporary rehabilitation practices had started to rethink use of outdoor settings and community resources in rehabilitation (1, 7, 8). How rehabilitation practices may be influenced by this development remains unexploited and in demand to guide a sustainable practice development (1, 10, 114).

Qualitative research was a suitable approach to meet my research enquiry (104). Conducting field work as a research strategy, including participant observations, photovoice and interviews, allowed me to produce new knowledge on PWDs' and HPs' experiences and perceptions on extending rehabilitation practices and establish a practice-based understanding of the prospects and contributions of urban green spaces and CBR for future rehabilitation.

This dissertation was embedded in the SPARK park. As the construction of the SPARK park was postponed, the knowledge produced in this PhD is created in a context under development (Figure 1 in the introduction section). To ensure credibility, these terms and conditions were adapted into the research design, aims, choice of methods as well as continuous critical reflection of its possible impacts on the findings, which I have built into the elaborations in the sections below.

6.5.1 Considerations on the literature review

Conducting the systematic literature review provided a solid foundation for the planning of the empirical studies (37). The fact that construction of the SPARK park was postponed meant that more of the aspects within the review, mainly regarding inclusion of the wider community, have not been addressed in this dissertation and thus provide insights relevant to pursue in future research.

It was a main consideration in the author team to conduct a critical appraisal, which in general is a contested area within qualitative research (168, 169). We chose the criteria described by the Critical Appraisal Skills Programme (CASP) (116). One of the articles had only one item appraised 'yes' out of the 10 items, based on an appraisal of me and two co-authors. This was subject to much discussion in the author team whether to exclude the study or not. As CASP is not a graded system with standards for when to include/exclude a study, we chose to include the study. The study was not an outlier and provided knowledge that contributed to the synthesis and underpinned the results across articles.

6.6 Credibility

6.6.1 Epistemological integrity

The epistemological integrity represents the extent to which there is consistency between the theoretical forestructure, study design and conduct of the research process as well as the research enquiry (104). To enhance the credibility in terms of the epistemological integrity of this dissertation, I pursued consistency between the epistemological standpoints and research aims. In agreement with ID methodology, my epistemological grounding was aligned with interpretive naturalistic explanations that acknowledge the constructed and contextual nature of human experiences (104). Besides, ID acknowledges that the world does not solely exist of social constructions (104, 170). Viewing human experiences as constructed and structured at the same time is in line with social practice that acknowledges relational configurations, complexity and diversity of individual experiences (110). Therefore, decisions on participant observations and interviewing of PWDs and HPs appeared credible to explore their experiences and perceptions on extending rehabilitation practices to urban green spaces and CBR. The organisational culture approach (111) operates within a notion of planned change, and was thus chosen as an additional approach to gain a further understanding of how the construction of the SPARK park may influence daily practices of the rehabilitation centres involved. Within this frame, culture is acknowledged as a dynamic process developed through learning and group dynamics (111). Therefore, I decided on focus-group interviews to explore PWDs' and HPs' perceptions on combining traditional indoor rehabilitation practices with an urban green rehabilitation context (40). By using social practice theory (110) and adding an organisational culture approach (111), I am aware that my choice of theory is not specific to ID, such as is the case for symbolic interactionism (171). Given the research enquiry of this PhD, the choice of theories proved to be relevant, enhancing the credibility of the epistemological integrity.

Because the ID methodology does not have one particular knowledge grounding, the responsibility of the researcher to account for, argue and form the line of reasoning that cut across the research process becomes very explicit and central to the epistemological integrity (104). As a researcher, I undertake the responsibility of using the elements relevant for this project with respect and make informed decisions and consideration of how they impact on each other and the knowledge generated (104). This element has been critically emphasised as a considerable challenge to undertake, especially for novice researchers, and it may ultimately affect the quality of the products of ID studies (170). Although I might be perceived a novice researcher, I have experienced my anthropological orientation to be a strength in undertaking this responsibility, by providing a robust grounding within various theories and methods. This insight has been a strength in creating a line of reasoning based on informed decisions of the choices and deselections made in this dissertation.

ID allowed me to capture, explore and strengthen elements from the unpredictable everyday rehabilitation practice for PWDs (104). In this way, my research enquiry was the driving force determining the research process rather than the methodological approach being the driving force for what is researched, as might be required in traditional methodologies such as grounded theory or phenomenology.

6.6.2 Representative credibility

Representative credibility depends on the extent to which there is consistency between theoretical assumptions and choices made regarding sampling (104). I found ID's recommendations of concurrent data collection and analysis beneficial, as it pragmatically allowed me to shift between different empirical sources in a no prearranged order (104).

The ID methodology recommends variation in the sample, and I sought to be able to gain knowledge from a broad range of participants, both within the group of PWDs and among HPs (104). The purposive sampling of participants from three different rehabilitation centres for data generation turned out to be a comprehensive task, but also rewarding in terms of variation in data and enhancement of the representative credibility (104). The broad composition of persons with impairments in the musculoskeletal system, persons with dementia or person recovering from acquired brain injury, allowed insights into the experiences and perceptions of people with different health conditions and disability experiences, from different centres, with different courses of rehabilitation and at different places in their life course. Further, this broad sampling is in accordance with the inclusive CBR approach and rehabilitation definition aimed at a person's functioning and not a specific diagnosis (9, 28, 43). Although a strength, the broad representation within the PWDs also represents a risk of diluting the findings, which was sought prevented through data triangulation. The broad variation in the sample may have impacted on the results as diagnosis or other particular characteristics may have provided more specific knowledge, although it was never the intention of this dissertation.

Data triangulation, including multiple data sources, seemed to enhance the representative credibility of the dissertation by providing different angles, depth and breadth to understand

and elucidate the overall aim (104). I relied on different data sources which provided both visual, texted and audio types of data and gave insights into discrepancies of what is said, what is done and what is said to be done (104). The fieldwork was conducted between March and July, which may have impacted on the experiences and perceptions of the participants, as the change in seasons may influence engagement, although this was addressed in the interviews.

Concerning transferability (104), the findings may be applicable internationally in countries with well-developed (public or private) health systems and established rehabilitation practices, e.g. in the UK, Australia, Canada, Netherlands, Scandinavia and elsewhere (37). Especially in the wake of the recent COVID-19 pandemic, a growing interest seems to appear in utilising urban green spaces for addressing public health issues and addressing equity among groups in society, including PWDs (153, 154). Thus, the findings of this dissertation are of relevance to the future work of practice development and implementation and can be used by managers and decision makers as well as HPs and for communication with PWDs and community stakeholders. Because this PhD focuses on understanding the underlying mechanisms at stake in extending rehabilitation practices, the transferability to low-and middle-income countries may be restricted, as they may not yet have an established rehabilitation practice due to prioritising acute health care (54). Still, a research enquiry regarding urban green spaces and CBR strategies as a part of health services may be of relevance for these countries.

6.6.3 Analytic logic

The analytic logic reflects the extent to which the choices and consequences of choices can be traced throughout the research process (104). To enhance credibility in terms of the analytic logic of this dissertation, I have made an explicit and thorough attempt to clarify the theoretical allegiances, my disciplinary orientation and my own position within the research ideas. The interpretive element of balancing description and interpretation in ID has impacted on my analytic logic (170). A considerable challenge, and also a point of criticism in ID, is to know as a researcher when an appropriate balance of description and interpretation has been reached (104). I experienced it as a fine balance, aiming for depth in the analysis without driving the interpretations further than what could be supported by the data available. Thorne does not provide a specific answer to how to reach this fine balance (170). Although the nature of interpretations is a general concern in qualitative research (104), constructing data in the developing context of SPARK had considerable consequence to the extent of interpretation. Much consideration was given to be careful not overstating what can be interpreted and concluded based on perceptions on future rehabilitation.

6.7 Reflexivity and interpretive authority

The interpretive authority refers to the trustworthiness of the interpretations made by me as a researcher and has to do with reflexivity and critical self-reflection (104). Due to my anthropological background and engagement within the field of rehabilitation practices for

PWDs, I occupied an outsider position conducting data for this dissertation (104). Engaging in applied practice research, it has been described in ID to be an advantage to hold clinical experience and thus an insight into potential challenges connected to entering the field (104). It is claimed that an inside perspective enables the researcher to pose well-founded research questions. To enhance the interpretive credibility and strengthen my limitations as an outsider, I chose to immerse into a five-month ethnographic field work to gain in-depth insights into native experiences and perceptions. Another element that might be complicated by my outsider position was the development of practice implications as it involves a thorough insight into the practice that is thought to benefit from the new knowledge. My supervisors and co-authors contributing to this dissertation compose an interdisciplinary team, including nursing, medicine, and physiotherapy and they have provided insider perspectives from the practice field of rehabilitation. This interdisciplinary aspect has critically contributed to inform the research process, which enhanced the credibility regarding the interpretive authority.

Despite limitations, I also consider my outsider position a strength. As a non-native I was not given a predisposed position as a native to the field. I was not pre-disposed by obvious behaviours or taking things for granted. These aspects may have assisted my positioning and relation to the persons attending rehabilitation by not being perceived as a professional as they showed great openness sharing their views and worries with me.

As an essential part of planning this dissertation, I have gained an in-depth understanding of the SPARK project including the project prospect, mission statement, management expectations, “what is going on behind the scenes” during planning and construction and the reasoning behind the decisions made. My insights into SPARK may have influenced my pre-understanding. Inevitably, my preunderstandings impact on the research process, as it influences “what I see” as a researcher, how I engage in the field, which questions I ask, how I position myself and interpret the data (104). As the idea behind SPARK comes from a knowledge-based foundation and is based on practice needs through thorough involvement (34), I may have had an underlying assumption about SPARK as a positive contribution to rehabilitation practices. However, being aware of this potential pitfall, I have been very considerate of exploring facilitators and barriers, and aiming to understand opportunities and challenges to remain critical of this underlying assumption. To further enhance the interpretive authority, I had continuous conversations with my supervisors regarding which pre-understandings might be at stake throughout the work with this dissertation.

7.0 Conclusion

The overall aim of this dissertation was to explore the experiences and perceptions of PWDs and HPs on extending rehabilitation practices and establish a practice-based understanding of the prospects and contributions of urban green spaces and CBR for future rehabilitation.

The combined findings lend important insights into the PWDs' and HPs' separate and shared experiences and perceptions on extending rehabilitation to urban green spaces and CBR. Together, an outline was provided of the underlying mechanisms to be considered in the future work of rehabilitation practice development and implementation. Based on the findings of this dissertation, the following conclusions can be drawn, followed by an outline of the implications for rehabilitation:

First, it was demonstrated how the existing qualitative literature conceptualises rehabilitation based in the community with focus on outdoor adaptive activities as an opportunity for PWDs to learn how to overcome challenges of everyday life. Outdoor adaptive activities were found to serve as a social gathering point, where all people could share experiences and be equally included in social communities. Although the possibilities of CBR in outdoor settings was emphasised, the HPs expressed a lack of experience with and shared direction on the content and practice of this extended approach to rehabilitation.

Second, the exploration of HPs' experiences and perceptions documented considerable variation and opposites regarding extending rehabilitation to urban green spaces and CBR. Some HPs acting as initiators experienced delivery of rehabilitation in urban green spaces as natural, utilising the *naturalistic learning opportunities*; other HPs experienced ambivalence due to personal struggles to build confidence delivering rehabilitation outside the conventional indoor centre-based context and to meet the organisational demands of health care systems.

Third, exploration of PWDs' experiences and perceptions documented that *revisiting the outdoor setting* as an integrated extension of conventional indoor rehabilitation had the potential to empower PWDs in *building autonomy, connecting with community* and *learning from embodied experiences*. Extending rehabilitation to urban green spaces and CBR may offer an intermediate step supporting PWDs on how to proceed with their daily life, in addition to the specific support needed due to their injury or illness.

Based on the combined findings, it was demonstrated how the PWDs were dependent on the HPs to act as initiators for introductory support and facilitation of *revisiting the outdoors*. However, in many cases the structural demands of effective pathways, documentation practices and disciplinary reasoning seemed to outweigh the HPs' motivations and the potential contributions of extending rehabilitation. Due to the current COVID-19 pandemic, the prospects and contributions of urban green spaces and CBR in future rehabilitation may be amplified. New practice experiences due to the reshaping of rehabilitation services for COVID-19, may have impacted positively on the readiness of the HPs to learn and build

practice competencies related to extending rehabilitation to urban green spaces and CBR, which otherwise appeared to be an ongoing challenge.

Finally, based on principles of urban green space interventions and CBR, parks like SPARK are suggested to provide platforms for rethinking and extending current rehabilitation practice frameworks. Meanwhile, the findings of this dissertation capitalise on the complexity and inherent professional dilemmas of extending current rehabilitation practices to include urban green spaces and CBR strategies. Based on the insights obtained by exploring the developing process of SPARK, it may be suggested that the finding of *revisiting the outdoors* as an integrated part of rehabilitation practices could serve as a first phase and create a platform for development of a CBR strategy at a later stage. The analyses cutting across the empirical studies showed signs that utilising a combined approach, may enable PWDs and HPs to negotiate and engage with the norms and social structures that are present in and outside the centre-based rehabilitation context.

7.1 Implications for rehabilitation

Based on the combined findings of this dissertation, I suggest attention should be paid to the following implications for rehabilitation to address challenges and enhance the potential benefits of and contributions from urban green spaces and CBR in future rehabilitation.

Introductory support and facilitation

It was demonstrated that the PWDs depend on HPs for introductory support and facilitation to enable their *revisiting of the outdoor settings* and possibly gain empowering experiences. A practice is suggested in which urban green rehabilitation contexts and community engagement are used as a resource to offer support and guidance for PWDs on how to proceed with their daily life concurrent with and following the rehabilitation course. By introducing opportunities for outdoor-based and community practices, the PWDs are not obliged to be a member of a sports club for maintenance or improvement of functioning. Thus, the rehabilitation activities might be more easily integrated into their everyday life routines, including work, family life, recovering and engaging in community life.

Adopting a combined approach

Focus should be on adopting a combined approach in which the diversities of practices in conventional indoor and urban green rehabilitation contexts are perceived as complementary rather than contradictory, and as an extension rather than a deselection. It is advised that the HPs take on the responsibility to predict and continuously re-evaluate whether the individual person in rehabilitation would benefit from *revisiting the outdoor settings* and to assess which terms of engagement would be relevant, as a part of the mandatory job tasks regarding future rehabilitation for PWDs. A combined approach may underpin tailoring of the rehabilitation course to the shifting needs and preferences of PWDs throughout the process, and enhance everyday transferability through a shifting focus between body functions and advancing levels of empowering experiences as well as activity and participation.

A practice is suggested in which HPs reframe challenges inherent to the unruly urban green rehabilitation context as resources to advance rehabilitation for PWDs. Besides benefitting from the restorative aspects of nature exposure, the urban green spaces offer a varying context with different levels of physical and social difficulty and situations comparable to everyday life of the PWDs, e.g. get to know one's limits of physical capacities and energy level as well as practicing orientation and socialising with people passing by. Extending rehabilitation to urban green spaces and CBR is suggested to underpin the building of enabling and empowering experiences for individual judgement or decision-making that teach one how to cope with and overcome possible challenges.

Preparing and educating HPs

Focus should be on preparing and educating HPs to extend rehabilitation and to utilise and distil the restorative, empowering and health promoting benefits from outdoor environments and community engagement. For instance, during the current pandemic, governments have utilised urban green spaces as an important public health tool. However, this has not led to further considerations of how to prepare the HP workforce to respond to this strategy. It is suggested that HPs may benefit from developing skills and competencies related to rehabilitation practices in urban and natural green spaces as a part of the mandatory training of the future rehabilitation workforce. To underpin this process, it is advised that educational institutions take responsibility and respond more effectively to the growing demands of utilising benefits of human health and nature connections and inclusive community development.

Organisational implications

It is further suggested that implications at an organisational level are relevant. It was demonstrated that the structural demands of effective pathways, documentation cultures and disciplinary reasoning in many cases seem to outweigh the HPs motivations and contributions of extending rehabilitation, despite documented benefits for PWDs. The organising of work conditions and procedures should be arranged in a way that underpins and allows for prioritisation of outdoor-based rehabilitation activities and community engagement on the same level as conventional indoor-based rehabilitation practices if assessed needed. To promote that HPs act as initiators, it is suggested that management are attentive to the possibilities for extending rehabilitation to facilitate and enable changes beyond artefact-level adaptations in practice.

A strengthened focus on inclusion of the wider community

Finally, to expand an inclusive community development beyond a formal rehabilitation programme context, a strengthened focus on inclusion of the wider community is essential. Urban green space projects such as SPARK, should not be perceived as an isolated event or an established intervention with expectations of standardised outcomes. It is suggested that by merging professional knowledge with community insights and putting the profound experiences of PWDs into play may help cultivate, reinforce and maintain an inclusive community spirit over time.

7.2 Suggestions for future research

This PhD dissertation lends insights into some of the underlying mechanisms at stake among PWDs and HPs when extending rehabilitation practices to include urban green spaces and CBR. Still, there are many areas for future research to explore further. The following suggested areas for future research can potentially challenge, and nuance or confirm the findings of this PhD.

1. Development and tailoring of current documentation practice in rehabilitation

Overall, the structural standards and quality demands for indoor centre-based rehabilitation settings were not applicable in the less controlled and varied urban green rehabilitation contexts according to HPs. Development of current documentation practices and measurement tools, adjusted to urban and natural green spaces are crucial and in demand.

2. Urban green space and inclusive community development in rehabilitation

The accomplishment of relating rehabilitation in urban green spaces to a CBR agenda, requires further analysis and more engagement at a structural level related to e.g., health legislation, volunteer regulations, social initiatives and urban masterplans as well as biodiversity strategies. The prospects of extending rehabilitation and utilise capacities of parks like SPARK, certainly depends on the development of sustainable governance strategies and calls for long-term follow-up research.

3. Competency framework

The findings documented considerable differences between rehabilitation practices in conventional indoor and urban green space rehabilitation contexts, respectively. The extension of rehabilitation practice contexts involved a more explorative, creative, and playful approach to rehabilitation practices as the urban green rehabilitation context was not defined by programmed exercises, specific equipment, and objective tests. Development of a shared direction or competency framework is required for use in undergraduate educations, in pre-service training and in-service training for HPs and in the communication with PWDs and community stake holders.

4. Perspectives of managers and stakeholders

In the project, I focused on the PWDs' and frontline HPs' experiences and perceptions on urban green spaces and CBR for future rehabilitation. Given the organisational mechanisms related to extending rehabilitation practices unfold themselves at several levels in the rehabilitation organisations, it could be beneficial to explore the perspectives of the managers and other stakeholders.

English summary

Rehabilitation for PWDs has traditionally been a primarily hospital-based subspecialty of medicine or an allied health intervention with an expert-driven approach. Growing evidence points to the link between human health and nature, and a need for inclusive community development for PWDs. As a result, contemporary practice have started to rethink use of urban green spaces and CBR as resources in rehabilitation for PWDs, to support functioning and diversity in the disability experience, including everyday life situations. Due to urbanisation, public parks have come to play an important role as sites of rehabilitation. This dissertation was embedded in SPARK, an urban rehabilitation park context under development in the outdoor surroundings of the national rehabilitation MC. Based on principles of urban green space interventions and CBR, the SPARK park has the contextual surroundings to be a potentially unique example of innovative rehabilitation solutions. In these initiatives, HPs are the pillars with a strong potential to endorse or dismiss such new practices.

The overall aim of this dissertation was to explore the experiences and perceptions of PWDs and HPs on extending rehabilitation practices and establish a practice-based understanding of the prospects and contributions of urban green spaces and CBR for future rehabilitation. This dissertation consists of four articles: a systematic review and three empirical papers. The methodology used was ID accompanied by social practice theory and organisational culture theory as the theoretical framework. The empirical articles are based on qualitative data from three rehabilitation centres; articles II and III are based on a five-month ethnographic field work (participant observations, photovoice and interviews), and article IV is based on FGIs conducted at a later stage. In all, 116 PWDs and 28 HPs participated in the dissertation.

In article I (37) the aim was to examine and synthesise qualitative knowledge on PWDs' and professionals' experiences and perceptions regarding facilitators and barriers to CBR approaches in outdoor settings. It was concluded that the existing qualitative literature highlights the interrelationship regarding the *Ability to overcome challenges, outdoor adaptive activities* and *inclusive social communities*. *This synergy seemed to create a mutual synergy that translated into a Culture of reciprocal interaction*. Even though the findings across the studies emphasised the possibilities of CBR in outdoor settings, misconceptions about disability and HPs' lack of experience and shared direction constituted ongoing barriers.

In article II (38) the aim was to examine HPs' experiences and perceptions of providing rehabilitation in outdoor community settings. The purpose was to use these experiences to generate practice-based knowledge in using outdoor settings to guide CBR. The analysis identified three main findings: *Naturalistic learning opportunities* were obtained from providing rehabilitation in an urban green context. Yet *Rehabilitation setting tensions* were invoked due to HPs' uncertainties and structural demands, forcing HPs to *Navigate a*

middle ground. The findings provide new knowledge of the extension of conventional rehabilitation practices to urban green spaces and CBR. Further, promotion of HPs' skills and competencies regarding urban green spaces and community engagement are suggested.

In article III (39) the aim was to examine the potential of outdoor contexts within CBR to empower PWDs in their rehabilitation. Analysis of the potential of outdoor contexts within CBR included four themes; *Revisiting the outdoors* appeared to be an overarching theme, which created a basis for *Building autonomy* among the participants. The varied outdoor experiences seemed to empower the participants to take on a more active role in their rehabilitation. Unique opportunities for *Connecting with community* and *Embodied learning* were obtained, which could be transferred to home and to other everyday contexts. These findings provide insights into potential benefits and approaches to guide practice in *revisiting the outdoors* as a possible contribution to future rehabilitation practices.

In article IV (40) the aim was to describe and analyse PWDs' and HPs' perceptions on combining traditional indoor rehabilitation practice with urban green rehabilitation contexts. Main findings included *Ambivalence due to contextual change*, which were affected through *Negotiating rehabilitation assumptions* and enabled Expanding the frame of rehabilitation. The PWDs' and HPs' joint perceptions offered insights into their shared views on what is essential to consider as a part of the future rehabilitation practice development.

It is suggested that the findings of this dissertation guide practice in aiming for a combined approach in which the diversities of practices in conventional indoor and urban green rehabilitation contexts are perceived as complementary rather than contradictory. The findings can contribute to development of a rehabilitation practice in which urban green rehabilitation contexts and CBR are used as resources to offer support and guidance for PWDs on how to proceed with their daily life during and after rehabilitation.

Dansk resumé

Rehabilitering for personer med nedsat funktionsevne har traditionelt været hospitalsbaseret inden for det medicinske område med en ekspertdrevet tilgang. Stigende evidens peger på et link mellem menneskers sundhed og naturen samt et behov for fokus på at skabe tilgængelige og socialt inkluderende omgivelser. Som følge heraf er praksis begyndt at gentænke brugen af urbane grønne områder og strategien *CBR* som en ressource i rehabiliteringen. Hensigten er at understøtte hele spektret af funktionsevnen samt situationer, der relaterer sig til hverdagslivet. Over halvdelen af verdens befolkning lever i byer, så urbane grønne områder og offentlige parker er kommet til at spille en vigtig rolle også i rehabilitering. Denne afhandling tager afsæt i SPARK projektet placeret i det nationale rehabiliteringscenter MarselisborgCentret, som er en urban grøn rehabiliteringspark under konstruktion, der tilbyder innovative omgivelser for udvikling af nye rehabiliteringsløsninger. I denne udvikling spiller sundhedsprofessionelle en grundlæggende rolle med potentiale for enten at bakke op omkring eller afvise sådanne nye tiltag i praksis.

Det overordnede formål med denne afhandling var at undersøge personer med nedsat funktionsevne, og sundhedsprofessionelles erfaringer med og opfattelser af at udvide rammen for rehabilitering. Hensigten var at etablere en praksisbaseret forståelse for hvordan urbane grønne områder, og *CBR* kan bidrage til fremtidens rehabiliteringspraksis. Denne afhandling består af fire artikler: En systematisk litteraturgennemgang og tre empiriske artikler. Den anvendte metodologi var *ID* ledsaget af social praksis teori og teori indenfor organisationskultur som overordnet ramme. De empiriske artikler er baseret på kvalitative data genereret i samarbejde med tre rehabiliteringscentre placeret på MC. Artiklerne II og III tager afsæt i data fra et fem måneders etnografisk feltarbejde (deltagerobservationer, photovoice og interviews) og artikel IV er baseret på fokusgruppeinterviews. I alt deltog 116 personer i rehabiliteringsforløb og 28 sundhedsprofessionelle i afhandlingen.

I artikel I (37) var formålet at undersøge og samle kvalitativ viden om muligheder og barrierer forbundet med anvendelse af en *CBR*-tilgang i udendørs omgivelser. Den undersøgte litteratur repræsenterede personer med nedsat funktionsevne og sundhedsprofessionelles erfaringer og opfattelser. Ud fra en systematisk gennemgang af litteraturen, kunne følgende tematikker fremhæves: *Evnen til at overvinde udfordringer*, *Tilpassede udendørs aktiviteter* og *Inkluderende sociale fællesskaber* samt en *Gensidig interaktionskultur*. Selvom resultaterne på tværs af de inkluderede artikler fremhævede de fremmende faktorer forbundet med rehabilitering i udendørs omgivelser, var der fortsat barrierer såsom opfattelsen af, hvad det vil sige at være begrænset i sin funktionsevne samt de sundhedsprofessionelles manglende erfaring med og fælles retning for, hvordan man tilgår rehabilitering i uderummet.

I artikel II (38) var formålet at undersøge sundhedsprofessionelles erfaringer med og opfattelser af rehabilitering i udendørs omgivelser. Formålet var at bruge disse erfaringer til

at generere praksisbaseret viden om, hvordan grønne omgivelser i rehabiliteringen kan fremme en *CBR* tilgang. Analysen viste tre overordnede tematikker: *Naturlige læringsmuligheder*, der blev opnået ved at tilbyde rehabilitering i en urban grøn kontekst. Dertil opstod også *Sundhedsfaglige dilemmaer* i form af personlig usikkerhed samt at skulle leve op til strukturelle bestemmelser. Hvilket stillede krav til de sundhedsprofessionelle om at kunne *Navigere i et krydsfelt*. Resultaterne bidrager med ny viden om udvidelse af rehabilitering i praksis til urbane grønne områder og *CBR*. Desuden fremhæves fokus på at fremme sundhedsprofessionelles kompetencer i at kunne fagligt underbygge og gøre brug af rehabilitering i urbane grønne områder.

I artikel III (39) var formålet at undersøge potentialet i at anvende grønne urbane omgivelser samt *CBR* i rehabilitering med henblik på at styrke oplevelsen af handlekompetence hos personer i rehabilitering. Analysen omfattede fire temaer; *Introduktion til uderummet* var det overordnede tema, der skabte et grundlag for *Øget selvstændighed* blandt deltagerne. De forskellige udendørs erfaringer understøttede deltagerne i at påtage sig en mere aktiv rolle i deres rehabilitering, og gav mulighed for opnå *En plads i fællesskabet* og at føle sig forbundet til sine omgivelser. Dertil opstod muligheden for *Læring gennem kropslige erfaringer*, som for mange kunne overføres til egen hverdagskontekst. Artiklens fund bidrager til en udvidet tilgang til at vejlede praksis i at introducere personer i rehabilitering til uderummet, og anvende det som en mulighed og ressource i fremtidig rehabiliteringspraksis.

I artikel IV (40) var formålet at beskrive og analysere personer i rehabilitering samt sundhedsprofessionelles opfattelse af at kombinere traditionel indendørs rehabiliteringspraksis med urbane grønne omgivelser. De overordnede fund omfattede *Ambivalens omkring ændring af konteksten*, som blev påvirket gennem *Forhandling af antagelser om rehabilitering*, og gjorde det muligt at *Udvide rammen for rehabilitering*. Personerne i rehabilitering samt sundhedsprofessionelles fælles opfattelser gav indsigt i deres samlede synspunkter om, hvad der er vigtigt at tage i betragtning som en del af udviklingen af fremtidens rehabiliteringspraksis.

Resultaterne i denne afhandling kan guide rehabiliteringspraksis med henblik på at anvende en kombineret tilgang, hvor de iboende forskelligheder i konventionelle indendørs og urbane grønne rehabiliteringskontekster anvendes som komplementære snarere end modstridende bidrag. Resultaterne kan bidrage til udviklingen af en rehabiliteringspraksis, hvor urbane grønne rehabiliteringskontekster og *CBR* strategier anvendes som ressourcer til at understøtte og vejlede personer i et rehabiliteringsforløb og til at understøtte disse personer i deres daglige liv under og/eller efter rehabilitering.

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9.0 Appendices

Appendix 1 Not included in this file

- Article I. **Community-based rehabilitation approaches in outdoor settings: a systematic review of people with disabilities' and professionals' experiences and perceptions**
Madsen, L.S.; Handberg, C.; Jensen, C.M.; Nielsen C.V.

Appendix 2 Not included in this file

- Article II. **Navigating a Middle Ground - Exploring Health Professionals' Experiences and Perceptions of Providing Rehabilitation in Outdoor Community Settings**
Madsen, L.S.; Nielsen C.V.; Oliffe J.L.; Handberg, C.

Appendix 3 Not included in this file

- Article III. **The potential of outdoor contexts within community-based rehabilitation to empower people with disabilities in their rehabilitation**
Madsen, L.S.; Jakubec, S.L.; Nielsen C.V.; Handberg, C.

Appendix 4

- Article IV. **“It Was Definitely an Eye-Opener to Me” - People with Disabilities' and Health Professionals' Perceptions on Combining Traditional Indoor Rehabilitation Practice with an Urban Green Rehabilitation Context.**
Madsen, L.S.; Poulsen, D.V.; Nielsen C.V.; Handberg, C.

Article IV



Article

“It Was Definitely an Eye-Opener to Me”—People with Disabilities’ and Health Professionals’ Perceptions on Combining Traditional Indoor Rehabilitation Practice with an Urban Green Rehabilitation Context

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Citation: Madsen, L.S.; Poulsen, D.V.; Nielsen, C.V.; Handberg, C. “It Was Definitely an Eye-Opener to Me”—People with Disabilities’ and Health Professionals’ Perceptions on Combining Traditional Indoor Rehabilitation Practice with an Urban Green Rehabilitation Context. *Int. J. Environ. Res. Public Health* **2021**, *18*, 5994. <https://doi.org/10.3390/ijerph18115994>

Academic Editors: David Rojas and Pauline Van den Berg

Received: 9 April 2021

Accepted: 31 May 2021

Published: 3 June 2021

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Abstract: Research points to the health benefits of rehabilitation in urban green spaces. Nevertheless, more studies indicate complexity of utilising urban green spaces in an established health system context. An understanding of challenges related to rehabilitation in urban green spaces remains unaddressed. Therefore, the aim was to describe and analyse people with disabilities’ and health professionals’ perceptions on combining traditional indoor rehabilitation practice with an urban green rehabilitation context. The interpretive description methodology was applied supplemented by Edgar Schein’s Model of Organisational Culture. Three online focus group interviews were conducted with people with disabilities ($n = 4$) and health professionals ($n = 10$). Three interrelated themes formed an understanding of rehabilitation practice in an urban green rehabilitation context: “ambivalence due to contextual change”, “negotiating rehabilitation assumptions” and “expanding the frame of rehabilitation”. Expanding the frame of rehabilitation to an urban green context may provide a basis for enhancing compatibility to everyday life for people with disabilities and still accommodate structural quality standards of professional rehabilitation practice.

Keywords: rehabilitation; urban green space; people with disabilities; health professionals; organisational culture; interpretive description

1. Background

Rehabilitation provides support to people with disabilities in obtaining optimal functioning in everyday life and improving life quality [1,2]. Traditionally, rehabilitation has primarily been considered a hospital-based subspecialty of medicine or an allied health intervention with an expert-driven approach and focus on body functioning [3,4]. Increasing research points to the health benefits of rehabilitation and health services in urban- and natural green spaces [5,6]. Worldwide, a range of initiatives have been established primarily within the fields of therapeutic gardens [7–9], green care farms [10,11] as well as public health agendas [5,12]. Improvements in mental health [13–15], holistic assessment [16] and empowering experiences of people with disabilities [9,17,18] have been documented. By facilitating a varying physical and social context with different levels of difficulty urban green spaces may enable people with disabilities to overcome challenges of community engagement [18,19] and encourage more physical activity [19,20]. The World Health Organization defines urban green space as all urban land covered by vegetation of any kind, irrespective of size and function, which can also include small water bodies (“blue spaces”) [21].

To address contemporary needs for developing urban green spaces for rehabilitation activities [2,19] and encourage inclusive community development of people with disabilities [22,23], the SPARK (Sound Park Activities, Rehabilitation and Climate) park will be established in Aarhus, the second-largest city in Denmark [18,24,25]. The SPARK park has the contextual surroundings to be a potential unique example of an urban green space intervention for an innovative rehabilitation solution [18,24,25]. Based on the increasing evidence on the positive link between health and nature [26,27], urban green spaces have grown into an important public health initiative, which has been conceptualised in political documents by the World Health Organization and the European Commission [21,28–30]. In addition, there exist indications of urban green spaces gaining acceptance into the established health systems [31].

By offering an additional avenue to rehabilitation, urban green spaces like the SPARK park may lead to a considerable change of longstanding practices, extending rehabilitation from the field of medicine to encompass urban green space interventions [21,32] and health-promoting aspects [5]. Practice changes are known to be challenging, as the process often encompasses a change in roles, attitudes and behaviours by the individuals and groups involved [33,34]. More studies indicate the complexity of including urban green spaces in established health system services [24,33,35]. An understanding of challenges related to rehabilitation in urban green spaces remains unaddressed. Exploring knowledge sharing among people with disabilities and health professionals may contribute to new mutual understandings and important practice insights to guide future practice development. Therefore, the aim was to describe and analyse people with disabilities' and health professionals' perceptions on combining traditional indoor rehabilitation practice with an urban green rehabilitation context.

2. Materials and Methods

2.1. Methodology and Theoretical Frame

This qualitative study used interpretive description [36] as the methodology and with Edgar Schein's Model of Organisational Culture [37] as the theoretical lens [36]. Interpretive description was used to generate practice-based knowledge on rehabilitation practices in collaboration with and to the benefit of people with disabilities and health professionals [36]. Interpretive description provided an organising logic throughout the study by asking questions based in practice and guided by research results from the same practice field, namely those of a previous ethnographic fieldwork embedded in the developing SPARK park [18,24]. Interpretive description differs from other methodologies by drawing on a variety of already known research traditions and methods, thus allowing for a pragmatic approach to the research aim in question [36]. An inductive analytical approach was used to obtain a coherent conceptual description [36]. Elaborating on associations, relationships and patterns [36] formed an understanding of the prospect of combining traditional indoor rehabilitation practice with an urban green rehabilitation context to inform practice [36].

Interpretive description was supplemented by Edgar Schein's Model of Organisational Culture to guide data interpretation [37]. To proceed systematically in the exploration of the aim, Schein's Model was chosen to unfold and gain a deeper understanding of what is at stake combining traditional indoor rehabilitation practice with an urban green rehabilitation context. Schein's culture framework is drawn from the field of organisational psychological science and has been shown to be beneficial to understand change processes within health practices [38]. Schein's culture framework is a dynamic model dividing culture into three levels: (1) *artefacts and behaviours*, the visible elements that one can see and feel thus marking the surface of the culture; (2) *espoused values*, the stated values, norms and rules of behaviour which are a less visible part of the culture; and (3) *basic assumptions*, the unwritten rules which are taken for granted as an acceptable way of perceiving the world, representing an underlying unconscious level of culture [37]. Schein advocates that basic assumptions play the strongest role in initiating culture change but are also the

hardest to influence as they are manifested as unconscious perceptions among members of the culture [37,39].

2.2. Setting

In Denmark, rehabilitation is provided free of charge as a part of a tax-financed welfare system. The MarselisborgCentre is a national centre for rehabilitation, organised as a cluster organisation with approximately 20 rehabilitation centres [25,40]. With the establishment of a SPARK park, the outdoor surroundings of the MarselisborgCentre are being transformed to a 7.2-hectare urban green space combining rehabilitation facilities, climate adaptation and health promotion [18,24,25].

In 2015, the final grants for establishing the SPARK park at the MarselisborgCentre were received (around EUR 6 million) and the actual development phase began (Figure 1) [25]. More than 263 future users, partners and stakeholders were involved in the co-creation of the design, content and approach of the park [25]. In 2018, the overall layout of the SPARK park was presented by the winning architect team. The overall purpose was to create innovative outdoor multifunctional solutions with high accessibility and utilise opportunities embedded in the natural elements.

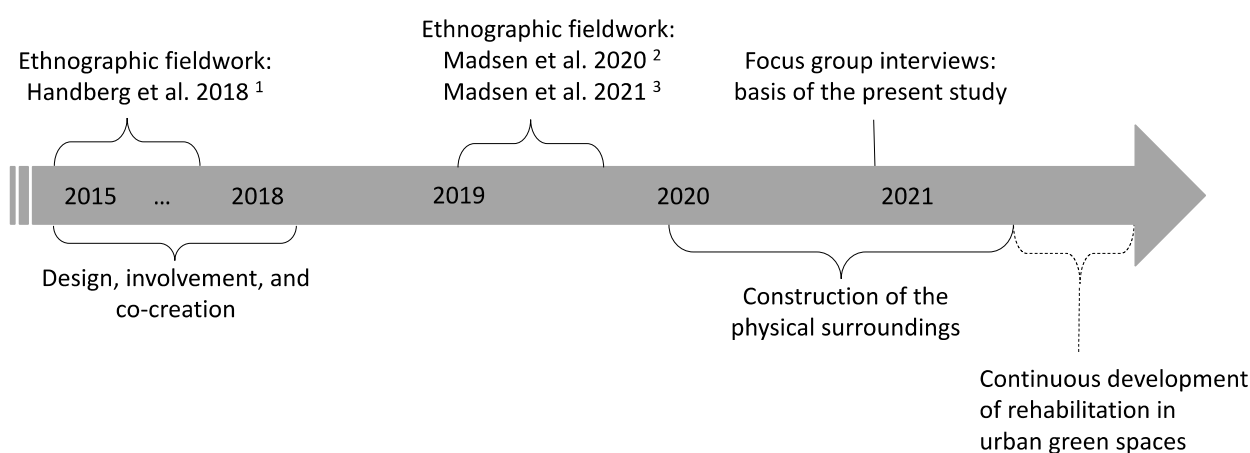


Figure 1. SPARK park timeline. ¹ Handberg, C.; Mygind, O.; Johansen, J.S. Lessons learnt on the meaning of involvement and co-creation in developing community-based rehabilitation. *Disabil. Rehabil.* 2018 [25]. ² Madsen, L.S.; Nielsen, C.V.; Oliffe, J.L.; Handberg, C. Navigating a Middle Ground—Exploring Health Professionals’ Experiences and Perceptions of Providing Rehabilitation in Outdoor Community Settings. *Qual. Health Res.* 2020 [24]. ³ Madsen, L.S.; Jakubec, S.L.; Nielsen, C.V.; Handberg, C. The potential of outdoor contexts within community-based rehabilitation to empower people with disabilities in their rehabilitation. *Disabil. Rehabil.* 2021 [18].

The physical transformation of the park has run parallel to this study (2020–2021). In this period, the outdoor surroundings were temporarily turned into a construction site with less attractive conditions for rehabilitation activities. The opportunities for developing specific new solutions were thus temporarily limited, and alternative areas were used as temporary sites for rehabilitation in an urban green context. This study was conducted in collaboration with three future key users of the SPARK park: The Orthopaedic Rehabilitation Centre, the Neurological Rehabilitation Centre and the Dementia Activity and Rehabilitation Centre (Table 1).

2.3. Sampling

The sample included 14 participants representing people with disabilities ($n = 4$) and health professionals ($n = 10$). A purposive sampling strategy [36] was chosen to select key informants from the original sample from an ethnographic fieldwork in connection with the SPARK park [18,24]. We aimed for a heterogeneous group composition [41] with different backgrounds, work experiences and types of disability. All participants had experiences

with rehabilitation in urban green spaces. Four participants (two persons in rehabilitation and two health professionals) dropped out due to the COVID-19 pandemic. Therefore, 2 of the 14 included participants were new informants. The sample size was guided by the concept of “information power” by Malterud et al. [42]. Inclusion criteria were as follows: health professionals employed at or people with disabilities previously attending rehabilitation at the Orthopaedic Rehabilitation Centre, the Neurological Rehabilitation Centre or the Dementia Activity and Rehabilitation Centre. The three rehabilitation centres were purposefully selected [36], representing future key users of the SPARK park, providing rehabilitation for diverse target groups with motor or cognitive disabilities (Table 1). Health professionals included physiotherapists ($n = 6$), occupational therapists ($n = 3$) and a social and health care assistant ($n = 1$), one male and nine females ranging between 28 and 62 years of age. The participants attending rehabilitation included people with acquired brain injury ($n = 1$), back injury ($n = 2$) and knee injury ($n = 1$), three males and one female ranging between 35 and 73 years of age.

Table 1. Characteristics of the included rehabilitation centres [18].

Centre	Conventional Indoor Rehabilitation Services	Rehabilitation in Outdoor Contexts	Types of Disabilities Handled
Orthopaedic Rehabilitation Centre: A multidisciplinary service for people with musculoskeletal injuries	<ul style="list-style-type: none"> - Individual consultations - Back training programmes in teams (physical training and patient education) - Leg training in teams - Training of walking with a leg prosthesis - Heated basin training - Fitness self-training 	Nature training programmes in teams delivered outside during all seasons of the year. Additionally, some individual consultations and team programmes were performed outside during the summer season.	<ul style="list-style-type: none"> - Back pains - Back injuries (surgically treated) - Leg amputations - Knee injuries - Achilles injuries - Hip fractures - Shoulder and neck injuries - Hand and wrist injuries - Elbow injuries
Neurological Rehabilitation Centre: A multidisciplinary service for people with acquired brain injury or related neurological injuries	<ul style="list-style-type: none"> - Individual consultations - Fitness training in teams - Balance training in teams - Stress relief in teams - Patient education about the brain in teams - Energy management training in teams - Home visits 	Balance training in teams was often performed outside during the summer season. Additionally, some individual consultations and home visits were performed outside, in the garden or in the local community.	<ul style="list-style-type: none"> - Apoplexy/stroke - Dysphagia - Cerebral palsy - Head and neck cancer - Meningitis
Dementia Activity and Rehabilitation Centre: A day and activity service for community-dwelling elderly with dementia or related issues	<ul style="list-style-type: none"> - Socialising around the dinner table - Cognitive stimulation - Playing games - Physical and balance training and gymnastics - Community singing 	Strolls in the park in suitable weather conditions. Weekly excursions to nearby communities and nature parks.	<ul style="list-style-type: none"> - Dementia - Alzheimer's - Socially marginalised populations

2.4. Data Source

A focus-group approach was chosen for the interviews [43], drawing inspiration from the Mutual Innovation and Learning Platform (MILP) approach [44], to create an interactive context for shared discussions and knowledge exchange. Based in the employment service field, Andersen et al. developed MILP, which set up a model for knowledge production that is made through cooperation between practice and research [44]. With the MILP approach, knowledge is regarded as equal but different. Instead of a typical one-way relation, where the researcher hands over knowledge to practitioners or consumers who may or may not find this knowledge useful, the relation in the MILP is reciprocal [44]. The practitioners and consumers help guide the attention of the researchers to the areas of greatest relevance. This furthers the production of knowledge that is of considerable use for everyday practice and to the benefit of the consumers [44].

2.5. Data Generation

The first author conducted three online (due to the COVID-19 pandemic) focus group interviews (FGIs): FGI 1 (the Dementia Activity and Rehabilitation Centre) consisted of three health professionals, FGI 2 (the Neurological Rehabilitation Centre) consisted of three health professionals and one person attending rehabilitation and FGI 3 (the Orthopaedic Rehabilitation Centre) consisted of four health professionals and three persons attending rehabilitation. The FGI at Dementia Activity and Rehabilitation Centre was conducted without the attendance of people with disabilities for ethical reasons as dementia caused severe cognitive disabilities in this group. The format chosen was synchronous group discussions face-to-face by use of webcams and application of the Microsoft Teams platform [41]. To prepare participants for the topic of discussion, a short summary using layman language to describe the research results and context was developed by condensing key points of the previous research [18,24] with the assistance of an external layperson to ensure understanding and clarity. The description was forwarded to participants one week prior to the FGIs [41].

The first author was the moderator and also took part in the shared discussions from a researcher position [44]. As a starting point for discussion [44], the moderator presented results from two research articles [18,24] with empirical data from the same setting (Table 1). Open-ended questions [45] based on the research aim and previous empirical knowledge [18,24] were subsequently posed: “Based on this presentation, I am curious to know what are your immediate thoughts?” “Based on the topics discussed, which changes can be implied?” “How do you consider your role in initiating change and new solutions in the rehabilitation area?” An assistant moderator attended the FGIs and asked follow-up questions. Each interview lasted 90 min and was video recorded and subsequently transcribed verbatim by the first author.

2.6. Analysis

Guided by interpretive description, four iterative inductive analytical steps were followed [36]:

1. Initial impression and coding in NVivo; organisation and comparison of data. The research team read through all transcripts, followed by a joint discussion of the initial impression of the data. The first author re-read and coded all data material using NVivo. Codes were developed based on the empirical data and the research aim, and interpretations were informed and guided by Schein’s culture framework [37].
2. Fractured coded data were subsumed using descriptive labels. The first author mapped data by hand to enhance mobility and expand on the associations in the data, followed by a joint discussion with the research team.
3. Themes and patterns were identified and tested through interpretive processes. The first author condensed and drafted memos on each theme with illustrative quotes, which were tested and challenged by the research team through written and verbal input. All quotes were translated from original language to English with the assistance of a professional translator.
4. Interpretations and relationships of the thematic findings; extraction of main messages arising from key insights in the data. The first author condensed and drafted the thematic findings, which were qualified and co-authored by the research team through joint critical discussions and are illustrated by a figure in the results section.

2.7. Ethical Considerations

The study was approved by the Danish Data Protection Agency (Approval No. 1-16-02-293-18). Written informed consent was given prior to the online group interviews and video-recording of the interviews.

3. Results

Three interrelated themes formed an understanding of people with disabilities' and health professionals' perceptions on combining traditional indoor rehabilitation practice with an urban green rehabilitation context: "ambivalence due to contextual change", "negotiating rehabilitation assumptions" and "expanding the frame of rehabilitation" (Figure 2).

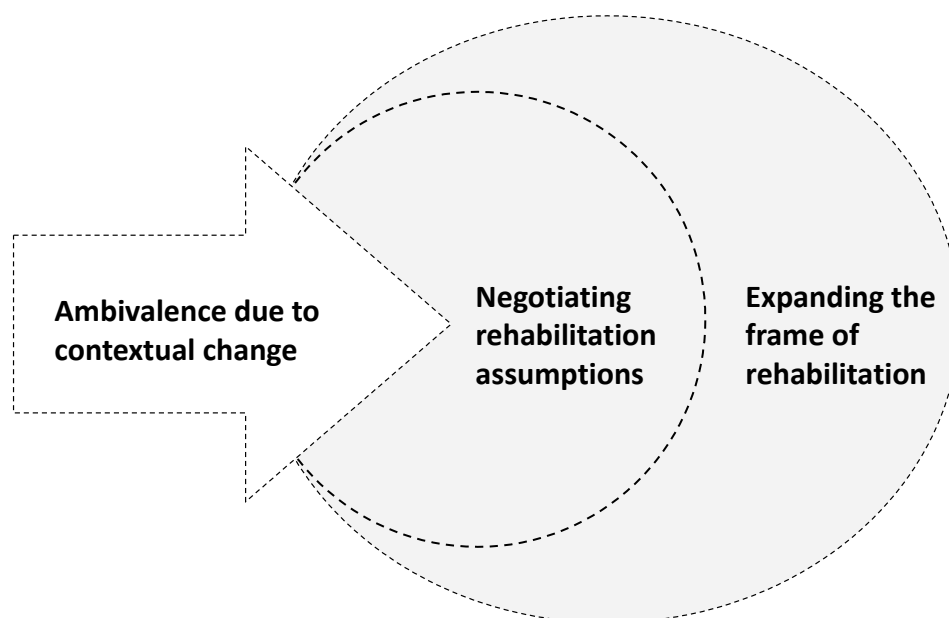


Figure 2. To convert ambivalence into possibilities of expanding the frame of rehabilitation, the assumptions of people with disabilities and health professionals were negotiated.

3.1. Ambivalence Due to Contextual Change

The transformative surroundings of the SPARK park context seemed to cause ambivalence among participants. Especially among health professionals, there was a certain ambivalence in relation to adapting rehabilitation practices to the new SPARK park facilities. The ambivalence was expressed by simultaneous and contradictory perceptions which seemed to loop between resistance of contextual change to practice on the one hand and recognising potential benefits on the other. A health professional with more than 20 years of professional experience expressed this ambivalence in terms of a professional dilemma:

"When you think about the health professional dilemmas, they are certainly there. When you on the one hand can find the meaningfulness and the motivation for the persons in rehabilitation out in the real world, right. And on the other hand, as a health professional can have doubts if it complies with the high-quality standards for a rehabilitation process, you know."

Occupational therapist, >50 years

The ambivalence expressed in this quotation between the meaningfulness of the individual and the quality of the rehabilitation practice appeared to cause critical perceptions among the health professionals. Although health professionals stressed practical and structural barriers (e.g., financial restrictions, time rationing and weather conditions) as the main challenges, these arguments seemed to be rooted in an underlying uncertainty related to the possible compromised quality of rehabilitation practices. A health professional with more than 15 years of professional experience shared an experience of how deep scepticism about rehabilitation in green spaces was gradually turned to reflective action:

"In the beginning, I had serious doubts if this was actually useful. Is it not just a sloppy job? We just walk around, right? This was of course because I didn't know anything about it and was really insecure. Along the process, I realised that maybe we were

not completely precise with the physical rehabilitation part, but it [the physical part] played a secondary role. There was a bunch of other benefits . . . And seeing how people improved . . . it made me change my attitude, you see."

Physiotherapist, 40–50 years

Although the quotation does not refer specifically to the SPARK park, the health professional used this retrospective experience to exemplify how building practice experiences over time may reduce professional uncertainty.

Parallel to the development process of the park, first movers among the health professionals initiated external adaptations to current practices, although scepticism among their colleagues persisted. For instance, they used the varied surfaces in the park for balance training, walked around the park to follow the transformation process or temporarily moved rehabilitation activities to other green spaces. Based on these first-mover initiatives, the persons who had previously attended rehabilitation—and thus shared their experiences from a retrospective point of view—expressed how they had been reluctant at first, doubting the effectiveness and overall purpose of including green spaces in their rehabilitation. Nevertheless, opposite the health professionals, the perceptions of people with disabilities reflected an immediate change in their experiences of rehabilitation. A participant who attended rehabilitation 1.5 years ago explained having changed the perception already after the first outdoor experience:

"I hadn't thought about going outside would be considered exercise. I thought it was a bit special in the beginning. But I could see that after the first five minutes you feel ready because there's a good atmosphere and it's another way of exercising. It was definitely an eye-opener to me."

Participant recovering from a back injury, <40 years

This quotation illustrates how a change of context represented new opportunities to people attending rehabilitation. In general, people with disabilities expressed great confidence in the health professionals and the activities initiated and appeared to build their own experiences in continuation hereof.

The arguments both for and against changes in the rehabilitation context appeared to be based on an artefact level of reasoning such as providing fresh air and light or an opportunity to get people outside and participate in organised activities involving physical artefacts such as a bonfire, a play field or a cross-fit area. As this artefact level of reasoning was not explicitly grounded in professional evaluation, it did not seem to constitute an evident imperative for change. To move beyond ambivalence and contrasting perceptions, negotiation of rehabilitation assumptions among people with disabilities and health professionals appeared a crucial step, bringing all three levels of culture into play.

3.2. Negotiating Rehabilitation Assumptions

The group discussions exposed an underlying divide in rehabilitation assumptions. The people with disabilities related to everyday experiences and complex life situations, whereas the health professionals seemed to relate to health structures and traditional disciplinary reasoning. It appeared central to establish a common ground of rehabilitation assumptions.

In the negotiations taking place through discussing what is at stake combining traditional indoor rehabilitation practice with an urban green rehabilitation context, more health professionals defended the traditions of the current rehabilitation practice culture and longstanding disciplinary assumptions. As an example, physiotherapists work with physical activity and body functions and occupational therapists work with daily activities one-to-one. The rehabilitation assumptions reflected a test culture with a focus on measuring body functions and documenting progression. A health professional with more than 15 years of professional experience expressed being stuck in the current practice values:

"We are in a health professional world where measuring things is a top priority . . . our municipality is very much in favour of data-documented work. Well, it is not a lot of

what we do outside that can be measured just like that. We are really stuck in this way of thinking!"

Occupational therapist, 40–50 years

This quotation illustrates how the health professionals continued to argue their case based on structural and disciplinary reasoning. In response, one of the participants who attended rehabilitation one year ago challenged the assumptions of the health professionals:

"You have a lot of methods and so on in your work. But right outside the door, there will be a park where you can re-think your way of managing your practice. It's a new opportunity of making the person in rehabilitation re-start, you know, after being ill . . . You have to go in front as professionals. It really means a lot that you take the first step. And that you dare to! To cross the barrier, I can hear you have. You all have a kind of barrier—is this beneficial or what? Will we be a little ridiculed for this? NO you won't [be ridiculed]!"

Participant recovering from stroke, >50 years

This quotation exemplifies how rehabilitation assumptions of people with disabilities and health professionals were negotiated through critical reflection during group discussions. In contrast to the structured healthcare systems, people with disabilities related to their everyday experiences and complex life situations. Reflecting on what was (and still is) meaningful to the rehabilitation process, they capitalised on the importance of being guided on how to proceed with their daily life in addition to the support of the specific injury or illness. To negotiate and develop a common ground for rehabilitation in an urban green space, sharing reflections and exchanging knowledge between and across diverse contextual understandings appeared relevant. A health professional with more than 10 years of professional experience explained having developed a new consciousness about their own rehabilitation assumptions, based on the research presented and the shared discussion with the people attending rehabilitation:

"There are many things I was not aware of . . . especially the part about challenging the established testing approach—that we have to document a result of the rehabilitation period they [the people in rehabilitation] have been through. Usually we make a 6-min walk test or a mini balance evaluation system test, and then think . . . we can't really do that outside, yet."

Physiotherapist, 40–50 years

This quotation exemplifies how exposing underlying assumptions enabled health professionals to critically reflect upon perceived barriers to expanding rehabilitation practices to urban green spaces. By negotiating underlying assumptions, the perceptions of rehabilitation practices among people with disabilities and health professionals seemed to expand, and new possibilities of combining traditional indoor rehabilitation practice with an urban green rehabilitation context were discussed.

3.3. Expanding the Frame of Rehabilitation

Expanding the way of rehabilitation practices to encompass urban green spaces may pave the way for accommodating structural quality standards and still enhance the everyday compatibility to the lives of people with disabilities. A health professional with more than 10 years of professional experience highlighted the possibilities of adopting a combined approach:

"Well, it shouldn't be either or; it should be a combination of the two. Because we get something positive from both worlds . . . Sometimes we as physiotherapists want to focus and only think about the bodily functions and the physical part. But it is also about daring to come out and bring the whole person [attending rehabilitation] into play, you know. It may not just be about the body, but you get a lot of other things. And I believe, that is also what rehabilitation is about."

Physiotherapist, 40–50 years

Across the participants, a combined approach was suggested: capitalising on the “best practices” of traditional indoor rehabilitation and building on the capacities in urban green spaces. During the construction phase of the SPARK park, basic elements influencing culture change could be extracted from the practice experiences of the first-mover initiatives already taking place. Four basic elements expanding the frame of the current rehabilitation practice culture were apparent: (1) engaging the whole life situation, (2) influencing role development, (3) enhancing everyday compatibility and (4) building inclusive social communities.

Engaging the whole life situation was widely considered a key possibility of expanding current rehabilitation practices to urban green spaces. Both health professionals and the people attending rehabilitation highlighted how focus on the specific injury or body part was supplemented by a wider perspective. The roles of people with disabilities and health professionals seemed to develop in an empowering sense with influence from the urban green context. A first-mover health professional with more than 20 years of professional experience outlined how the green space could be used as a conscious strategy to support people with disabilities in taking on an active role in their rehabilitation:

“The outdoor environment is everybody’s space. We work with the whole person and not just the body . . . And it may seem that we just play outside in the green area, but it all has a deeper meaning, and it also takes a lot to both be able to see—what is actually needed—and to take a step back and know when to assist and when you have to step back and allow the persons [in rehabilitation] to do it their own way; or to allow the participants to interact.”

Physiotherapist, >50 years

This quotation exemplifies how the green space supported health professionals in targeting the rehabilitation to the individual needs of people with disabilities. By creating identifiable situations, challenges and feelings, rehabilitation in an urban green context may be a powerful means for the individual development of people with disabilities. The urban green space was perceived to be a neutral arena, enhancing the compatibility to everyday contexts of people with disabilities, and thus appeared a central element for changing the culture of rehabilitation practices. A participant who had just ended rehabilitation explained how the outdoor experiences enhanced compatibility to everyday life and provided additional opportunities for including one’s family in the sustained rehabilitation:

“The transformation from rehabilitation or training to your everyday life has been really easy . . . in this way it has meant that we [he and his family] use the green areas in our neighbourhood more than ever before (laughing) . . . If you had only trained in a fitness centre or a gym, then you would probably have thought about the fitness centre when transferring it to your everyday life. And this can be difficult if you live far away [from a fitness centre or gym] or you, as it has been mentioned, don’t want to be part of a formal sports community or fitness centre.”

Participant recovering from a back injury, <40 years

The context and variety of opportunities introduced during rehabilitation seemed to have a considerable impact on what people with disabilities experienced as available and validated options for their sustained rehabilitation. The people attending rehabilitation perceived the future SPARK park as a possibility for expanding rehabilitation to being more supportive of the transitional phase in the rehabilitation process. By providing a basis for an inclusive environment, the SPARK park was highlighted as a future arena for building inclusive social communities operating in the intersection between formal rehabilitation centres, organised sports clubs and conventional community networks.

In summary, the ambivalence due to contextual change, specifically expressed by health professionals, appeared to be rooted in an artefact level of reasoning. By negotiating rehabilitation assumptions of people with disabilities and health professionals, all three levels of culture (artefacts, espoused values and basic assumptions) were brought into play and enabled shared perceptions to be formed. Expanding the frame of rehabilitation to

urban green spaces seemed to provide a basis for enhancing compatibility to the everyday lives of people with disabilities and still comply with structural quality standards for rehabilitation.

4. Discussion

Expanding the frame of rehabilitation to urban green spaces is not simply a matter of moving the recreational activities from an exercise room to outdoor contexts. Based on the results of this research, rehabilitation in an urban green context may induce a shift in professional rehabilitation culture in order to progress.

In relation to the prospects of combining traditional indoor rehabilitation practice with an urban green rehabilitation context, role identity appeared both as a barrier and motive for action. The negotiation of rehabilitation assumptions of people with disabilities and health professionals may be grounded in contemporary discussions regarding professional–consumer relationships in rehabilitation [1,3,46]. In the last decades, increasing attention has been drawn to the normative relationship between people attending rehabilitation and health professionals taking an expert role [1,3,47]. The increasingly active participation and involvement of people attending rehabilitation represents a culture change in practice as well as a major change in the roles of people attending rehabilitation and health professionals [47]. On the one hand, traditional roles of, for instance, physiotherapists prescribing a treatment programme are gradually being developed to guide and support people attending rehabilitation through the complexities of everyday life [47]. On the other hand, health professionals' perceptions and established practice frameworks may still pose significant barriers [24,33]. For instance, a survey by Wolsko et al. exploring mental health professionals' ($n = 231$) employment of the restorative capacity of nature showed that “overstepping therapist–client boundaries” was perceived as a main barrier [35]. This barrier included concerns that outdoor activities with a client would promote a too personal relationship, resulting in lost objectivity within the traditional therapeutic frame [35]. In the present research, the health professionals expressed being stuck in current health structures and traditional disciplinary frameworks, restricting role development. Expanding the frame of rehabilitation to urban green spaces seems to potentially support health professionals in enabling people with disabilities to actively take part in rehabilitation. To that end, parks like the SPARK park may provide platforms for rethinking current practice frameworks.

In this research, the people with disabilities perceived rehabilitation in urban green spaces as a possibility for being guided on how to proceed with their daily life, in addition to the specific support of their injury or illness. Still, concerns of compromising the quality of rehabilitation practices were raised by the health professionals. Expanding rehabilitation to urban green spaces thus seems to give rise to reconsidering how the quality of rehabilitation may be obtained. To help people regain loss in functioning, or maintain functioning, it is essential to build empowering experiences that teach how to cope with and overcome possible barriers in public settings somehow comparable to the individuals' everyday context [18,48]. Besides being a health-promoting context [5,26,27], green spaces have been framed as challenging and risky environments providing opportunities to test and promote the physical and mental stamina of people with disabilities [49]. Still, we do acknowledge that safety is a core component of the quality of professional practice [49–51]. In professional rehabilitation, practice safety is often considered in the absence of risks and often relates to following strict procedures, obtaining a high degree of control and minimising risks and challenges [35,49,52]. However, the absence of risks has been argued to potentially prevent people with disabilities from learning how to manage and cope in outdoor physically and socially challenging environments, resulting in adverse consequences [33,49–51]. In this research, a combined approach is suggested: capitalising on the “best practices” of conventional indoor rehabilitation and building on the capacities offered by urban green spaces. Expanding the frame of rehabilitation to urban green spaces may provide a basis for enhancing compatibility to everyday life for people with disabilities and still accommodate structural quality standards of professional rehabilitation practice.

The future work of expanding the frame of rehabilitation to urban green spaces may involve a fundamental change in or expansion of professional norms, values and practice culture. To understand change processes within health practices, the consideration of different levels of cultural influence on the organisation and groups involved has been suggested as beneficial [38]. Organisational culture is known to shape the attitudes and behaviours of health professionals and impact ways of communicating with users, thus often directly impacting the quality of services delivered [38]. Changing cultures of health organisations is, however, known to be a considerable challenge, and most initiatives fail either immediately or over time [38]. To increase possibilities for practice change due to parks like the SPARK park and move forward beyond ambivalence (Figure 2), a long-term strategy is required. To expand the frame of rehabilitation to urban green spaces, the first-mover initiatives need to be accompanied by strong leadership facilitating and enabling changes beyond artefact-level adaptations [37–39]. Without such leadership supporting culture change at a basic assumptions level, the possibilities connected to urban green spaces, like the SPARK park, may remain unutilised.

Moreover, it is critical to be able to document, assess and evaluate initiatives to promote sustainable change and ensure political and financial support [53]. Central to the long-term work to expand the frame of rehabilitation and to future research, are the development and tailoring of current documentation practices, as well as skills and competencies of health professionals to the urban green space context [33].

5. Methodological Considerations

The credibility and trustworthiness of the findings were enhanced by providing a clear description of the analytical process elaborated in four iterative steps [36]. All authors read the data transcripts to qualify analytic discussions and interpretations, which added to the trustworthiness of the results. Throughout the analytical process, the interpretations were linked to the original data sources by continuously returning to the raw data [36]. The author team represented different professional backgrounds, including anthropological, public health, nature-based therapy and medical science, and employed different areas of research within the field of rehabilitation and health promotion. The composition of the author team provided different angles to the research process, leading to critical methodological discussions and considerations, which may have prevented blind spots and biases of a single researcher influencing the results of the study [36].

The application of the cultural analytical approach by Schein [37] provided new understandings of the influence of cultural levels on rehabilitation practices and combining traditional indoor rehabilitation practice with an urban green rehabilitation context. The fact that the SPARK park was under development during the time of this study may have impacted the results, as we were not able to gain insight into new concrete rehabilitation solutions and practice experiences of the finished park. Although a limitation, the developmental phase at the time of the study enabled early detection of potential countermeasures such as ambivalence due to contextual changes and advanced understandings of future possibilities within parks like the SPARK context. In an action plan on urban green space interventions provided by the World Health Organization, a key point is that potential challenges should ideally be considered during an ongoing planning process with the involvement of key users [29]. The SPARK park being established in the tax-financed health and social welfare context in Denmark may limit the transferability of results and application, as this governance model to rehabilitation is not the framework used in all parts of the world.

The fact that the first author had previously conducted an ethnographic fieldwork in the same practice field meant that pre-understandings were inevitable [36]. However, pre-understandings are seen not only as a weakness and source of bias for the results, but also as an essential element to generate knowledge based on a contextual understanding of the practice field under study [36]. To identify and address possible blind spots, the implications of pre-understandings were continuously and thoroughly discussed among

the author team. This pre-understanding was consciously integrated into the choice of methods and data generation by using research results derived from people with disabilities' and the health professionals' own everyday rehabilitation practice context [18,24] as the starting point for critical discussions [44]. Examination of the knowledge exchange between the researcher, health professionals and people with disabilities appeared to be a major strength, as the results reflect mutual understanding and meaningful collaborations between researchers and the practice field [44]. Although we have merely taken the first steps, this collaborative approach has created room for discussing the exclusivity of traditional professional rehabilitation practices provided in conventional indoor settings.

The composition of people with disabilities and health professionals in the FGIs created an interesting dynamic in the discussions, challenging each other's perceptions and creating new reflections. The sample size is a limitation, as twice as many health professionals as people with disabilities participated. Due to the COVID-19 pandemic, we unsuccessfully tried to recruit a higher number of people attending rehabilitation. The imbalance in the sample may have impacted the results, as the reflections of health professionals may have dominated the topics discussed. Health professionals seemed to have more restrictive attitudes than people attending rehabilitation regarding future possibilities (and challenges) within the SPARK park. Further, conducting online FGIs may have limited interaction between participants [41,43]. To ensure that the point of view of people with disabilities was not overlooked, an active moderator role was applied asking directed follow-up questions to engage all participants in the discussions [41,43].

To expand the frame of rehabilitation, future research would benefit from examining and developing current documentation practices and interventions adjusted to urban green spaces. Further, examining the perspective of leaders and managers regarding the expansion of the frame of rehabilitation is relevant in future research.

6. Conclusions

This study takes the first steps to understand people with disabilities' and health professionals' perceptions on combining traditional indoor rehabilitation practice with an urban green rehabilitation context. Expanding the frame of rehabilitation to an urban green space context is not simply a matter of moving the recreational activities from an exercise room to outdoor contexts. In the present research, the health professionals expressed being stuck in current health structures and traditional disciplinary frameworks, which caused ambivalence. The expansion of rehabilitation to urban green spaces seems to potentially support health professionals in enabling people with disabilities to take an active part in rehabilitation. Based on the results, a combined approach is suggested: capitalising on the "best practices" of conventional indoor rehabilitation and building on the capacities in urban green spaces. Expanding the frame of rehabilitation to urban green spaces may provide a basis for enhancing compatibility to everyday life for people with disabilities and still accommodate structural quality standards of professional rehabilitation practice.

Linking research results with the perceptions of people with disabilities and health professionals enabled the building of a mutual understanding and meaningful collaborations between researchers and the practice field to generate new forms of impact. The perceptions of people with disabilities and health professionals provided insights into their shared views on what needs to be considered as part of the future work of implementation.

Author Contributions: Conceptualisation, L.S.M., D.V.P., C.V.N. and C.H.; data generation, L.S.M.; methodology, L.S.M., D.V.P., C.V.N. and C.H.; formal analysis, L.S.M., D.V.P., C.V.N. and C.H.; project administration, L.S.M.; writing—original draft preparation, L.S.M.; writing—review and editing, D.V.P., C.V.N. and C.H. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by the Aarhus University, Faculty of Health (Denmark), grant number 81264, and The Foundation of Central Denmark Region (Denmark), grant number A1369.

Institutional Review Board Statement: The study was approved by the Danish Data Protection Agency (Approval No. 1-16-02-293-18), date 22 June 2018.

Informed Consent Statement: Written informed consent was obtained from study participants for the online group interviews and video-recording of the interviews.

Data Availability Statement: The data are not publicly available due to restrictions regarding privacy and ethical consideration of the study participants.

Acknowledgments: The authors would like to thank all the participants who generously contributed to this study. Further, we would like to thank Lene Klem Olesen, who participated as an assistant moderator during focus group interviews.

Conflicts of Interest: The authors declare no conflict of interest.

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Appendices continued (in Danish)

Appendix 5	Interview guides article II Article II – phase 1 Article II – phase 2
Appendix 6	Interview guide article III
Appendix 7	Fieldwork timeline
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Appendix 5. Interview guide article II - phase 1

Spørgsmål		Minutter
1.	Velkomst og introduktion til interview	5
Åbningsspørgsmål		
2.	<p>Selvom I arbejder med forskellige målgrupper, så har jeg på baggrund af de første fokus-gruppe interviews lavet en opsummering af det som er den overordnede kerneopgave som er fælles for Jeres arbejde med borgerne:</p> <ul style="list-style-type: none"> - Rehabilitering: fysisk, psykisk, socialt og kognitivt - Komme hele vejen rundt om borgeren – fokus på det hele menneske - Tilrettelægge et individuelt forløb, hvor borgeren gøres aktiv gennem stimuli på mange måder - Finde en vej til at forbedre eller opretholde funktionsevne - Hjælpe borgeren til et så godt hverdagsliv som muligt - Fokus på det sociale og det at være sammen med andre - Hjælpe borgeren til at finde glæden igen med de begrænsninger der nu evt. kan være. - Sikre overførbare til borgerens eget hverdagsliv - Og understøtte at borgeren har en tilknytning til samfundet generelt <p>Med afsæt i det, så vil jeg gerne at vi lige har en kort præsentationsrunde, hvor I siger jeres navn, faglige baggrund, og på hvilken måde I arbejder med at løse kerneopgaven i Jeres daglige praksis?</p>	10
Introduktionsspørgsmål		
3.	Med afsæt i løsningen af jeres kerneopgave – Hvad kan uderummet så bidrage med? eller skabe udfordringer for?	10
Overgangsspørgsmål + Nøglespørgsmål <i>I har alle taget billeder der repræsenterer de muligheder og udfordringer I oplever der er forbundet med at bruge uderummet i rehabilitering.</i> <i>Ud fra billederne og nogle af de emner der yderligere kom frem i gruppediskussionerne, så vil jeg præsentere jer for nogle overordnede sammenhænge som jeg gerne vil have jer med til at kvalificere. Så ud fra de forskellige emner jeg kommer til at præsentere for jer, vil jeg gerne have jer til at diskutere hvordan I ser at det hænger sammen; Ser I det på en anden måde? Er der noget der overrasker jer? Er det sådan I oplever det?</i>		
4.	<p>Jeg har 5 emner der repræsenterer noget betydningsfuldt i forhold til brug af uderummet i rehabilitering, og de indeholder både udfordringer og muligheder.</p> <p>(ud fra matrix sætter jeg nogle få stikord på det enkelte emne sammen med de billeder der knytter sig til, efterfulgt af følgende spørgsmål:)</p> <ol style="list-style-type: none"> 1. Sammenhængen mellem brug af uderummet og overførbareheden til borgerens eget hverdagsliv bliver fremhævet mange gange, hvordan oplever I det i Jeres arbejde med borgeren? 2. Det ser ud til at der sker noget i relationen mellem mennesker når det er omgivelserne udenfor der danner rammen - både mellem den professionelle og borgeren, men også mødet med andre mennesker i nærområdet – hvilken betydning tænker I at det har for borgerens rehabiliteringsforløb? 3. Meget tyder på at uderummet kan opleves meget udfordrende, der er mindre mulighed for kontrol og det kan få en ud af ens komfort-zone - det gælder både for den professionelle og 	45

Appendix 5. Interview guide article II - phase 1

	<p>borgeren - hvordan oplever i det? (På en positiv eller negativ måde?)</p> <p>4. Uderummet er meget blevet beskrevet som frie rammer og det udefinerede og indbyder til en anderledes måde at tænke omkring rehabilitering på, hvilke værdier - hvis i tænker på kerneopgaven - er det så der bliver bragt i spil på en anden måde her?</p> <p>5. Langt de største udfordringer der bliver nævnt er i form af praktiske omstændigheder som tid, forberedelse, prioritering og at det er lettere at gøre det man plejer og kender til i en presset hverdag med mange forskellige opgaver. Hvad ville jeres løsning på de udfordringer være?</p>	
Nøglespørgsmål		
5.	Har det givet jer nogle aha-oplevelser eller nye tanker omkring de udfordringer og muligheder der er forbundet til rehabilitering i uderummet og på hvilken måde det bidrager til at borgerens rehabilitering?	5
6.	Ud fra at kerneopgaven som i arbejder med er sammenlignelig, Og de udfordringer og muligheder i oplever på nogle punkter er overlappende, Hvordan ser I så muligheden for at komme til at arbejde mere sammen på tværs af husene her i MC parken? Altså i har uderummet som noget fælles, men kan noget rehabiliteringen også være fælles?	5
Afrundende spørgsmål		
7.	Hvis du skulle fortælle en kollega om det mest interessante fra interviewet i dag, hvad skulle det så være?	5

Nuancerende spørgsmål

- Er der andre der ser det på en anden måde?
- Er der nogen der har nogle andre erfaringer?
- Er der nogen med andre synspunkter?

Opfølgende spørgsmål

- Kan du forklare det nærmere?
- Kan du komme med et eksempel?
- Og hvad betyder det at...?
- Kan du måske sætte lidt flere ord på?
- Hvad tænker du i forhold til det?
- Kan du beskrive nærmere hvad du mener med...?
- Det forstår jeg måske ikke lige helt...

Fordelingsspørgsmål

- X – du har ikke haft mulighed for at byde ind endnu. Hvad tænker du om...?
- For at alle får mulighed for at byde ind bliver jeg nødt til at afbryde...
- X – hvis du skulle give dit bud på... hvad skulle det så være?

Appendix 5. Interview guides article II – phase 2

Spørgsmål		Minutter
1.	Velkomst og rammerne for interviewet	2
Åbningsspørgsmål		
2.	Nu har jeg jo fået et indblik i hvordan det fungerer med de forskellige hold og individuelle forløb. Jeg vil gerne have Jer til at fortælle hvad der ligesom er kernen i Jeres daglige arbejde og forløb med borgerne?	5
3.	Med afsæt i det, hvad er så Jeres forventninger til SPARK ud fra det som i ved om projektet? - Har i nogle forventninger?	5
Introduktionsspørgsmål + overgangsspørgsmål <i>For at opnå en lidt mere overordnet forståelse for brug af uderummet i rehabilitering så er fire af Jer blevet stillet til opgave hver især at medbringe fire billeder til interviewet.</i> - 2 der repræsenterer de muligheder det giver at bruge uderummet mere i rehabilitering - og 2 der repræsenterer de udfordringer der er forbundet med at bruge uderummet mere <i>Til at starte med får i lige et minut hver især til at præsentere billederne og så diskuterer vi dem fælles efterfølgende hvor I andre skal være med til at byde ind.</i>		
4.	A) X vil du starte, så går vi videre over til Y osv. Prøv og fortæl lidt om de 2 billeder der repræsenterer muligheder – hvorfor har du taget lige netop de billeder? B) Så vil jeg gerne have Jer til at bruge billederne som afsæt for at diskutere hvor i er enige eller uenige og begrunde hvorfor. Hvis der er noget som ikke er blevet nævnt endnu så byd også meget gerne ind med det.	5+10
5.	Hvad kan uderummet som inde rummet ikke kan?	5
6.	A) X, Prøv og fortæl lidt om de 2 billeder der repræsenterer udfordringer – hvorfor har du taget lige netop de billeder? B) Så vil jeg gerne have Jer til at bruge billederne som afsæt for at diskutere hvor i er enige eller uenige og begrunde hvorfor. Hvis der er noget som ikke er blevet nævnt endnu så byd også meget gerne ind med det.	5+10
7.	Hvad kan inde rummet som uderummet ikke kan?	5
Nøglespørgsmål		
8.	Nu har I både talt om udfordringer og muligheder. Hvad skal der til for at skabe de bedste rammer for at I kan lykkes med det I gerne vil?	5
9.	Hvis I tænker på de udfordringer som i generelt møder i Jeres daglige praksis og forløb med borgerne – det må i gerne sige lidt om hvad det kunne være af forskellig slags - Er der så noget af det vi har snakket om som kunne være med til at løse de udfordringer – eller måske komme til at skabe endnu større udfordringer?	10
10.	Nu var xxx her i tirsdags for at fortælle om sin nye brobygger funktion mellem Jeres borgere og lokale sociale fælleskaber. Hvad tænker I om det tiltag? Kan det bidrage til noget? (for Jer? Eller for borgerne?)	10
11.	(Assistent moderator: opfølgende spørgsmål på baggrund af noter)	10
Afrundende spørgsmål		
C)	Ud fra alt det vi har diskuteret hvad er så det vigtigste at fremhæve?	5
D)	Ud fra at formålet har været at opnå indsigt i - muligheder og udfordringer forbundet med brug af uderummet i rehabilitering - er der så noget vi har overset eller ikke været omkring? (– hvis i skulle nævne største udfordring og mulighed hvad er det så?)	5

Appendix 6. Interview article III

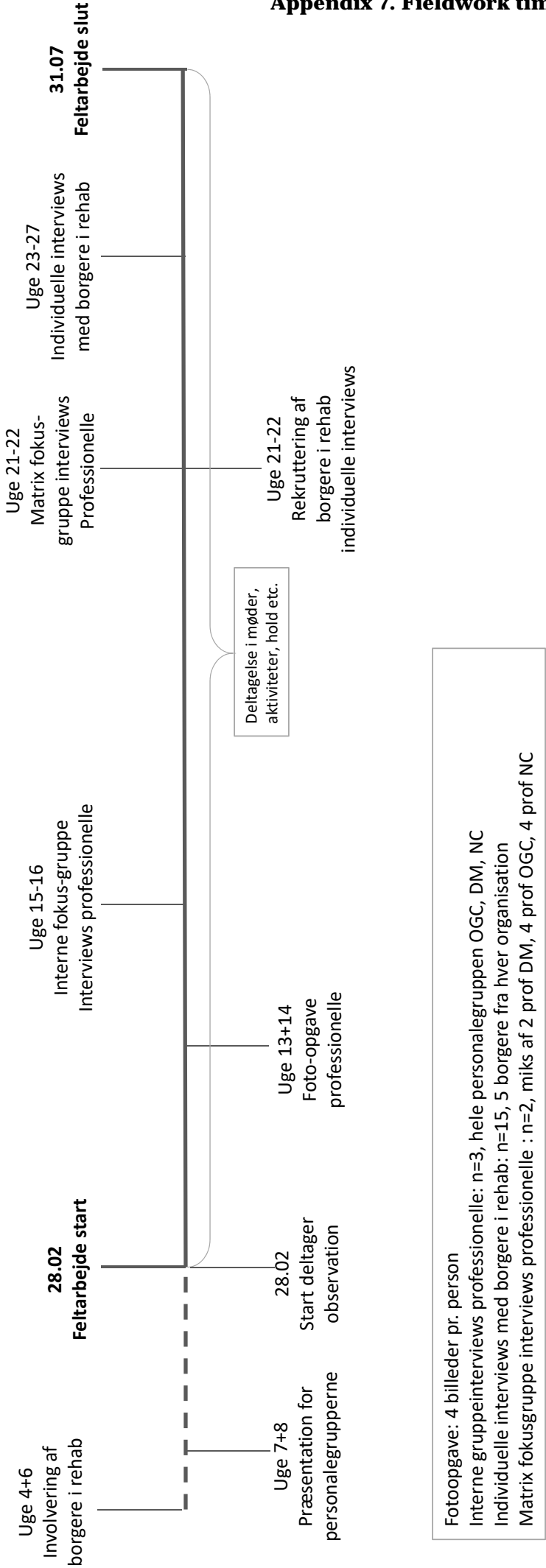
Walking interviews - personer i rehabiliteringsforløb

Område	Spørgsmål
Introduktion	<ul style="list-style-type: none"> - Alder - Beskæftigelse
"In place"	1. <i>Nu er vi jo udenfor, hvad er din generelle oplevelse af at være udenfor?</i>
Rehabiliteringsforløb	2. <i>Kan du fortælle lidt om, hvad der ligger til grund for at du er i genoptrænings/aktivitetsforløb ved xxx</i> 3. <i>Hvad var/er dine forventninger til, hvad du skulle have ud af forløbet?</i>
Ændret livssituation	4. <i>Kan du prøve at beskrive hvordan dit hverdagsliv er som det ser ud nu?</i> 5. <i>Oplever du begrænsninger i dit hverdagsliv? (hvis ja hvilke)?</i>
Erfaringer med brug af uderummet i rehabilitering	Du har i forbindelse med dit genoptrænings/aktivitetsforløb været udenfor sammen med en/ flere af terapeuterne. 6. <i>Kan du prøve at beskrive hvordan din oplevelse var af det?</i>
Muligheder og udfordringer forbundet med brug af uderummet i rehabilitering	(kobling til ovenstående) 7. <i>Hvilke fordele – hvis nogen - er der forbundet med, at dele af dit rehabiliteringsforløb foregår udenfor?</i> 8. <i>Hvilke begrænsninger – hvis nogen - er der forbundet med, at dele af dit rehabiliteringsforløb foregår udenfor?</i> 9. <i>Oplever du, at muligheden for at være udenfor, har indflydelse på hvordan du har det? (hvordan)</i>
"In place"	10. <i>Hvis du skulle fremhæve en ting omkring det at være udenfor - det kan være både positivt og negativ - hvad skulle det så være?</i>
Frie rammer - det udefinerede	I løbet af mit feltarbejde har jeg oplevet, at det at være udenfor, af mange, bliver defineret som noget med nogle frie rammer 11. <i>Hvordan oplever du det?</i>
Ude af 'comfort zone' - udfordringer - det ukontrollerede	Jeg har flere gange oplevet at det at være udenfor også kan frembringe usikkerhed, fordi der er flere udfordringer, og det kan være sværere at kontrollere. 12. <i>Hvordan oplever du det?</i>
Overførbare til hverdagslivet	I løbet af mit feltarbejde er jeg også stødt på, at de aktiviteter som i laver udenfor sammen med terapeut(erne), at de opleves som mere relevante og nemmere at overføre til hverdagslivet. 13. <i>Hvordan oplever du det?</i>
Møder mellem mennesker	Uderummet bliver også beskrevet som et mere socialt rum, der er med til at fremme møder mellem mennesker og stimulere til nye sociale fællesskaber. 14. <i>Hvordan oplever du det?</i>

Appendix 6. Interview article III

Walking interviews - personer i rehabiliteringsforløb

"Empower"	<i>15. Føler du dig rustet til at håndtere den livssituation som du befinder dig i nu?</i> <i>16. Hvordan oplever du at uderummet kan være med til enten at styrke eller begrænse det, som du gerne vil?</i>
Afslutning	<i>17. Hvis vi skal opsummere lidt, hvad er så henholdsvis den største fordel og største begrænsning ved det?</i> <i>18. Tænder du, at der er noget som vi ikke har været omkring?</i>



Uge 12 + 14 (lige uger)				
Mandag	Tirsdag	Onsdag	Torsdag	Fredag
8.30-10.00 Dese OGC	8.00-9.30 LFP	8.00-9.30 Midtvejsopfølgning	8.00-13.00 Aktiviteter NC	8.00-16.00 Diverse ph.d.-opgaver På kontoret Bygning 1b
10.00-12.00 LFP B OGC	9.30-11.30 Amputholdet OGC	9.30-14.00 Aktiviteter DM	13.00-14.00 Personalemøde NC – faglig udvikling	
12.45-13.30 Personalemøde NC	12.30-13.30 Personalemøde OGC	14.00-16.00 Kursus i udendørs rehabilitering	14.00-16.00 Aktiviteter NC	
13.30-15.30 Aktiviteter NC	13.30-16.00 daglige aktiviteter OGC			
Uge 11 + 13 (ulige uger)				
Mandag	Tirsdag	Onsdag	Torsdag	Fredag
10.00 - 12.00 Naturtræning OGC	8.00-12.30/16.00 Diverse ph.d.-opgaver På kontoret Bygning 1b	8.15-10.00 Teammøde og monofagligt møde NC	8.00-09.30 LFP OGC	9.00-13.00 Aktiviteter DM
12.45-13.30 Personalemøde NC		10.00-14.00 Aktiviteter NC	10.00-12.00 Naturtræning OGC	13.00-16.00 Opfølgning på ugens forløb
13.30-15.30 Aktiviteter NC	12.30-15.00 Evt. udflugter DM	14.00-16.00 Kursus i udendørs rehabilitering	12.30-14.00 Personalemøde, vidensdeling	
			14.00-16.00 daglige aktiviteter OGC	
Ortopædisk genoptræningscenter (OGC)	Dagcenter Midtpunktet (DM)	Neurocenter (NC)	Diverse ph.d.-opgaver	

Appendix 9. Interview guide article IV

Form	Spørgsmål	Tid
Introduktion	Præsentation af formål og form	5 min
Åbningsspørgsmål	Vi starter med en runde, hvor i kort introducerer jer selv med: Fornavn, og tilknytning til x (OGC, NC, DM)	5 min
1. Del Forskningsresultater	Forskningsresultater præsenteres på lægmandssprog som afsæt for fælles diskussion 1. Artikel om borgernes perspektiv 2. Artikel om sundhedsprofessionelles perspektiv	10 min
	<ul style="list-style-type: none"> - Jeg er nysgerrig på at høre jeres umiddelbare tanker omkring det jeg her har præsenteret? - Er der noget der undrer jer eller som i har svært ved at forstå? Hvad gør indtryk på Jer? - Ser i nogle forskelle eller ligheder i de resultater, jeg har beskrevet? - Ud fra det jeg har præsenteret og de emner vi har haft oppe at vende, hvilke forandringer tænker I, det kan give anledning til? 	30 min
2. Del SPARK	Tankerne bag SPARK præsenteres, inkl. charteret for Marselisborgcentret	5 min
<i>Nøglespørgsmål 1 SPARK</i>	<ul style="list-style-type: none"> - Ud fra det jeg har præsenteret og de emner vi har haft oppe at vende, hvilke forandringer tænker I, SPARK kan give anledning til? - Hvordan ser du din rolle i forhold til at igangsætte eller indgå som en del af den forandring? 	10 min
<i>Nøglespørgsmål 2 Civilsamfund</i>	<ul style="list-style-type: none"> - Forestiller I jer, at de, der bruger området til rehabiliteringen af borgere, de frivillige netværk og andre institutioner på området kan udvikle en form for fællesskab? - Eksempelvis til at fastholde det, at bruge naturen og være en del af et fællesskab efter et rehabiliteringsforløb? 	10 min
Opsamling	Nu har I lyttet og talt med hinanden her i gruppen; jeg vil gerne vide, om det har forandret noget hos jer hver især (i forhold til SPARK og hvilken betydning i forestiller jer det får fremadrettet)	5 min
Afrunding	Ud fra alt det vi har diskuteret, <ul style="list-style-type: none"> - hvad er så den største udfordring? - og hvad vil være den nemmeste forandring? 	5 min

Appendix 10. Participant information and preparation article IV

Forberedelse forud for online gruppe interview

Hej ...

I forbindelse med det online gruppe interview den ..., kl... , sender jeg her nogle praktiske oplysninger med to dokumenter vedhæftet.

Hvad er formålet med gruppe interviewet?

At videreudvikle eksisterende viden om uderummet som ramme for rehabilitering baseret i lokalområdet, ved at facilitere erfarings- og videns-udveksling mellem forskere, borgere i rehabilitering og sundhedsprofessionelle.

Dine input er vigtige, for at omsætte viden fra forskning til nye løsninger på rehabiliteringsområdet, der går på tværs af faglig praksis, hverdagsliv, og lokalsamfund.

Hvad skal jeg forberede inden gruppe interviewet?

Jeg har vedhæftet en *kort præsentation af forskningsresultaterne*, med henblik på at:

- 1) Give et indblik i hvilke emner der bringes på banen til fælles diskussion og erfaringsudveksling.
- 2) Danne et afsæt for at tale om, hvad det er for nogle forandringer SPARK giver (eller ikke giver) anledning til, og hvilke konkrete handlinger og tiltag der skal igangsættes.

Hvad skal jeg vide omkring gruppe interviewet?

Jeg har vedhæftet en *samtykkeerklæring* til underskrift inden interviewet. Print dokumentet, læs det igennem og skriv under. Send det til mig på: lmaden@rm.dk, ved enten at tage et billede af blanketten med telefon eller ipad eller scanne det ind. Det er frivilligt at deltage, og du kan til enhver tid trække dit samtykke om at deltage tilbage. Gruppeinterviewet vil blive optaget gennem Teams med lyd og med billede, og alle oplysninger vil blive behandlet anonymt og fortroligt.

Hvordan deltager jeg i gruppe interviewet?

Du modtager en mødeindkaldelse til interviewet fra min kollega Lene Klem Olesen.

I mødeindkaldelsen er der direkte link til Teams mødet, og en beskrivelse af, hvordan du deltager. Lene vil også være til stede og yde teknisk support under interviewet. Ring til hende hvis du oplever problemer på tlf: xx xx xx xx.

Jeg ser frem til at mødes på skærmen og få dine input til fælles forandring!

De bedste hilsner

Louise S. Madsen

Ph.d.-studerende, antropolog

DEFACTUM & Aarhus Universitet

Tlf. Xx xx xx xx



I foråret 2019 blev der gennemført to forskningsundersøgelser ved Ortopædisk genoptræningscenter, Neurocentret og Dagcenter Midtpunktet med afsæt i det kommende SPARK projekt ved MarselisborgCentret. Resultaterne er nu publiceret i to videnskabelige artikler med fokus på:

- 1) **Hvordan borgere, som er i rehabiliteringsforløb ved Ortopædisk genoptræningscenter, Neurocentret eller Dagcenter Midtpunktet, oplever uderummet som ramme for rehabilitering baseret i lokalområdet.**
- 2) **Hvilke erfaringer og opfattelser sundhedsprofessionelle tilknyttet Ortopædisk genoptrænings-center, Neurocentret eller Dagcenter Midtpunktet har med uderummet som ramme for rehabilitering forankret i lokalområdet.**

SPARK projektet udvider rammen for rehabilitering ved, at natur- og lokalområder inkluderes som en naturlig del af omgivelserne. Dine input er vigtige for at omsætte viden fra forskning til nye løsninger på rehabiliteringsområdet, der går på tværs af faglig praksis, hverdagsliv og lokalsamfund.

Potentialer forbundet med inklusion af natur og lokalområder i et traditionelt rehabiliteringsforløb

Jeg har undersøgt, hvilken betydning det har for borgernes rehabiliteringsforløb, at uderummet inddrages som ramme for indsatsen. Igennem fem måneder deltog jeg i rehabiliteringsaktiviteter ved Ortopædisk Genoptræningscenter, Neurocentret og Dagcenter Midtpunktet, som foregik både indendørs og udendørs samt individuelt og i hold. I alt deltog 115 borgere og heraf deltog 15 i individuelle 'walk and talk' interviews med bevægelse rundt i parken. Resultaterne kan opsummeres i følgende fire temaer:

1. Inklusion af natur og lokalområder

Ved at udvide rammerne for traditionel rehabilitering fik deltagerne mulighed for at blive introduceret til natur- og lokalområder på ny samt genopdage dets betydning ud fra de ændrede livsvilkår, som sygdom eller skade havde ført med sig. Derudover blev deltagerne støttet i at udvikle strategier tilpasset dagligdagsudfordringer som eksempelvis; at skabe social kontakt, og at navigere i lokalområdet under varierende terræn- og vejrforhold. Situationer der for flere var forbundet med usikkerhed og frygt og dermed en potentiel barriere for deltagelse. På den måde medvirkede inklusion af natur- og lokalområder i rehabilitering til, at sygdommen naturligt trådte mere i baggrunden.

2. Øget selvstændighed

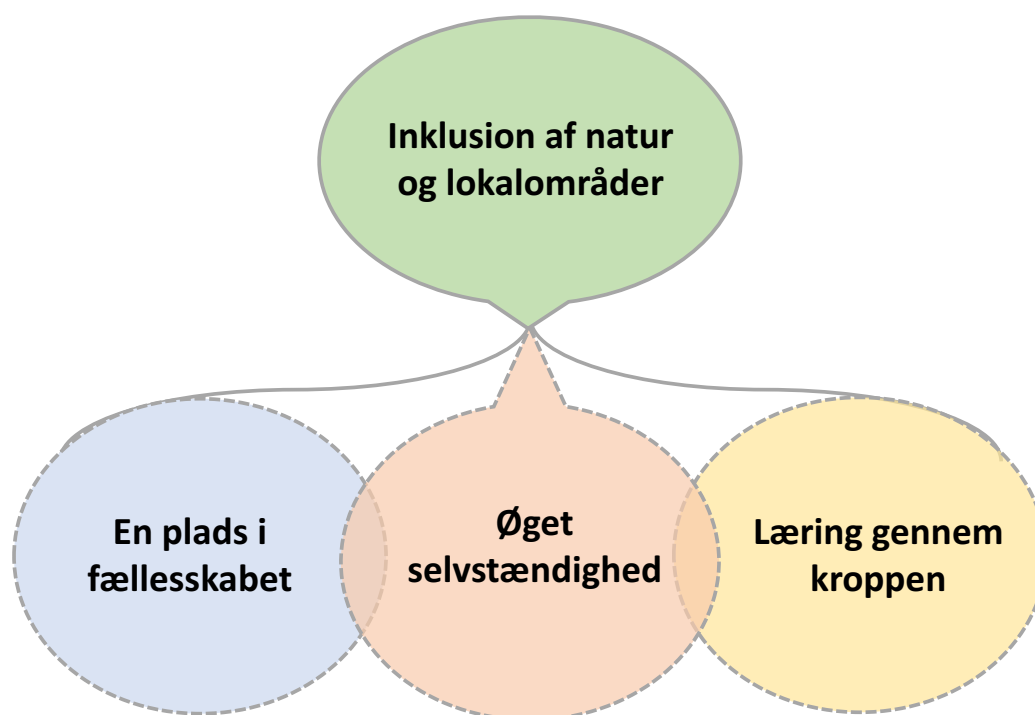
Med uderummet som ramme for rehabilitering begyndte deltagerne gradvist at udvise øget selvstændighed og følge egen intuition. Ved at indtage en mere aktiv rolle i eget rehabiliteringsforløb voksede også bevidstheden om ansvaret for at fortsætte processen på egen hånd eller med fortsat støtte samt selv at kunne vurdere egne muligheder og begrænsninger.

3. En plads i fællesskabet

Uderummet blev fremhævet som et vigtigt skridt på vejen mod at finde eller genfinde en plads i fællesskabet i en ellers sårbar periode med mange timer i hjemmet. På den måde oplevede deltagerne, at inklusion af natur- og lokalområder i rehabilitering var medvirkende til at de psykiske og sociale aspekter af deres liv blev naturligt bragt mere i spil.

4. Læring gennem kroppen

Ved at udvide rammen for traditionel rehabilitering og inkludere varierende natur- og lokalområder gav det mulighed for, at deltagerne kunne lære gennem egne kropslige erfaringer. Den læring, som deltagerne havde fået med sig gennem rehabiliteringsforløbet, kunne omsættes til konkrete handlinger i uderummet, hvilket for deltagerne gav en mere direkte kobling til deres hverdagsliv.



Figur 1. Figuren demonstrer, hvordan borgerne i rehabilitering oplevede inklusion af natur- og lokalområder som et afsæt for at opnå; en øget selvstændighed, en plads i fællesskabet og læring gennem kroppen, som havde en naturlig kobling til egen dagligdag.

Artikel 2:

Navigation i et krydsfelt: Sundhedsprofessionelles erfaringer med uderummet som ramme for rehabilitering baseret i lokalområdet.

Jeg har undersøgt, hvilke udfordringer og muligheder sundhedsprofessionelle oplever i arbejdet med naturen som ramme for rehabilitering baseret i lokalområdet. Igennem fem måneder deltog jeg i rehabiliteringsaktiviteter ved Ortopædisk Genoptræningscenter, Neurocentret og Dagcenter Midtpunktet, som foregik både indendørs og udendørs samt individuelt og i hold. 27 sundhedsprofessionelle deltog i fem gruppe interviews, hvor billeder blev brugt som taleemne. Resultaterne kan opsummeres i følgende tre temaer:

1. Naturlige læringsmuligheder

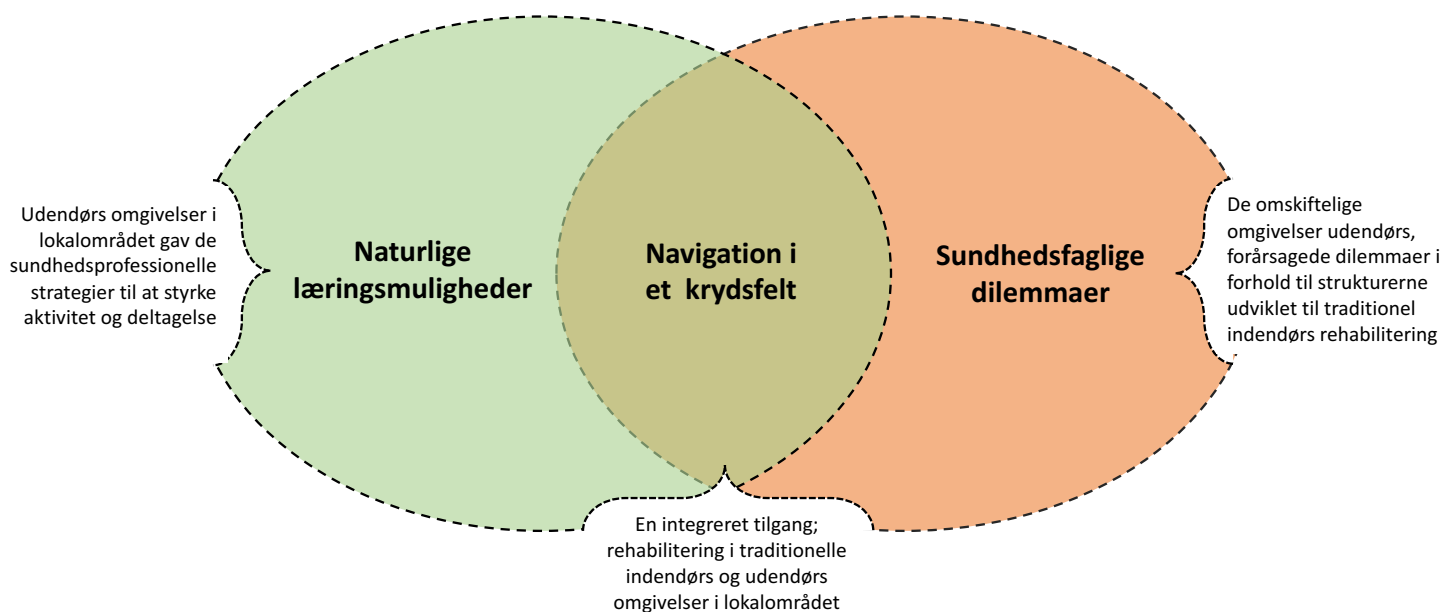
Inklusion af natur- og lokalområder i rehabilitering gav de sundhedsprofessionelle naturlige muligheder for at lære omkring borgerens funktionsevne og coping-strategier i et udfordrende miljø med forskelligartede fysiske og sociale input. Med naturen som ramme var rehabiliteringen ikke planlagt ud fra skemalagte øvelser, specifikt udstyr og opstillede tests, men med afsæt i sociale aktiviteter, varierende terræn og større fleksibilitet i forhold til borgerens skiftende behov og præferencer. På den måde oplevede de sundhedsprofessionelle også at indtage en mere guidende og mindre synlig rolle, der for nogen gav anledning til tvivl og usikkerhed.

2. Sundhedsfaglige dilemmaer

Naturen som ramme for rehabilitering gav også anledning til sundhedsfaglige dilemmaer ved at udfordre de institutionelle krav om dokumentation, målsætning og effektmåling, der traditionelt set er udviklet til brug i indendørs kontrollerede omgivelser. De sundhedsprofessionelle gav på den ene side udtryk for godt at kunne se relevansen af at inkludere natur- og lokalområder i rehabiliteringen. På den anden side kunne de opleve en personlig usikkerhed og tvivl omkring det at skabe trygge rammer og sikre en høj kvalitet, der kunne leve op til de traditionelle rehabiliteringsnormer.

3. Navigation i et krydsfelt

Inklusion af natur- og lokalområder i rehabilitering krævede af de sundhedsprofessionelle, at de kunne "tænke ud af boksen" og navigere i et krydsfelt mellem institutionelle krav og forløb tilpasset borgerens hverdagsliv. Det var således et spørgsmål om "både – og" og ikke "enten eller", når det gjaldt om at inkludere natur og lokalområder i den daglige praksis. Naturen som ramme for rehabilitering, gjorde det muligt at udfordre borgerens funktionsevne på nye måder og dermed udvide rækkevidden af eksisterende indsatser. Det udfordrede samtidig også traditionelle tilgange, som var dybt forankret i de professionelles sundhedsfaglige identitet.



Figur 2. Figuren demonstrer, hvordan sundhedsprofessionelle oplevede, at uderummet som ramme for rehabilitering medførte naturlige læringsmuligheder men også gav anledning til sundhedsfaglige dilemmaer, som involverede navigation i et krydsfelt.

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Sygefravær og rehabilitering
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8000 aarhusAarhus C



Vedrørende projektet: SPARK - rehabilitering i en ny kontekst

Sagsnr.: 1-16-02-293-18

Ovennævnte projekt er anmeldt til Region Midtjyllands interne fortegnelse over forskningsprojekter.

Side 1

Behandlingen af personoplysningerne ønskes påbegyndt den 01-08-2018.

Personoplysningerne slettes, anonymiseres eller indsendes til Rigsarkivet senest ved projektets afslutning den 31-07-2025, eller tidligere hvis det ikke længere er nødvendigt og relevant at behandle personoplysningerne.

Personoplysningerne vil blive opbevaret eller behandlet på følgende adresser:

1. DEFACTUM, Region Midtjylland
rehabilitering og sygefravær
P-P Ørumsgade 11, bygning 1b
8000 Aarhus C

Projektet omfatter ikke en biobank.

Der må alene behandles lovligt indsamlede personoplysninger. Det forudsættes, at alle øvrige nødvendige tilladelser er indhentet, herunder eventuelle skriftlige patientsamtykker.

For behandlingen af journaloplysninger gælder særlige regler. Vi henviser til Region Midtjyllands retningslinje om "Opslag i patientjournaler og andre elektroniske patientsystemer, regional retningslinje", der ligger i eDok.

Projektet er registeret på Region Midtjyllands interne fortegnelse over forskningsprojekter. Registreringen slettes ved projektets afslutning.

Eventuelle ændringer af de forhold, der indgår i anmeldelsen, skal anmeldes til Juridisk kontor, Region Midtjylland via databasen snarest muligt og inden den anmeldte afslutningsdato.

Opmærksomheden skal henledes på følgende:

Det følger af databeskyttelseslovens § 10, stk. 1, at personoplysninger som nævnt i databeskyttelsesforordningens artikel 9, stk. 1, og artikel 10 må behandles, hvis dette alene sker med henblik på at

Dato 22-06-2018
Sagsbehandler Helle Nikkel
forskningsprojekter@rm.dk
Tel. +45 7841 0188

udføre statistiske eller videnskabelige undersøgelser af væsentlig samfundsmæssig betydning, og hvis behandlingen er nødvendig af hensyn til udførelsen af undersøgelserne.

Det fremgår desuden af § 10, stk. 2, at de oplysninger, der er omfattet af stk. 1, må ikke senere behandles i andet end videnskabeligt eller statistisk øjemed. Det samme gælder behandling af andre oplysninger, som alene foretages i statistisk eller videnskabeligt øjemed efter databeskyttelsesforordningens artikel 6.

De omhandlede oplysninger nævnt i artikel 9, stk. 1, og artikel 10 omfatter følsomme oplysninger om race eller etnisk oprindelse, politisk, religiøs eller filosofisk overbevisning eller fagforeningsmæssigt tilhørsforhold samt behandling af genetiske data, biometriske data med det formål entydigt at identificere en fysisk person, helbredsoplysninger eller oplysninger om en fysisk persons seksuelle forhold eller seksuelle orientering. Det omfatter endvidere oplysninger om straffedomme og lovovertrædelser.

Det følger endvidere af Databeskyttelseslovens § 10, stk. 3, at videregivelse af oplysninger omfattet af stk. 1 og 2 til tredjemand kræver forudgående tilladelse fra Datatilsynet, når videregivelsen:

- sker til behandling uden for databeskyttelsesforordningens, territoriale anvendelsesområde
- vedrører biologisk materiale eller
- sker med henblik på offentliggørelse i et anerkendt videnskabeligt tidsskrift el.lign.

Opmærksomheden skal endvidere henledes på nedenstående generelle vilkår:

1. Louise Sofia Madsen, Ph.d.-studerende, DEFACTUM, Region Midtjylland og Aarhus Universitet, fakultetet health, institut for folkesundhed, Sygefravær og rehabilitering er ansvarlig for overholdelsen af de fastsatte vilkår.
2. Oplysningerne må kun anvendes til brug for projektets gennemførelse.
3. Alle, der deltager i behandling af personoplysninger, skal efterleve vilkårene i dette brev.
4. Databehandlerens behandling af oplysninger skal tilsvarende efterleve vilkårene i dette brev.
5. Lokaler, der benyttes til opbevaring og anden behandling af oplysninger, skal være indrettet således, at uvedkommende ikke kan få adgang.
6. Den projektansvarlige skal i overensstemmelse med Region Midtjyllands retningslinjer og politikker for

informationssikkerhed sikre, at personoplysninger behandles på en måde, der sikrer tilstrækkelig sikkerhed for de pågældende oplysninger, herunder beskyttelse mod uautoriseret eller ulovlig behandling og mod hædeligt tab, tilintetgørelse eller beskadigelse, under anvendelse af passende tekniske eller organisatoriske foranstaltninger.

Den projektansvarlige skal desuden sikre, at der ikke behandles urigtige eller vildledende oplysninger. Oplysninger skal være korrekte og om nødvendigt ajourførte; der skal tages ethvert rimeligt skridt for at sikre, at personoplysninger, der er urigtige i forhold til de formål, hvortil de behandles, straks slettes eller berigtiges.

7. Oplysninger skal opbevares på en sådan måde, at det ikke er muligt at identificere de personer, der behandles oplysninger om, i et længere tidsrum end det, der er nødvendigt til de formål, hvortil de pågældende personoplysninger behandles.
8. Anden lovgivning med krav til behandling af oplysninger i forbindelse med projektet forudsættes overholdt.

Behandlingsregler

9. Personoplysninger, der er omfattet af databeskyttelseslovens § 10, må ikke indgå i administrativ eller konkret sagsbehandling. Oplysningerne må heller ikke anvendes som grundlag for konkrete retlige eller faktiske foranstaltninger over for de omhandlede personer eller andre personer. Det er kun resultatet af den videnskabelige eller statistiske bearbejdning af personoplysninger, der kan bruges i administrativ sammenhæng, og kun under forudsætning af, at anvendelsen af resultaterne sker på en sådan måde, at det ikke er muligt at identificere enkeltpersoner. (Databeskyttelseslovens § 10, stk. 2)
10. Oplysningerne skal i videst muligt omfang behandles i en form, hvor de ikke er umiddelbart personhenførbare, f.eks. i krypteret form eller under et løbenummer i stedet for under personnummer. (Databeskyttelsesforordningen artikel 5, stk. 1, litra e.)
11. Formidling af undersøgelsesresultater skal ske på en sådan måde, at det ikke er muligt for udenforstående at identificere enkeltpersoner.
12. Personoplysningerne skal ved en undersøgelses afslutning slettes, anonymiseres eller tilintetgøres, således at det efterfølgende ikke er muligt at identificere enkeltpersoner, der indgår i undersøgelsen. Alternativt kan oplysninger overføres til opbevaring i arkiv efter reglerne i arkivlovgivningen. (Databeskyttelsesforordningens artikel 5, stk. 1, litra e, og databeskyttelseslovens § 14)

13. Den dataansvarlige myndighed skal selv fastsætte uddybende sikkerhedsregler, der beskriver hvordan myndigheden i praksis har implementeret de krævede sikkerhedsforanstaltninger. De uddybende bestemmelser skal som minimum omfatte organisatoriske forhold og fysisk sikring, herunder sikkerhedsorganisation, administration af adgangskontrolordninger og autorisationsordninger samt kontrol med autorisationer. Der skal endvidere fastsættes instrukser, som fastlægger ansvaret for og beskriver behandling og destruktion af ind- og uddatamateriale samt anvendelse af it-udstyr. Desuden skal der fastsættes retningslinjer for myndighedens eget tilsyn med overholdelsen af sikkerhedsforanstaltningerne. De interne bestemmelser skal gennemgås mindst én gang hvert år med henblik på at sikre, at de er fyldestgørende og afspejler de faktiske forhold i myndigheden.
14. Medarbejdere, der håndterer personoplysninger i forbindelse med statistiske og videnskabelige undersøgelser, skal have instruktion og oplæring i, hvad de må gøre med oplysninger, og hvordan de skal beskytte oplysningerne. Myndigheden skal bl.a. gøre medarbejderne bekendt med de regler, der er fastsat i medfør af punkt 1.
15. Adgang til personoplysningerne skal begrænses til personer, der har et sagligt behov for adgang. Det skal være så få personer som muligt. Der bør være tale om medarbejdere, som ikke samtidig beskæftiger sig med almindelig administrativ sagsbehandling vedrørende personer, om hvem der behandles oplysninger i statistisk eller videnskabeligt øjemed. Autorisationer skal angive, i hvilket omfang brugeren må forespørge, inddatere eller slette personoplysninger.
16. Der skal mindst hvert halve år foretages kontrol af, at de autoriserede personer fortsat opfylder betingelserne for at have adgang til oplysningerne.
17. Der skal etableres en teknisk adgangskontrol i it-systemerne, således at autoriserede personer skal identificere sig over for systemet for at få adgang til at foretage behandlinger i overensstemmelse med autorisationen.
18. Det skal registreres, hvis der er forgæves forsøg på at få adgang til it-systemerne. Hvis der registreres et nærmere fastsat antal på hinanden følgende afviste adgangsforsøg, skal der blokeres for yderligere forsøg.
19. Der skal foretages maskinel registrering (logging) af alle anvendelser af personoplysninger. Registreringen skal mindst indeholde oplysning om tidspunkt, bruger, type af anvendelse og angivelse af den person, de

anvendte oplysninger vedrørte, eller det anvendte søgekriterium. Loggen skal opbevares i 6 måneder, hvorefter den skal slettes.

20. Ved brug af eksterne databehandlere til håndtering af personoplysninger skal der foreligge skriftlige databehandleraftaler. Det gælder eksempelvis, når der anvendes en ekstern part til statistisk bearbejdning af oplysningerne.

Databehandleraftalerne skal leve op til Databeskyttelsesforordningens artikel 28. Det skal bl.a. fremgå af en aftale, at databehandlerne udelukkende handler efter instruks fra den dataansvarlige. Hvis den eksterne part også benytter databehandlere ved opgavens løsning, er disse også databehandlere for den dataansvarlige (såkaldte underdatabehandlere), og pålægges samme databeskyttelsesretlige forpligtelser som selve databehandleren. Der skal tillige udfærdiges en databehandleraftale med en underdatabehandler.

Note:

Der vil være tale om en databehandler i de tilfælde, hvor oplysninger overlades til en ekstern part, der skal udføre opgaver på vegne af den dataansvarlige, og hvor databehandleren udelukkende handler på instruks fra den dataansvarlige. Databehandleren får ikke selv ejerskab over oplysningerne og kan ikke selv anvende oplysningerne til egne formål.

Der vil til gengæld være tale om videregivelse til en ny dataansvarlig i de tilfælde, hvor en tredjepart modtager oplysninger fra Region Midtjylland, uden at regionen har mulighed for instruere modtageren i behandlingen af oplysningerne. Ved en videregivelse får modtageren et selvstændigt ejerskab over oplysningerne.

21. Den projektansvarlige varetager indgåelse af eventuel databehandleraftale i overensstemmelse med Region Midtjyllands retningslinjer herfor:

intranet.rm.dk/organisation/informationssikkerhed/databehandleraftaler

Hvis databehandleren er etableret i en anden medlemsstat, skal det desuden af aftalen fremgå, at de yderligere bestemmelser om sikkerhedsforanstaltninger for databehandlere, som eventuelt er fastsat i den pågældende medlemsstat, også er gældende for databehandleren.

22. Den dataansvarlige skal aktivt sikre, at de krævede sikkerhedsforanstaltninger overholdes hos alle databehandlere og eventuelle underdatabehandlere.
23. Hvis behandling af personoplysninger finder sted på it-udstyr uden for den dataansvarlige myndigheds lokaliteter (eller på udstyr, som ikke er en del af myndighedens almindelige system), skal myndigheden

sikre de fornødne sikkerhedsforanstaltninger og fastsætte særlige retningslinjer herom.

24. Der må kun etableres eksterne kommunikationsforbindelser, hvis der træffes særlige foranstaltninger for at sikre, at uvedkommende ikke gennem disse forbindelser kan få adgang til personoplysninger.
25. På steder, hvor der foretages behandling af personoplysninger, skal der træffes forholdsregler med henblik på at forhindre uvedkommendes adgang til oplysningerne. Hvis personoplysningerne lagres på udtagelige og mobile datamedier, f.eks. på USB-nøgler, skal der sikres mod, at uvedkommende kan tilgå oplysningerne på det bærbare datamedie i tilfælde af, at det mistes/stjæles. Alternativt skal bærbare datamedier opbevares forsvarligt aflåst, så uvedkommende er fysisk afskåret fra at tilgå mediet eller fjerne det fra den fysiske lokalitet. Samme forholdsregler skal træffes i forhold til sikkerhedskopier af data.
26. I forbindelse med reparation og service af dataudstyr, der indeholder personoplysninger, og når datamedier skal sælges eller kasseres, skal der træffes de fornødne foranstaltninger for at sikre, at personoplysninger ikke kan komme til uvedkommendes kendskab.
27. Ind- og uddatamateriale skal opbevares og håndteres på en sådan måde, at uvedkommende ikke kan få adgang til at gøre sig bekendt med de personoplysninger, som er indeholdt heri. Medarbejdere, som samtidig beskæftiger sig med almindelig administrativ sagsbehandling vedrørende personer, om hvem der behandles oplysninger i statistisk eller videnskabeligt øjemed, bør herunder ikke have adgang til materialet.

Ind- og uddatamateriale skal slettes eller tilintetgøres, når det ikke længere skal anvendes til de formål, hvortil det er indsamlet og behandlet, dog senest efter en af den dataansvarlige myndighed nærmere fastsat frist. Ved tilintetgørelse skal det sikres, at materialet ikke misbruges eller kommer til uvedkommendes kendskab.

Manuelle ("papir") oplysninger

28. Manuelt materiale, herunder udskrifter, fejl- og kontrollister mv. med oplysninger, der direkte eller indirekte kan henføres til bestemte personer, skal opbevares forsvarligt aflåst og på en sådan måde, at uvedkommende ikke kan gøre sig bekendt med indholdet.

Biobank og biologisk materiale

29. Prøver med biologisk materiale og biologisk materiale i biobanker skal opbevares forsvarligt aflåst, således at uvedkommende ikke har adgang til det, og på en sådan måde, at det sikres, at materialet ikke fortabes, forringes eller hændeligt eller ulovligt tilintetgøres.
30. Biologisk materiale, der er mærket med personnummer eller navn, skal opbevares under iagttagelse af særlige sikkerhedshensyn.
31. Projektansvarlige skal fastsætte interne retningslinjer i projektet for opbevaring af biologisk materiale. Retningslinjerne skal ajourføres mindst én gang om året.
32. Senest ved projektets afslutning skal biologisk materiale enten destrueres eller anonymiseres fuldstændigt og oplysningerne slettes, tilintetgøres eller anonymiseres, således at det efterfølgende ikke er muligt at identificere enkeltpersoner, der indgår i undersøgelsen.

Videregivelse/udlevering

33. Videregivelse/udlevering af personhenførbare oplysninger til andre (dataansvarlige) må kun ske, hvis oplysningerne hos modtageren udelukkende skal bruges i statistisk eller videnskabeligt øjemed. Det fremgår af databeskyttelseslovens § 10, stk. 2.
34. Videregivelse/udlevering må kun ske efter forudgående tilladelse fra Region Midtjylland.

I tilfælde hvor der skal ske udlevering/videregivelse til tredjemand uden for databeskyttelsesordningens territoriale område, af biologisk materiale eller med henblik på offentliggørelse i et anerkendt videnskabeligt tidsskrift el.lign., skal Datatilsynets forudgående tilladelse tillige indhentes.
35. Oplysninger kan herudover videregives, hvis det fremgår af anden lovgivning, at oplysningerne skal videregives.

Ændringer i projektet

36. Ændringer, herunder forlængelse, skal anmeldes i databasen.

Der henvises til Region Midtjyllands hjemmesider for yderligere oplysninger vedr. korrekt anmeldelse af ændringer: www.rm.dk/sundhed/faginfo/forskning/Forskningsprojekter

Der gøres opmærksom på, at det kun er den projektansvarlige, der kan anmelde ændringer til projektet.

Ved projektets afslutning

37. Oplysninger (herunder også biologisk materiale) skal slettes, anonymiseres eller tilintetgøres senest ved projektets afslutning, medmindre en fortsat opbevaring kræves efter anden gældende lovgivning. Det må efterfølgende ikke være muligt at identificere enkeltpersoner i projektet.
38. Alternativt kan oplysningerne overføres til arkiv efter arkivlovens regler.
39. Sletning/anonymisering af oplysninger fra elektroniske medier mv. skal ske på en sådan måde, at oplysningerne ikke kan genetableres og at der på ingen mulig måde via koder eller andet, kan findes tilbage til en identificerbar person.

Overførsel af oplysninger til tredjelande

40. Overførsel af oplysninger til tredjelande, herunder overførsel til behandling hos databehandler, kræver forudgående tilladelse fra Datatilsynet.
41. Overførsel kan dog ske uden tilladelse fra Datatilsynet ved anvendelse af Kommissionens standardkontrakter. Overførsel kan desuden ske uden tilladelse fra Datatilsynet, hvis den registrerede konkret har givet udtrykkeligt samtykke hertil.
42. Overførsel af oplysninger skal ske med bud eller anbefalet post. Ved elektronisk overførsel skal der træffes de fornødne sikkerhedsforanstaltninger mod, at oplysningerne kommer til uvedkommendes kendskab. Herunder skal der anvendes kryptering, hvis følsomme personoplysninger overføres via internettet (eller andre åbne net), og sikring af sikkerhed for autenticitet (afsenders og modtagers identitet) og integritet (de transmitterede oplysningers ægthed) skal ske i fornødent omfang ved anvendelse af passende sikkerhedsforanstaltninger.

Ovenstående vilkår er gældende indtil videre. Region Midtjylland forbeholder sig ret til senere at tage vilkårene op til revision, hvis der skulle vise sig behov for det.

Anmeldelsen offentliggøres på Region Midtjyllands hjemmeside i fortegnelsen over forskningsprojekter: www.rm.dk/sundhed/faginfor/forskning/Forskningsprojekter

Oplysningspligt over for den registrerede

I de tilfælde hvor der ikke sker indsamling hos de registrerede selv, er der som udgangspunkt ikke en oplysningspligt.

I de tilfælde, hvor der sker indsamling af oplysninger hos den registrerede/deltageren (ved interview, spørgeskema, klinisk eller paraklinisk undersøgelse, behandling, observation m.v.) skal der imidlertid uddeles/fremsendes nærmere information om projektet til den

registrerede/deltageren i overensstemmelse med Databeskyttelsesforordningens artikel 13. Der skal dermed gives følgende oplysninger:

- Navn og kontaktoplysninger (telefonnummer, e-mailadresse eller lignende) på den dataansvarlige.
- Kontaktoplysninger (navn, telefonnummer, e-mailadresse eller lignende) på databeskyttelsesrådgiveren.
- Formålene med og lovgrundlaget for behandlingen.
- Eventuelle modtagere eller kategorier af modtagere. Der er her tale om overordnede angivelser af modtagere såsom andre offentlige myndigheder, samarbejdspartnere mv.
- Om oplysningerne vil blive overført til et land eller en international organisation udenfor EU/EØS.
- Det tidsrum, hvor personoplysningerne vil blive opbevaret, eller de kriterier, der anvendes til at fastlægge dette tidsrum.
- Retten til at anmode om berigtigelse.
- Retten til at anmode om sletning.
- Retten til at anmode om begrænsning af behandling af personoplysninger.
- Retten til at gøre indsigelse mod behandling af personoplysninger.
- Retten til at trække et samtykke tilbage.
- Retten til at klage til Datatilsynet.
- Borgeren skal oplyses om automatiske afgørelser (herunder profilering).
- Hvis borgeren har pligt til at oplyse regionen om sine personoplysninger, skal regionen gøre borgeren opmærksom på denne pligt. Borgeren skal oplyses om retsgrundlaget og konsekvenserne af ikke at give de nødvendige oplysninger.

Den registrerede bør endvidere oplyses om, at projektet er anmeldt internt i Region Midtjylland, samt at Region Midtjylland har fastsat nærmere vilkår for projektet til beskyttelse af den registreredes privatliv.

Indsigtsret

Den registrerede har ikke krav på indsigt i de oplysninger, der behandles om den pågældende.

Offentliggørelse af forskningsresultater

Offentliggørelse af forskningsprojektets resultater må ikke indeholde oplysninger, der kan henføres til de registrerede.

Ved offentliggørelse af *Word-filer* eller *PowerPoint* præsentationer skal det sikres, at alle personlige oplysninger slettes.

Vejledning til sikring heraf findes på Regions Midtjyllands hjemmeside samt pjece fra IT- og Telestyrelsen "*Gemmer I på skjulte data i Office-filer?*"

Videregivelse af forskningsoplysninger kræver Datatilsynets tilladelse, når videregivelsen sker med henblik på offentliggørelse i et anerkendt videnskabeligt tidsskrift el.lign.

Læs mere

Du kan læse mere om databeskyttelse på Region Midtjyllands intranet via følgende link:
intranet.rm.dk/organisation/Informationssikkerhed/databeskyttelsesforordning

Derudover kan der findes mere information om databeskyttelse på Datatilsynets hjemmeside:
www.datatilsynet.dk

Venlig hilsen

Juridisk Kontor – Fortegnelse over forskningsprojekter i Region Midtjylland

Helle Nikkel

CVR: 29190925-RID: 76081066

22-06-2018 13:05:19

Bilag - Formular

Louise Sofia Madsen, Ph.d.-studerende
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Vedrørende projektet: SPARK - rehabilitering i en ny kontekst

Sagsnr.: 1-16-02-293-18

Ovennævnte projekt er anmeldt til Region Midtjyllands interne fortegnelse over forskningsprojekter med anmodning om følgende ændringer:

Projektets formål er opdateret.

Kontaktpersonens ansættelsessted og kontaktoplysninger er opdateret.

Teknologi i praksis er fjernet som samarbejdspartner.

Ortopædisk genoptræningscenter - Aarhus kommune,
Neurocentret - Aarhus kommune og Dagcenter Midtpunktet
-Aarhus kommune er tilføjet som samarbejdspartnere.

Oplysningerne under Personkategorier og Oplysningstyper er opdateret.

Antal personer der indgår i projektet er ændret fra 50 til 150.

Ændringerne til projektet er hermed registeret på Region Midtjyllands interne fortegnelse over forskningsprojekter. Registreringen slettes ved projektets afslutning.

Behandlingen af personoplysningerne blev påbegyndt den 01-08-2018.

Personoplysningerne slettes, anonymiseres eller indsendes til Rigsarkivet senest ved projektets afslutning den 31-07-2025, eller tidligere hvis det ikke længere er nødvendigt og relevant at behandle personoplysningerne.

Personoplysningerne vil blive opbevaret eller behandlet på følgende adresser:

1. DEFACTUM, Region Midtjylland
rehabilitering og sygefravær
P-P Ørumsgade 11, bygning 1b
8000 Aarhus C

Projektet omfatter ikke en biobank.

Der må alene behandles lovligt indsamlede personoplysninger. Det forudsættes, at alle øvrige nødvendige tilladelser er indhentet, herunder eventuelle

skriftlige patientsamtykker.

For behandlingen af journaloplysninger gælder særlige regler. Vi henviser til Region Midtjyllands retningslinje om "Opslag i patientjournaler og andre elektroniske patientsystemer, regional retningslinje", der ligger i eDok.

Eventuelle ændringer af de forhold, der indgår i anmeldelsen, skal anmeldes til Juridisk kontor, Region Midtjylland via databasen snarest muligt og inden den anmeldte afslutningsdato.

Opmærksomheden skal henledes på følgende:

Det følger af databeskyttelseslovens § 10, stk. 1, at personoplysninger som nævnt i databeskyttelsesforordningens artikel 9, stk. 1, og artikel 10 må behandles, hvis dette alene sker med henblik på at udføre statistiske eller videnskabelige undersøgelser af væsentlig samfundsmæssig betydning, og hvis behandlingen er nødvendig af hensyn til udførelsen af undersøgelserne.

Det fremgår desuden af § 10, stk. 2, at de oplysninger, der er omfattet af stk. 1, må ikke senere behandles i andet end videnskabeligt eller statistisk øjemed. Det samme gælder behandling af andre oplysninger, som alene foretages i statistisk eller videnskabeligt øjemed efter databeskyttelsesforordningens artikel 6.

De omhandlede oplysninger nævnt i artikel 9, stk. 1, og artikel 10 omfatter følsomme oplysninger om race eller etnisk oprindelse, politisk, religiøs eller filosofisk overbevisning eller fagforeningsmæssigt tilhørsforhold samt behandling af genetiske data, biometriske data med det formål entydigt at identificere en fysisk person, helbredsoplysninger eller oplysninger om en fysisk persons seksuelle forhold eller seksuelle orientering. Det omfatter endvidere oplysninger om straffedomme og lovovertrædelser.

Videregivelse af personoplysninger må kun ske efter forudgående tilladelse fra Region Midtjylland, Juridisk Kontor.

Det følger endvidere af Databeskyttelseslovens § 10, stk. 3, at videregivelse af oplysninger til tredjemand uden for databeskyttelsesordningens territoriale område, af biologisk materiale eller med henblik på offentliggørelse i et anerkendt videnskabeligt tidsskrift el.lign., kræver tillige forudgående tilladelse fra Datatilsynet.

Opmærksomheden skal endvidere henledes på nedenstående generelle vilkår:

1. Louise Sofia Madsen, Ph.d.-studerende, DEFACTUM, Region Midtjylland og Aarhus Universitet, fakultetet health, institut for folkesundhed, Sygefravær og rehabilitering er ansvarlig for overholdelsen af de fastsatte vilkår.
2. Oplysningerne må kun anvendes til brug for projektets gennemførelse.

3. Alle, der deltager i behandling af personoplysninger, skal efterleve vilkårene i dette brev.
4. Databehandlerens behandling af oplysninger skal tilsvarende efterleve vilkårene i dette brev.
5. Lokaler, der benyttes til opbevaring og anden behandling af oplysninger, skal være indrettet således, at uvedkommende ikke kan få adgang.
6. Den projektansvarlige skal i overensstemmelse med Region Midtjyllands retningslinjer og politikker for informationssikkerhed sikre, at personoplysninger behandles på en måde, der sikrer tilstrækkelig sikkerhed for de pågældende oplysninger, herunder beskyttelse mod uautoriseret eller ulovlig behandling og mod hændeligt tab, tilintetgørelse eller beskadigelse, under anvendelse af passende tekniske eller organisatoriske foranstaltninger.

Den projektansvarlige skal desuden sikre, at der ikke behandles urigtige eller vildledende oplysninger. Oplysninger skal være korrekte og om nødvendigt ajourførte; der skal tages ethvert rimeligt skridt for at sikre, at personoplysninger, der er urigtige i forhold til de formål, hvortil de behandles, straks slettes eller berigtiges.

7. Oplysninger skal opbevares på en sådan måde, at det ikke er muligt at identificere de personer, der behandles oplysninger om, i et længere tidsrum end det, der er nødvendigt til de formål, hvortil de pågældende personoplysninger behandles.
8. Anden lovgivning med krav til behandling af oplysninger i forbindelse med projektet forudsættes overholdt.

Behandlingsregler

9. Personoplysninger, der er omfattet af databeskyttelseslovens § 10, må ikke indgå i administrativ eller konkret sagsbehandling. Oplysningerne må heller ikke anvendes som grundlag for konkrete retlige eller faktiske foranstaltninger over for de omhandlede personer eller andre personer. Det er kun resultatet af den videnskabelige eller statistiske bearbejdning af personoplysninger, der kan bruges i administrativ sammenhæng, og kun under forudsætning af, at anvendelsen af resultaterne sker på en sådan måde, at det ikke er muligt at identificere enkeltpersoner. (Databeskyttelseslovens § 10, stk. 2)
10. Oplysningerne skal i videst muligt omfang behandles i en form, hvor de ikke er umiddelbart personhenførbare, f.eks. i krypteret form eller under et løbenummer i stedet for under personnummer. (Databeskyttelsesforordningen artikel 5, stk. 1, litra e.)
11. Formidling af undersøgelsesresultater skal ske på

en sådan måde, at det ikke er muligt for udenforstående at identificere enkeltpersoner.

12. Personoplysningerne skal ved en undersøgelses afslutning slettes, anonymiseres eller tilintetgøres, således at det efterfølgende ikke er muligt at identificere enkeltpersoner, der indgår i undersøgelsen. Alternativt kan oplysninger overføres til opbevaring i arkiv efter reglerne i arkivlovgivningen. (Databeskyttelsesforordningens artikel 5, stk. 1, litra e, og databeskyttelseslovens § 14)

Datasikkerhed

13. Den dataansvarlige myndighed skal selv fastsætte uddybende sikkerhedsregler, der beskriver hvordan myndigheden i praksis har implementeret de krævede sikkerhedsforanstaltninger. De uddybende bestemmelser skal som minimum omfatte organisatoriske forhold og fysisk sikring, herunder sikkerhedsorganisation, administration af adgangskontrolordninger og autorisationsordninger samt kontrol med autorisationer. Der skal endvidere fastsættes instrukser, som fastlægger ansvaret for og beskriver behandling og destruktion af ind- og uddatamateriale samt anvendelse af it-udstyr. Desuden skal der fastsættes retningslinjer for myndighedens eget tilsyn med overholdelsen af sikkerhedsforanstaltningerne. De interne bestemmelser skal gennemgås mindst én gang hvert år med henblik på at sikre, at de er fyldestgørende og afspejler de faktiske forhold i myndigheden.
14. Medarbejdere, der håndterer personoplysninger i forbindelse med statistiske og videnskabelige undersøgelser, skal have instruktion og oplæring i, hvad de må gøre med oplysninger, og hvordan de skal beskytte oplysningerne. Myndigheden skal bl.a. gøre medarbejderne bekendt med de regler, der er fastsat i medfør af punkt 1.
15. Adgang til personoplysningerne skal begrænses til personer, der har et sagligt behov for adgang. Det skal være så få personer som muligt. Der bør være tale om medarbejdere, som ikke samtidig beskæftiger sig med almindelig administrativ sagsbehandling vedrørende personer, om hvem der behandles oplysninger i statistisk eller videnskabeligt øjemed. Autorisationer skal angive, i hvilket omfang brugeren må forespørge, inddatere eller slette personoplysninger.
16. Der skal mindst hvert halve år foretages kontrol af, at de autoriserede personer fortsat opfylder betingelserne for at have adgang til oplysningerne.
17. Der skal etableres en teknisk adgangskontrol i it-systemerne, således at autoriserede personer skal identificere sig over for systemet for at få adgang til at

foretage behandlinger i overensstemmelse med autorisationen.

18. Det skal registreres, hvis der er forgæves forsøg på at få adgang til it-systemerne. Hvis der registreres et nærmere fastsat antal på hinanden følgende afviste adgangsforsøg, skal der blokeres for yderligere forsøg.
19. Der skal foretages maskinel registrering (logning) af alle anvendelser af personoplysninger. Registreringen skal mindst indeholde oplysning om tidspunkt, bruger, type af anvendelse og angivelse af den person, de anvendte oplysninger vedrørte, eller det anvendte søgekriterium. Loggen skal opbevares i 6 måneder, hvorefter den skal slettes.
20. Ved brug af eksterne databehandlere til håndtering af personoplysninger skal der foreligge skriftlige databehandleraftaler. Det gælder eksempelvis, når der anvendes en ekstern part til statistisk bearbejdning af oplysningerne.

Databehandleraftalerne skal leve op til Databeskyttelsesforordningens artikel 28. Det skal bl.a. fremgå af en aftale, at databehandlerne udelukkende handler efter instruks fra den dataansvarlige. Hvis den eksterne part også benytter databehandlere ved opgavens løsning, er disse også databehandlere for den dataansvarlige (såkaldte underdatabehandlere), og pålægges samme databeskyttelsesretlige forpligtelser som selve databehandleren. Der skal tillige udfærdiges en databehandleraftale med en underdatabehandler.

Note:

Der vil være tale om en databehandler i de tilfælde, hvor oplysninger overlades til en ekstern part, der skal udføre opgaver på vegne af den dataansvarlige, og hvor databehandleren udelukkende handler på instruks fra den dataansvarlige. Databehandleren får ikke selv ejerskab over oplysningerne og kan ikke selv anvende oplysningerne til egne formål.

Der vil til gengæld være tale om videregivelse til en ny dataansvarlig i de tilfælde, hvor en tredjepart modtager oplysninger fra Region Midtjylland, uden at regionen har mulighed for instruere modtageren i behandlingen af oplysningerne. Ved en videregivelse får modtageren et selvstændigt ejerskab over oplysningerne.

21. Den projektansvarlige varetager indgåelse af eventuel databehandleraftale i overensstemmelse med Region Midtjyllands retningslinjer herfor:
intranet.rm.dk/organisation/informationssikkerhed/databehandleraftaler

Hvis databehandleren er etableret i en anden medlemsstat, skal det desuden af aftalen fremgå, at de yderligere bestemmelser om

sikkerhedsforanstaltninger for databehandlere, som eventuelt er fastsat i den pågældende medlemsstat, også er gældende for databehandleren.

22. Den dataansvarlige skal aktivt sikre, at de krævede sikkerhedsforanstaltninger overholdes hos alle databehandlere og eventuelle underdatabehandlere.
23. Hvis behandling af personoplysninger finder sted på it-udstyr uden for den dataansvarlige myndigheds lokaliteter (eller på udstyr, som ikke er en del af myndighedens almindelige system), skal myndigheden sikre de fornødne sikkerhedsforanstaltninger og fastsætte særlige retningslinjer herom.
24. Der må kun etableres eksterne kommunikationsforbindelser, hvis der træffes særlige foranstaltninger for at sikre, at uvedkommende ikke gennem disse forbindelser kan få adgang til personoplysninger.
25. På steder, hvor der foretages behandling af personoplysninger, skal der træffes forholdsregler med henblik på at forhindre uvedkommendes adgang til oplysningerne. Hvis personoplysningerne lagres på udtagelige og mobile datamedier, f.eks. på USB-nøgler, skal der sikres mod, at uvedkommende kan tilgå oplysningerne på det bærbare datamedie i tilfælde af, at det mistes/stjæles. Alternativt skal bærbare datamedier opbevares forsvarligt aflåst, så uvedkommende er fysisk afskåret fra at tilgå mediet eller fjerne det fra den fysiske lokalitet. Samme forholdsregler skal træffes i forhold til sikkerhedskopier af data.
26. I forbindelse med reparation og service af dataudstyr, der indeholder personoplysninger, og når datamedier skal sælges eller kasseres, skal der træffes de fornødne foranstaltninger for at sikre, at personoplysninger ikke kan komme til uvedkommendes kendskab.
27. Ind- og uddatamateriale skal opbevares og håndteres på en sådan måde, at uvedkommende ikke kan få adgang til at gøre sig bekendt med de personoplysninger, som er indeholdt heri. Medarbejdere, som samtidig beskæftiger sig med almindelig administrativ sagsbehandling vedrørende personer, om hvem der behandles oplysninger i statistisk eller videnskabeligt øjemed, bør herunder ikke have adgang til materialet.

Ind- og uddatamateriale skal slettes eller tilintetgøres, når det ikke længere skal anvendes til de formål, hvortil det er indsamlet og behandlet, dog senest efter en af den dataansvarlige myndighed nærmere fastsat frist. Ved tilintetgørelse skal det sikres, at materialet ikke misbruges eller kommer til uvedkommendes kendskab.

Manuelle ("papir") oplysninger

28. Manuelt materiale, herunder udskrifter, fejl- og kontrollister mv. med oplysninger, der direkte eller indirekte kan henføres til bestemte personer, skal opbevares forsvarligt aflåst og på en sådan måde, at uvedkommende ikke kan gøre sig bekendt med indholdet.

Biobank og biologisk materiale

29. Prøver med biologisk materiale og biologisk materiale i biobanker skal opbevares forsvarligt aflåst, således at uvedkommende ikke har adgang til det, og på en sådan måde, at det sikres, at materialet ikke fortabes, forringes eller hændeligt eller ulovligt tilintetgøres.
30. Biologisk materiale, der er mærket med personnummer eller navn, skal opbevares under iagttagelse af særlige sikkerhedshensyn.
31. Projektansvarlige skal fastsætte interne retningslinjer i projektet for opbevaring af biologisk materiale. Retningslinjerne skal ajourføres mindst én gang om året.
32. Senest ved projektets afslutning skal biologisk materiale enten destrueres eller anonymiseres fuldstændigt og oplysningerne slettes, tilintetgøres eller anonymiseres, således at det efterfølgende ikke er muligt at identificere enkeltpersoner, der indgår i undersøgelsen.

Videregivelse/udlevering

33. Videregivelse/udlevering af personhenførbare oplysninger til andre (dataansvarlige) må kun ske, hvis oplysningerne hos modtageren udelukkende skal bruges i statistisk eller videnskabeligt øjemed. Det fremgår af databeskyttelseslovens § 10, stk. 2.
34. Videregivelse/udlevering må kun ske efter forudgående tilladelse fra Region Midtjylland, Juridisk Kontor.

Det fremgår af Databeskyttelseslovens § 10, stk. 3, at videregivelse af oplysninger omfattet af stk. 1 og 2 til tredjemand tillige kræver forudgående tilladelse fra Datatilsynet, når videregivelsen:
 - sker til behandling uden for databeskyttelsesforordningens territoriale anvendelsesområde,
 - vedrører biologisk materiale eller
 - sker med henblik på offentliggørelse i et anerkendt videnskabeligt tidsskrift el.lign.
35. Oplysninger kan herudover videregives, hvis det fremgår af anden lovgivning, at oplysningerne skal

videregives.

Ændringer i projektet

36. Ændringer, herunder forlængelse, skal anmeldes i databasen.

Der henvises til Region Midtjyllands hjemmesider for yderligere oplysninger vedr. korrekt anmeldes af ændringer: www.rm.dk/sundhed/faginfo/forskning/Forskningsprojekter

Der gøres opmærksom på, at det kun er den projektansvarlige, der kan anmelde ændringer til projektet.



Ved projektets afslutning

Side 8

37. Oplysninger (herunder også biologisk materiale) skal slettes, anonymiseres eller tilintetgøres senest ved projektets afslutning, medmindre en fortsat opbevaring kræves efter anden gældende lovgivning. Det må efterfølgende ikke være muligt at identificere enkeltpersoner i projektet.
38. Alternativt kan oplysningerne overføres til arkiv efter arkivlovens regler.
39. Sletning/anonymisering af oplysninger fra elektroniske medier mv. skal ske på en sådan måde, at oplysningerne ikke kan genetableres og at der på ingen mulig måde via koder eller andet, kan findes tilbage til en identificerbar person.

Overførsel af oplysninger til tredjelande

40. Overførsel af oplysninger til tredjelande, herunder overførsel til behandling hos databehandler, kræver forudgående tilladelse fra Datatilsynet.
41. Overførsel kan dog ske uden tilladelse fra Datatilsynet ved anvendelse af Kommissionens standardkontrakter. Overførsel kan desuden ske uden tilladelse fra Datatilsynet, hvis den registrerede konkret har givet udtrykkeligt samtykke hertil.
42. Overførsel af oplysninger skal ske med bud eller anbefalet post. Ved elektronisk overførsel skal der træffes de fornødne sikkerhedsforanstaltninger mod, at oplysningerne kommer til uvedkommendes kendskab. Herunder skal der anvendes kryptering, hvis følsomme personoplysninger overføres via internettet (eller andre åbne net), og sikring af sikkerhed for autenticitet (afsenders og modtagers identitet) og integritet (de transmitterede oplysningers ægthed) skal ske i fornødent omfang ved anvendelse af passende sikkerhedsforanstaltninger.

Ovenstående vilkår er gældende indtil videre. Region

Midtjylland forbeholder sig ret til senere at tage vilkårene op til revision, hvis der skulle vise sig behov for det.

Anmeldelsen offentliggøres på Region Midtjyllands hjemmeside i fortegnelsen over forskningsprojekter:
www.rm.dk/sundhed/faginfo/forskning/Forskningsprojekter

Oplysningspligt over for den registrerede

I de tilfælde hvor der ikke sker indsamling hos de registrerede selv, er der som udgangspunkt ikke en oplysningspligt.

I de tilfælde, hvor der sker indsamling af oplysninger hos den registrerede/deltageren (ved interview, spørgeskema, klinisk eller paraklinisk undersøgelse, behandling, observation m.v.) skal der imidlertid uddeles/fremsendes nærmere information om projektet til den registrerede/deltageren i overensstemmelse med Databeskyttelsesforordningens artikel 13. Der skal dermed gives følgende oplysninger:

- Navn og kontaktoplysninger (telefonnummer, e-mailadresse eller lignende) på den dataansvarlige.
- Kontaktoplysninger (navn, telefonnummer, e-mailadresse eller lignende) på databeskyttelsesrådgiveren.
- Formålene med og lovgrundlaget for behandlingen.
- Eventuelle modtagere eller kategorier af modtagere. Der er her tale om overordnede angivelser af modtagere såsom andre offentlige myndigheder, samarbejdspartnere mv.
- Om oplysningerne vil blive overført til et land eller en international organisation udenfor EU/EØS.
- Det tidsrum, hvor personoplysningerne vil blive opbevaret, eller de kriterier, der anvendes til at fastlægge dette tidsrum.
- Retten til at anmode om berigtigelse.
- Retten til at anmode om sletning.

For projekter godkendt efter Komitéloven kan personoplysninger, der allerede er indgået i projektet, ikke kræves slettet, jf. Komitélovens §3, stk. 4.

- Retten til at anmode om begrænsning af behandling af personoplysninger.
- Retten til at gøre indsigelse mod behandling af personoplysninger.
- Retten til at trække et samtykke tilbage.
- Retten til at klage til Datatilsynet.
- Borgeren skal oplyses om automatiske afgørelser

(herunder profilering).

- Hvis borgeren har pligt til at oplyse regionen om sine personoplysninger, skal regionen gøre borgeren opmærksom på denne pligt. Borgeren skal oplyses om retsgrundlaget og konsekvenserne af ikke at give de nødvendige oplysninger.

Den registrerede bør endvidere oplyses om, at projektet er anmeldt internt i Region Midtjylland, samt at Region Midtjylland har fastsat nærmere vilkår for projektet til beskyttelse af den registreredes privatliv.

Indsigtsret

Den registrerede har ikke krav på indsigt i de oplysninger, der behandles om den pågældende.

Offentliggørelse af forskningsresultater

Offentliggørelse af forskningsprojektets resultater må ikke indeholde oplysninger, der kan henføres til de registrerede.

Ved offentliggørelse af *Word-filer* eller *PowerPoint* præsentationer skal det sikres, at alle personlige oplysninger slettes.

Vejledning til sikring heraf findes på Regions Midtjyllands hjemmeside samt pjece fra IT- og Telestyrelsen "*Gemmer I på skjulte data i Office-filer?*"

Videregivelse af forskningsoplysninger kræver Datatilsynets tilladelse, når videregivelsen sker med henblik på offentliggørelse i et anerkendt videnskabeligt tidsskrift el.lign.

Læs mere

Du kan læse mere om databeskyttelse på Region Midtjyllands intranet via følgende link:
intranet.rm.dk/organisation/Informationssikkerhed/databeskyttelsesforordning

Derudover kan der findes mere information om databeskyttelse på Datatilsynets hjemmeside:
www.datatilsynet.dk

Venlig hilsen

Juridisk Kontor – Fortegnelse over forskningsprojekter i Region Midtjylland

Annette Engsig

CVR: 29190925-RID: 60743017

07-12-2020 15:32:31

Bilag - Formular

Kære alle

Tak for at indvillige i at deltage i et fokus-gruppe interview omkring brug af uderummet i rehabilitering.

Som et led i mit feltarbejde har jeg nu fået indblik i en del af Jeres daglige praksis og arbejde med rehabiliteringsforløb ved at deltage på forskellige hold (inde og ude), individuelle konsultationer og diverse møder. For at komme mere i dybden med projektets fokus på uderummet, men også sociale fællesskabers betydning for rehabiliteringsforløbet, gennemfører jeg et fokus-gruppe interview i forbindelse med Jeres vidensdeling **torsdag den 11 april kl 12.30-14.00**.

Det betyder at du deltager i en fælles diskussion med dine kollegaer omkring emnet. Jeg er interesseret i at høre dine erfaringer og tanker om brug af uderummet i rehabilitering, i forhold til hvilke udfordringer og muligheder det giver i Jeres daglige praksis og forløb med borgerne.

Den viden som jeg genererer på baggrund af fokus-gruppe interviewet og Ph.d.-projektets øvrige studier skal bidrage til at udvikle en praksis-baseret model for brug af uderummet i rehabilitering. En sådan model skal guide fag-professionelle, beslutningstagere, og politikere i henhold til hvilke forhold der er vigtige at tage højde for, i udviklingsprocessen mod at skabe de bedst mulige rammer for at mere rehabilitering flyttes ud.

Jeg vil have forberedt nogle spørgsmål til fælles diskussion blandt dig og dine kollegaer, men der er også fire terapeuter som er blevet stillet til opgave at medbringe billeder som vil danne udgangspunkt for at igangsætte samtalen. Din rolle er, at byde aktivt ind med dine egne erfaringer og oplevelser omkring de enkelte diskussionsemner, og det er ikke hensigten at der skal skabes enighed. Det er forventet at I har forskellige erfaringer og synspunkter.

Interviewet vil blive optaget og efterfølgende transskriberet og anonymiseret i overensstemmelse med databeskyttelsesforordningen.

Inden interviewet igangsættes, bedes du at have orienteret dig i, og skrevet under på, den vedhæftede samtykkeerklæring. Jeg medbringer ekstra eksemplarer til underskrift på dagen.

Hvis du på forhånd ved at du ikke har mulighed for at deltage, så meld gerne fra til mig på mail;
Imaden@rm.dk

Jeg sætter stor pris på din tid, men håber også at denne diskussion kan bidrage til nye faglige indsigter.

De bedste hilsner
Louise Sofia Madsen ☺



Appendix 12. Article II - participant information photovoice

Fotoopgave, fokus-gruppe interview

Kære (navn)

Tak for at indvillige i gennemføre en fotoopgave forud for din deltagelse i to fokus-gruppe interviews:

1. Det første fokus-gruppe interview gennemføres sammen med dine kollegaer den **xx**
2. Det næste fokus-gruppe interview gennemføres i slutningen af maj i en sammensat gruppe med terapeuter fra xx centret og xx centret. Du modtager en ny instruktion for denne del.

Hvad kan man bruge billeder til i et interview?

Billeder er en måde at skabe indsigt og viden om et emne på. I forhold til at bruge ord, så er billeder gode til at igangsætte hukommelsen og refleksion. På den måde hjælper billeder med til at gøre et abstrakt taleemne mere konkret og bringe en realitet ind i interviewet, der baserer sig på deltagerens oplevelser og meninger.

Tre af dine kollegaer har fået stillet den samme opgave, og det er Jeres billeder der tilsammen skal guide diskussionerne blandt hele personalegruppen.

Hvad går fotoopgaven ud på?

Du får til opgave at tage i alt fire billeder som du skal medbringe til interviewet:

- 2 billeder skal repræsentere de muligheder det giver at bruge uderummet mere i rehabilitering
- 2 billeder skal repræsentere udfordringer forbundet med at bruge uderummet mere i rehabilitering

Det kan være på individuelt niveau såvel som på organisatorisk niveau og det kan være baseret på egne faglige erfaringer eller opfattelser omkring borgernes specifikke situationer. Du er velkommen til at drøfte opgaven med dine kollegaer for inspiration og faglig sparring om, hvad billederne skal repræsentere og tankerne bag. Tanken er at billederne skal kunne tages som en del af din daglige praksis, og på den måde ikke være tidskrævende. Du kan bruge telefon eller ipad alt efter hvad du finder lettest.

Hvad skal der være på billedet?

Billedet kan være af et konkret motiv, men også af noget mere abstrakt der tillægges en bestemt betydning. Til interviewet vil du blive bedt om kort at præsentere hvad der ligger til grund for at du har taget netop disse billeder, og uddybe dine tanker omkring løsning af fotoopgaven.

Af hensyn til persondataloven må der ikke tages billeder af ansigter eller identificerbare informationer.

Hvad skal jeg gøre når jeg har taget billedet?

Senest den **xx** skal de fire billeder sendes til min mail: Imaden@rm.dk

Jeg sørger for at printe billederne i flere eksemplarer og medbringer dem til interviewet.

På forhånd mange tak for din tid ☺

Mange hilsner
Louise Sofia Madsen

Imaden@rm.dk

Appendix 12. Article III- participant information interview

Hej

Jeg er ph.d.-studerende indskrevet ved Aarhus Universitet, og uddannet antropolog. Jeg er i gang med et forskningsprojekt, der omhandler: *'Brug af uderummet i rehabilitering'*. Jeg skal undersøge hvilke udfordringer og muligheder, der er forbundet med at mere rehabilitering flyttes udenfor, da meget tyder på, at det har en gavnlig effekt både fysisk, psykisk og socialt.

I den forbindelse skal jeg gennemføre en række interviews med personer, der har været igennem et rehabiliteringsforløb. Formålet er, at opnå viden om, hvilke udfordringer og muligheder, der er forbundet med at rehabilitering flyttes udenfor i en offentlig rehabiliteringspark. Herunder, at identificere betydningsfulde faktorer som skal tages i betragtning i den videre udvikling af SPARK projektet, og ved opstart af lignende projekter både i Danmark og i udlandet. Hensigten er, at forbedre funktionsevnen hos personer i rehabiliteringsforløb og øge deres deltagelse i positive sociale fællesskaber.



Projektet er indlejret i den kommende rehabiliteringspark SPARK (Sundhed, Park, Aktiviteter, Rehabilitering og Klimatilpasning), som etableres i udearealet omkring MarselisborgCentret i løbet af de næste to år. Ambitionen er, at skabe inkluderende omgivelser for udendørs rehabilitering og styrke mødet mellem mennesker. Tilgængelige grønne områder, variation i omgivelserne og frivillige aktiviteter skal fungere som sociale samlingspunkter i parken. Hvis du er interesseret i at vide mere om SPARK-projektet, kan du se mere på hjemmesiden: <https://www.marselisborgcentret.dk/spark/>

Den viden som jeg genererer på baggrund af interviewet og ph.d.-projektets øvrige studier skal bidrage til at udvikle en praksis-baseret model for brug af uderummet i rehabilitering. En sådan model skal guide fagprofessionelle, beslutningstagere, og politikere i henhold til hvilke forhold der er vigtige at tage højde for, i udviklingsprocessen mod at skabe de bedst mulige rammer for at mere rehabilitering flyttes udenfor.

Jeg er meget glad for, at du eventuelt kunne have lyst til at deltage i projektet.

Dit input vil dreje sig om dine oplevelser og overvejelser omkring dit nuværende rehabiliteringsforløb, og hvordan aktiviteter i uderummet og involvering i sociale fællesskaber kan indgå bedst muligt i processen (dine forestillinger).

Det vil kræve omkring 1 time af din tid. Så vidt det er muligt vil jeg forsøge at planlægge interviewet i forbindelse med dine øvrige aftaler på xx-centret. Interviewet vil blive gennemført som en 'walk and talk', hvor vi går en tur rundt i parken, og evt. sidder på en bæk og får et hvil, i de omgivelser som det hele drejer dig om.

Interviewet vil blive optaget og efterfølgende transskriberet og anonymiseret i overensstemmelse med databeskyttelsesforordningen.

Inden interviewet igangsættes, bedes du at have orienteret dig i, og skrevet under på, den tilsendte samtykkeerklæring. Jeg medbringer ekstra eksemplarer til underskrift på dagen.

På forhånd mange tak for din tid ☺

Mange hilsner

Louise Sofia Madsen

DEFACTUM, Region Midtjylland

lmaden@rm.dk



Skriftligt samtykke

Samtykkeerklæring til behandling af mine personoplysninger

I forbindelse med forskningsprojektet: "SPARK Rehabiliteringspark", har jeg brug for dit samtykke til, at må behandle dine personoplysninger i overensstemmelse med Databeskyttelsesforordningen.

Formålet med behandling af personoplysningerne

Formålet med dette studie er, at opnå viden om, hvilke udfordringer og muligheder som fagprofessionelle oplever og beskriver, der er forbundet med at bruge uderummet i rehabiliteringsforløb.

Ved at undersøge hvad der er på spil under etableringsprocessen af SPARK rehabiliteringspark er det muligt at identificere betydningsfulde faktorer for at mere rehabilitering flyttes udenfor og belyse lokale sociale fællesskabers betydning for rehabiliteringsforløbet.

I projektet indsamles der personoplysninger i form af interviews. Det er ph.d.-studerende Louise Sofia Madsen, der behandler oplysningerne.

I interviewet vil følgende spørgsmål blive afdækket:

- Hvad oplever og beskriver fagprofessionelle som centrale udfordringer og muligheder forbundet med at bruge uderummet i rehabiliteringsforløb?

Du giver samtykke til at du vil deltage i studiet, og at ph.d.-studerende Louise Sofia Madsen foretager et interview sammen med dig og dine kollegaer.

Beskriv hvilke personoplysninger der behandles

Dit samtykke giver tilladelse til behandling af følgende personoplysninger:

- Navn
- Køn
- Alder
- Job
- Uddannelse

Behandling af oplysningerne indebærer at disse anonymiseres ved brug.

Beskriv hvor der indsamles personoplysninger

Personoplysningerne fra interviews indsamles på Ortopædisk Genoptræningscenter, Neurocentret, og Dagcenter Midtpunktet, Aarhus Kommune i forbindelse med gennemførelse af Ph.d.-projekt. Personoplysningerne opbevares ved DEFACTUM, MarselisborgCentret, Region Midtjylland.

Region Midtjylland er dataansvarlig for behandlingen af dine personoplysninger.

Hvem der behandler personoplysningerne

Appendix 13. Declaration of consent article II - HPs

Ph.d.- studerende og projektleder Louise Sofia Madsen er ansvarlig for projektet og behandler dine data. Hun kan kontaktes på: Adresse: MarselisborgCentret, P.P. Ørumsgade, 11, bygn. 1b, 8000 Aarhus C., Mobil: 6168 8074
Opbevaringstid for indsamling af personoplysninger
Dine personoplysninger vil blive opbevaret indtil august 2025.
Mulighed for at trække samtykke tilbage
Deltagelse er frivilligt, og du kan til enhver tid og uden begrundelse trække dit samtykke til behandling af personoplysninger tilbage. Hvis du trækker dit samtykke tilbage, betyder det, at der ikke vil ske yderligere behandling af dine oplysninger i projektet. Allerede trykt/udgivet materiale kan dog ikke tilbagekaldes. Dette kan ske ved at kontakte ph.d.- studerende projektleder Louise Sofia Madsen: Adresse: MarselisborgCentret, P.P. Ørumsgade, 11, bygn. 1b, 8000 Aarhus C., Mobil: 6168 8074
Hvis du vil vide mere samtykke
<ul style="list-style-type: none">- Du kan læse mere om samtykke i Datatilsynets vejledning: https://www.datatilsynet.dk/media/6562/samtykke.pdf- Du kan læse mere om vores behandling af dine personoplysninger og om dine rettigheder: http://www.rm.dk/siteassets/om-os/dine-data/borgerens-rettigheder/den-registreredes-rettigheder.pdf- Databeskyttelsesforordningen artikel 6, stk. 1, litra a, artikel 9, stk. 2, litra a samt artikel 7.

Jeg bekræfter at have modtaget, læst og forstået ovenstående, som baggrund for mit samtykke til behandling af mine personoplysninger i forbindelse med forskningsprojektet: **SPARK Rehabiliteringspark**

Navn: _____

Dato og underskrift: _____



Skriftligt samtykke

Samtykkeerklæring til behandling af mine personoplysninger

I forbindelse med forskningsprojektet: "SPARK Rehabiliteringspark", har jeg brug for dit samtykke til, at må behandle dine personoplysninger i overensstemmelse med Databeskyttelsesforordningen.

Formålet med behandling af personoplysningerne

Formålet med dette studie er, at opnå viden om, hvilke udfordringer og muligheder som fagprofessionelle oplever og beskriver, der er forbundet med at bruge uderummet i rehabiliteringsforløb.

Ved at undersøge hvad der er på spil under etableringsprocessen af SPARK rehabiliteringspark er det muligt at identificere betydningsfulde faktorer for at mere rehabilitering flyttes udenfor og belyse lokale sociale fællesskabers betydning for rehabiliteringsforløbet.

I projektet indsamles der personoplysninger i form af interviews og billeder, der tages af deltageren selv forud for interviewet. Det er ph.d.-studerende Louise Sofia Madsen, der behandler oplysningerne.

I interviewet vil følgende spørgsmål blive afdækket:

- Hvad oplever og beskriver fagprofessionelle som centrale udfordringer og muligheder forbundet med at bruge uderummet i rehabiliteringsforløb?

Du giver samtykke til at du vil deltage i studiet, og at ph.d.-studerende Louise Sofia Madsen foretager et interview sammen med dig og dine kollegaer, hvor billeder du har taget forud for interviewet indgår. Du giver ydermere samtykke til at de billeder du har taget må bruges til faglige oplæg eller publikationer i forbindelse med ph.d.-projektet.

Beskriv hvilke personoplysninger der behandles

Dit samtykke giver tilladelse til behandling af følgende personoplysninger:

- Navn
- Køn
- Alder
- Job
- Uddannelse

Behandling af oplysningerne indebærer at disse anonymiseres ved brug.

Beskriv hvor der indsamles personoplysninger

Personoplysningerne fra interviews indsamles på Ortopædisk Genoptræningscenter, Neurocentret, og Dagcenter Midtpunktet, Aarhus Kommune i forbindelse med gennemførelse af Ph.d.-projekt. Personoplysningerne opbevares ved DEFACTUM, MarselisborgCentret, Region Midtjylland.

Region Midtjylland er dataansvarlig for behandlingen af dine personoplysninger.

Appendix 13. Declaration of consent article II - HPs photovoice

Hvem der behandler personoplysningerne



Ph.d.- studerende og projektleder Louise Sofia Madsen er ansvarlig for projektet og behandler dine data. Hun kan kontaktes på:

Adresse: MarselisborgCentret, P.P. Ørumsgade, 11, bygn. 1b, 8000 Aarhus C.,
Mobil: 6168 8074

Opbevaringstid for indsamling af personoplysninger

Dine personoplysninger vil blive opbevaret indtil august 2025.

Mulighed for at trække samtykke tilbage

Deltagelse er frivilligt, og du kan til enhver tid og uden begrundelse trække dit samtykke til behandling af personoplysninger tilbage. Hvis du trækker dit samtykke tilbage, betyder det, at der ikke vil ske yderligere behandling af dine oplysninger i projektet. Allerede trykt/udgivet materiale kan dog ikke tilbagekaldes.

Dette kan ske ved at kontakte ph.d.- studerende projektleder Louise Sofia Madsen:

Adresse: MarselisborgCentret, P.P. Ørumsgade, 11, bygn. 1b, 8000 Aarhus C.,
Mobil: 6168 8074

Hvis du vil vide mere samtykke

- Du kan læse mere om samtykke i Datatilsynets vejledning:
<https://www.datatilsynet.dk/media/6562/samtykke.pdf>
- Du kan læse mere om vores behandling af dine personoplysninger og om dine rettigheder:
<http://www.rm.dk/siteassets/om-os/dine-data/borgerens-rettigheder/den-registreredes-rettigheder.pdf>
- Databeskyttelsesforordningen artikel 6, stk. 1, litra a, artikel 9, stk. 2, litra a samt artikel 7.

Jeg bekræfter at have modtaget, læst og forstået ovenstående, som baggrund for mit samtykke til behandling af mine personoplysninger i forbindelse med forskningsprojektet: **SPARK Rehabiliteringspark**

Navn: _____

Dato og underskrift: _____



Skriftligt samtykke

Samtykkeerklæring til behandling af mine personoplysninger

I forbindelse med forskningsprojektet: **”SPARK Rehabiliteringspark”**, har jeg brug for dit samtykke til, at må behandle dine personoplysninger i overensstemmelse med Databeskyttelsesforordningen.

Formålet med behandling af personoplysningerne

Formålet med dette studie er, at opnå viden om, hvilke udfordringer og muligheder som mennesker i rehabiliteringsforløb oplever og beskriver, der er forbundet med brug af uderummet i rehabilitering.

Ved at undersøge hvad der er på spil under etableringsprocessen af SPARK rehabiliteringspark, er det muligt at udvikle en praksis-baseret model for brug af uderummet i rehabilitering. En sådan model skal guide fag-professionelle, beslutningstagere, og politikere til at skabe de bedst mulige rammer for at mere rehabilitering flyttes udenfor.

I projektet indsamles der personoplysninger i form af interviews. Det er ph.d.-studerende Louise Sofia Madsen, der behandler oplysningerne.

I interviewet vil følgende spørgsmål blive afdækket:

- Hvad oplever og beskriver mennesker i rehabiliteringsforløb som centrale udfordringer og muligheder forbundet med at bruge uderummet i rehabiliteringsforløb?

Du giver samtykke til at du vil deltage i studiet, og at ph.d.-studerende Louise Sofia Madsen foretager et interview sammen med dig.

Beskriv hvilke personoplysninger der behandles

Dit samtykke giver tilladelse til behandling af følgende personoplysninger:

- Navn
- Køn
- Alder
- Job
- Uddannelse
- Helbredstilstand

Behandling af oplysningerne indebærer at disse anonymiseres ved brug.

Beskriv hvor der indsamles personoplysninger

Personoplysningerne fra interviews indsamles på MarselisborgCentret med tilknytning til Ortopædisk Genoptræningscenter, Neurocentret, og Dagcenter Midtpunktet, Aarhus Kommune i forbindelse med gennemførelse af Ph.d.-projekt. Personoplysningerne opbevares ved DEFACTUM, MarselisborgCentret, Region Midtjylland.

Region Midtjylland er dataansvarlig for behandlingen af dine personoplysninger.

Appendix 13. Declaration of consent article III - PWDs



Hvem der behandler personoplysningerne
Ph.d.- studerende og projektleder Louise Sofia Madsen er ansvarlig for projektet og behandler dine data. Hun kan kontaktes på: Adresse: MarselisborgCentret, P.P. Ørumsgade, 11, bygn. 1b, 8000 Aarhus C. Mobil: 6168 8074
Opbevaringstid for indsamling af personoplysninger
Dine personoplysninger vil blive opbevaret indtil august 2025.
Mulighed for at trække samtykke tilbage
Deltagelse er frivilligt, og du kan til enhver tid og uden begrundelse trække dit samtykke til behandling af personoplysninger tilbage. Hvis du trækker dit samtykke tilbage, betyder det, at der ikke vil ske yderligere behandling af dine oplysninger i projektet. Allerede trykt/udgivet materiale kan dog ikke tilbagekaldes. Dette kan ske ved at kontakte ph.d.- studerende projektleder Louise Sofia Madsen: Adresse: MarselisborgCentret, P.P. Ørumsgade, 11, bygn. 1b, 8000 Aarhus C., Mobil: 6168 8074
Hvis du vil vide mere samtykke
<ul style="list-style-type: none">- Du kan læse mere om samtykke i Datatilsynets vejledning: https://www.datatilsynet.dk/media/6562/samtykke.pdf- Du kan læse mere om vores behandling af dine personoplysninger og om dine rettigheder: http://www.rm.dk/siteassets/om-os/dine-data/borgerens-rettigheder/den-registreredes-rettigheder.pdf- Databeskyttelsesforordningen artikel 6, stk. 1, litra a, artikel 9, stk. 2, litra a samt artikel 7.

Jeg bekræfter at have modtaget, læst og forstået ovenstående, som baggrund for mit samtykke til behandling af mine personoplysninger i forbindelse med forskningsprojektet: **SPARK Rehabiliteringspark**. Jeg har modtaget det underskrevne dokument.

Navn: _____

Dato og underskrift: _____



Skriftligt samtykke

Samtykkeerklæring til behandling af mine personoplysninger

I forbindelse med forskningsprojektet: ”**SPARK – uderummet som ramme for rehabiliteirng baseret i lokalområdet**”, har jeg brug for dit samtykke til, at må behandle dine personoplysninger i overensstemmelse med Databeskyttelsesforordningen.

Formålet med behandling af personoplysningerne

Formålet med dette studie er, at videreudvikle eksisterende viden om uderummet som ramme for rehabilitering baseret i lokalområdet, ved at facilitere erfarings- og videns-udveksling mellem forskere, borgere i rehabilitering og sundhedsprofessionelle.

Hensigten er, at omsætte viden fra forskning til nye løsninger på rehabiliteringsområdet, der går på tværs af faglig praksis, hverdagsliv, og lokalsamfund.

Studiet tager afsæt i SPARK projektet, der udvider rammen for rehabilitering ved at natur og lokalområder inkluderes som en naturlig del af omgivelserne.

I projektet indsamles der personoplysninger i form af online interviews, som optages med lyd og med billede. Det er ph.d.-studerende Louise Sofia Madsen, der behandler oplysningerne.

I interviewet vil følgende spørgsmål blive afdækket:

- Hvad kan vi lære af erfarings- og videns-udveksling mellem forskere, borgere i rehabilitering og sundhedsprofessionelle med henblik på at videreudvikle eksisterende viden om uderummet som ramme for rehabilitering baseret i lokalområdet?

Du giver samtykke til, at du vil deltage i studiet, og at ph.d.-studerende Louise Sofia Madsen foretager et online interview sammen med dig andre deltagere.

Beskriv hvilke personoplysninger der behandles

Dit samtykke giver tilladelse til behandling af følgende personoplysninger:

- Navn
- Køn
- Alder
- Job
- Uddannelse
- Online skærm-billede

Behandling af oplysningerne indebærer at disse anonymiseres ved brug.

Beskriv hvor der indsamles personoplysninger

Personoplysningerne fra interviews indsamles online på Teams, med deltagere tilknyttet Ortopædisk Genoptræningscenter, Neurocentret, og Dagcenter Midtpunktet, Aarhus Kommune i forbindelse med gennemførelse af Ph.d.-projekt. Personoplysningerne opbevares ved DEFACTUM, MarselisborgCentret,



Region Midtjylland.

Region Midtjylland er dataansvarlig for behandlingen af dine personoplysninger.

Hvem der behandler personoplysningerne

Ph.d.- studerende og projektleder Louise Sofia Madsen er ansvarlig for projektet og behandler dine data. Hun kan kontaktes på:

Adresse: MarselisborgCentret, P.P. Ørumsgade, 11, bygn. 1b, 8000 Aarhus C.,

Mobil: 6168 8074

Opbevaringstid for indsamling af personoplysninger

Dine personoplysninger vil blive opbevaret indtil august 2025.

Mulighed for at trække samtykke tilbage

Deltagelse er frivilligt, og du kan til enhver tid og uden begrundelse trække dit samtykke til behandling af personoplysninger tilbage. Hvis du trækker dit samtykke tilbage, betyder det, at der ikke vil ske yderligere behandling af dine oplysninger i projektet. Allerede trykt/udgivet materiale kan dog ikke tilbagekaldes.

Dette kan ske ved at kontakte ph.d.- studerende projektleder Louise Sofia Madsen:

Adresse: MarselisborgCentret, P.P. Ørumsgade, 11, bygn. 1b, 8000 Aarhus C.,

Mobil: 6168 8074

Hvis du vil vide mere samtykke

- Du kan læse mere om samtykke i Datatilsynets vejledning:
<https://www.datatilsynet.dk/media/6562/samtykke.pdf>
- Du kan læse mere om vores behandling af dine personoplysninger og om dine rettigheder:
<http://www.rm.dk/siteassets/om-os/dine-data/borgerens-rettigheder/den-registreredes-rettigheder.pdf>
- Databeskyttelsesforordningen artikel 6, stk. 1, litra a, artikel 9, stk. 2, litra a samt artikel 7.

Jeg bekræfter at have modtaget, læst og forstået ovenstående, som baggrund for mit samtykke til behandling af mine personoplysninger i forbindelse med forskningsprojektet: **SPARK – uderummet som ramme for rehabilitering baseret i lokalområdet.**

Navn og tlf: _____

Dato og underskrift: _____