

Review Article

Occupational therapy interventions in community settings for people with acquired brain injury: a scoping review

Intervenções de terapia ocupacional em contextos comunitários para pessoas com lesão cerebral adquirida: revisão de escopo

Intervenciones de terapia ocupacional en contextos comunitarios para personas con lesión cerebral adquirida: revisión de alcance

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Abstract

Acquired brain injury (ABI) is one of the leading causes of disability worldwide, generating growing interest in community-based rehabilitation interventions. Occupational therapy, with its focus on participation and performance in meaningful occupations, plays a key role in this field. However, the evidence on community-based interventions led by occupational therapists remains scattered and poorly systematised. To analyse the scientific evidence on community-based interventions developed by occupational therapists for people with ABI, characterising their components, theoretical frameworks, assessment tools, facilitators, and barriers. A scoping review was conducted following Arksey and O'Malley's framework, supported by PRISMA-ScR. Studies published between 2019 and 2024 in English or Spanish were included and identified across four databases. A total of 23 studies met the inclusion criteria. A wide heterogeneity in intervention types, outcome measures, and populations was observed. The most common approaches included real-world community settings, assistive technologies, and telerehabilitation. There was limited use of explicit theoretical frameworks and a broad dispersion of assessment tools. Key facilitators included

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family and social support, while the main barriers involved economic, cognitive, and interinstitutional coordination difficulties. Community-based interventions led by occupational therapists show promising results but face important challenges related to theoretical grounding, methodological standardisation, and contextual adaptability. More rigorous and culturally relevant studies are needed to strengthen their effectiveness and sustainability.

Keywords: Brain Injury, Occupational Therapy, Community Involvement.

Resumo

A lesão cerebral adquirida (LCA) é uma das principais causas de incapacidade em nível mundial, o que tem impulsionado um crescente interesse pelas intervenções de reabilitação comunitária. A terapia ocupacional pode focar-se na participação e no desempenho em ocupações significativas, desempenhando um papel fundamental. No entanto, a evidência sobre intervenções comunitárias lideradas por terapeutas ocupacionais continua dispersa e pouco sistematizada. Analisar a evidência científica sobre intervenções comunitárias desenvolvidas por terapeutas ocupacionais em pessoas com LCA, caracterizando seus componentes, modelos teóricos, ferramentas de avaliação, facilitadores e barreiras. Foi realizada uma revisão de escopo segundo as diretrizes de Arksey e O'Malley, com apoio do PRISMA-ScR. Foram incluídos estudos publicados entre 2019 e 2024, em inglês ou espanhol, identificados em quatro bases de dados. Seleccionaram-se 23 estudos que cumpriam os critérios de inclusão. Evidenciou-se grande heterogeneidade nos tipos de intervenção, medidas de resultado e populações abordadas. Predominaram intervenções em contextos comunitários reais, tecnologias assistivas e telereabilitação. Observou-se uso limitado de modelos teóricos explícitos e ampla dispersão nas ferramentas de avaliação. Os principais facilitadores foram o apoio familiar e social, enquanto as barreiras incluíram dificuldades econômicas, cognitivas e de coordenação interinstitucional. As intervenções comunitárias lideradas por terapeutas ocupacionais mostram resultados promissores, mas enfrentam desafios importantes relacionados à fundamentação teórica, padronização metodológica e adaptabilidade contextual. São necessários estudos mais rigorosos e culturalmente pertinentes para fortalecer sua efetividade e sustentabilidade.

Palavras-chave: Lesão Cerebral, Terapia Ocupacional, Envolvimento de Comunidade.

Resumen

La lesión cerebral adquirida (LCA) es una de las principales causas de discapacidad a nivel mundial, lo que ha impulsado un creciente interés en las intervenciones de rehabilitación comunitaria. La terapia ocupacional, puede enfocarse en la participación y el desempeño en ocupaciones significativas, cumpliendo un rol clave. Sin embargo, la evidencia sobre intervenciones comunitarias lideradas por terapeutas ocupacionales sigue siendo dispersa y poco sistematizada. Analizar la evidencia científica sobre intervenciones comunitarias desarrolladas por terapeutas ocupacionales en personas con LCA, caracterizando sus componentes, marcos teóricos, herramientas de evaluación, facilitadores y barreras. Se realizó una revisión de alcance siguiendo las directrices de Arksey y O'Malley, con apoyo de PRISMA-ScR. Se incluyeron estudios publicados entre 2019 y 2024 en inglés o español, identificados en cuatro bases de

datos. Se seleccionaron 23 estudios que cumplían los criterios de inclusión. Se evidenció una gran heterogeneidad en los tipos de intervención, medidas de resultado y poblaciones abordadas. Predominaron intervenciones en entornos comunitarios reales, tecnologías de asistencia y telerehabilitación. Se observó un uso limitado de modelos teóricos explícitos, y una amplia dispersión de herramientas de evaluación. Los principales facilitadores fueron el apoyo familiar y social, mientras que las barreras incluyen dificultades económicas, cognitivas y de coordinación interinstitucional. Las intervenciones comunitarias lideradas por terapeutas ocupacionales muestran resultados prometedores, pero enfrentan desafíos importantes relacionados con su fundamentación teórica, estandarización metodológica y adaptabilidad contextual. Se requieren estudios más rigurosos y culturalmente pertinentes para fortalecer su efectividad y sostenibilidad.

Palabras clave: Lesiones Encefálicas, Terapia Ocupacional, Participación Comunitaria.

Introduction

Acquired brain injury (ABI), which includes traumatic brain injury (TBI) and stroke, among other causes, is a major cause of global disability (Dávila, 2019; Irene, 2018). An estimated 69 million new cases of TBI and more than 6.5 million deaths from stroke occur annually (GBD 2019 Stroke Collaborators, 2021).

In Chile, TBI is the leading cause of death in young adults aged 20 to 40, and cerebrovascular diseases are the third leading cause of death in adults (Medina & Kaempfer, 2007). In 2021, there were 29,542 hospital discharges due to stroke and 7,501 deaths (Chile, 2022). TBI accounts for approximately 40% of traffic fatalities and has a hospitalization rate of 200 per 100,000 inhabitants annually (Acevedo Palacios, 2016; Moyano, 2010).

Acquired brain injury (ABI) is classified as traumatic (TBI) and non-traumatic (stroke, anoxia, tumors, etc.). This distinction is vital for treatment (Brain Injury Association of Colorado, 2022). Chronic sequelae, even in mild cases, require prolonged interventions. Since many ABI survivors require intensive care and prolonged support, especially after a stroke, the transition home involves not only continuity of treatment but also a reorganization of the role of family caregivers, who often assume caregiving responsibilities without sufficient preparation and with impacts on their daily lives (Fonseca-Mardones & Hernández-Lanas, 2025; Jiménez et al., 2010). In this context, the approach to care has evolved from the hospital to community-based rehabilitation (CBR), understood as a multisectoral strategy aimed at promoting social inclusion through the participation of different sectors of society (García-Ruiz et al., 2019; Ossandón, 2014).

In this context, occupational therapy is key in promoting participation in meaningful activities and role restructuring (Powell et al., 2016). From a Latin American perspective, community occupational therapy has developed frameworks and practices that shift the focus from an exclusively clinical approach toward processes of socio-community inclusion and territorial work, articulated with community-based rehabilitation (CBR) (Pino & Ceballos, 2015; Satizabal Reyes et al., 2024; Zango, 2017). This shift has also been problematized from a critical community occupational therapy perspective that calls for recognizing the community as an active subject and situating intervention

“in, with, and from” the territories, avoiding neutral or decontextualized practices (Pino et al., 2015).

Furthermore, articulation with primary health care is relevant for sustaining continuity of rehabilitation, territorial proximity, and the coordination of interdisciplinary and intersectoral teams (Organización Mundial de la Salud, 2023; Organización Panamericana de Salud, 2019, 2024).

Additionally, manuals and intervention proposals emphasize that conceptual clarity regarding types and strategies of intervention is essential for aligning objectives, goals, and evaluation with participation as the central outcome (Mercado & Ramírez, 2007; Zango, 2017). In populations with ABI, recent practice-oriented reviews support occupation-based interventions that transcend isolated clinical performance and impact daily performance and citizenship (Cariman & Arriagada, 2023), in accordance with the tradition of occupational therapy in neurology and physical dysfunction of intervening throughout the care continuum and in real-life environments (Agorreta et al., 2015).

The community-based approach in the health field recognizes the community as an active participant in the construction of well-being, not merely as a recipient of services. It is based on principles such as community orientation, participation, multisectoral action, and multidisciplinary teamwork, which allow interventions to be contextualized according to the social and physical characteristics of each population (Martínez, 2006; Cotonieto-Martínez & Rodríguez-Terán, 2021). In occupational therapy, this approach involves developing interventions “in, with, and from” the community, under the principles of justice and empowerment, promoting occupational participation, the exercise of meaningful roles, and the identification of facilitators and barriers in everyday environments (Estrany-Munar et al., 2021; Palacios Tolvett, 2017). Facilitators are understood as environmental factors that improve functioning and reduce limitations that generate disability, while barriers are those that limit functioning and increase restrictions, generating greater disability.

In this review, we define *community-based* interventions as any therapeutic action carried out in natural living environments, and community-focused *interventions as those co-designed with the community*, oriented toward participation and role-related goals, and coordinated with intersectoral resources.

Community-based interventions have proven effective in the functional recovery and social integration of people with acquired brain injury (ABI). Studies highlight the effectiveness of community programs involving telerehabilitation and assistive technologies to improve performance and inclusion (Kim & Colantonio, 2010; Jacobs-Nzuzi Khuabi et al., 2021). However, their implementation faces economic, administrative, and structural barriers, as well as a scarcity of replicable local models (Ferro & Santos, 2020).

Based on this framework, our objective was to characterize interventions, theoretical frameworks, tools, facilitators, and barriers in ABI, and to examine the extent to which these interventions respond to a community-based approach.

Research question. What is the current evidence on community-based occupational therapy interventions for people with acquired brain injury?

General objective: To analyze the scientific evidence on community-based interventions developed by occupational therapists for people with acquired brain injury. Specific objectives: (1) to characterize the included studies; (2) to identify facilitators and barriers to implementation; (3) to report the assessment tools used; and (4) to recognize the disciplinary models and frameworks applied.

Registration

This project is registered in the Open Science Framework (OSF) and is accessible through the following DOI: <https://doi.org/10.17605/OSF.IO/WXPHC>

Method

The design of this review followed the methodological steps proposed by Arksey and O'Malley (2005), with recommendations from Levac et al. (2010), and was reported according to the PRISMA-ScR guidelines (Tricco et al., 2018).

Eligibility criteria

The following were included:

1. Studies with individuals diagnosed with ABI who received occupational therapy interventions with a community focus.
2. Participants of any age and ABI severity.
3. Interventions in community settings with the participation of occupational therapists.
4. Publications from the last five years, in English or Spanish.
5. Original articles, systematic reviews, meta-analyses, or scoping reviews.

The following were excluded:

1. Studies on other neurological or medical conditions.
2. Community interventions without occupational therapists.
3. Theses, opinion articles, editorials, conference abstracts, or non-peer-reviewed literature.
4. Studies without full-text access.

Search strategy

Searches were conducted in the SAGE Journals, PubMed, Scopus, and EBSCOhost databases. The following terms were used in Spanish and English: “Lesión cerebral adquirida” / “Acquired brain injury,” “Terapia ocupacional” / “Occupational therapy,” and “Enfoque comunitario” / “Community-based,” applying Boolean operators and filters by language, publication type, and date.

Selection of evidence sources

The process was carried out in Covidence by two independent reviewers, with a third acting as an arbitrator in case of disagreement.

Data extraction and analysis

Data extraction was performed using a Microsoft Excel spreadsheet with variables such as: author and year, population, objective, type of community intervention, assessment tools, and main results. Two reviewers extracted the data independently, and a third consolidated and verified the information.

Content analysis was conducted through team consensus, identifying thematic categories aligned with the objectives. This allowed for the integration and synthesis of qualitative and quantitative findings related to the interventions.

Visualization of results

Absolute and relative frequencies were calculated. The results were presented in Excel using tables and bar graphs to highlight trends and gaps in the literature. Participation outcomes were defined a priori as those informing intervention goals and decisions beyond clinical performance, with an observable impact on roles, networks, and citizenship. The tools were classified according to their main function (baseline, goals, monitoring).

Critical appraisal

No critical appraisal of the studies was performed, as it was not part of the objectives of this scoping review.

Ethical considerations

This scoping review of the scientific literature did not involve direct interaction with individuals or sensitive data. All data were obtained from publicly available secondary sources; therefore, informed consent and institutional ethical approval were not required.

Results

Of the initial 372 studies, 296 were excluded after reviewing titles and abstracts. Subsequently, 44 full-text articles were assessed, resulting in 23 studies included in the final analysis (see Figure 1).

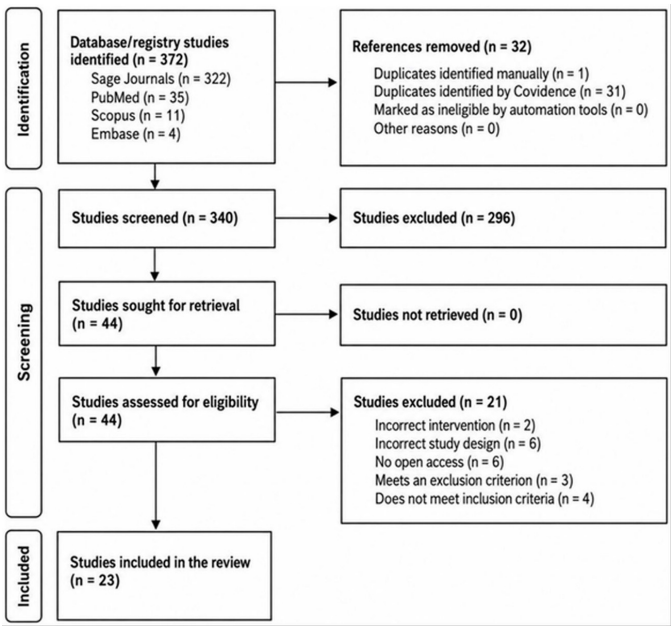


Figure 1. PRISMA-ScR Flow Diagram of Article Selection.

The included studies were characterized according to predefined criteria (see Table 1), which summarize key information such as authorship, objective, population, type of intervention, assessment tools, and main findings.

Table 1. Characterization of the studies included in the article.

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Beit Yosef et al., 2019	5 adults with ABI	Explore the feasibility of a metacognitive intervention.	15 sessions of Cognitive Orientation to Daily Occupational Performance (CO-OP).	MMSE, MoCa, COPM, MPAI-4-P, SIS, mRS, Satisfaction Questionnaire, and Semi-structured Interview.	Improvements in COPM and participation, and nearly significant improvements in quality of life in “memory and thinking” and “communication.”
Prescott et al., 2019	58 patients with ABI and rehabilitation professionals	Explore the application of the framework in daily practice.	Not applicable.	C-COGS, COPM.	COPM was used to facilitate “progress feedback.”
Beit Yosef et al., 2022	25 adults in the chronic phase of ABI	Examine aspects of participation among adults in the chronic phase after ABI.	Explore participation multidimensionally among users living in the community.	COPM, Mayo-Portland-4, mRS scale, PHQ-9, GDS, DEX, perceived environmental accessibility measure.	Limitations were identified in the domains of leisure, residence, and employment.

Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale “Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen” (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Objective (PART-O), Participation Assessment with Recombined Tools-Satisfaction (PART-S), Enfranchisement Scale, Customer Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Schrader et al., 2024	243 adults with stroke, predominantly men.	Describe the characteristics of a transsectoral, multiprofessional, long-term neurorehabilitation concept and its effects on the ICF.	Professionals taught aspects of daily life through guided practice and facilitative support.	BI, HMBW, COPM.	Improvements were observed in BI, HMBW, and COPM. Seventy-two percent of patients moved with moderate support, and cognitive deficit was the main predictor of discharge destination.
Tsow et al., 2024	22 people with ABI from community associations.	Characterize the implementation of programs supporting acceptance and resilience among people with ABI.	Participants described how their programs helped attendees establish connections with themselves and their community.	Not applicable.	Fund management, stable leaders, and a welcoming environment were key. Shared experiences strengthened the community and personal development.

Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale “Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen” (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Objective (PART-O), Participation Assessment with Recombined Tools-Satisfaction (PART-S), Enfranchisement Scale, Customer Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Vibholm et al., 2023	4 physiotherapists and 3 occupational therapists applying nature-based rehabilitation (NBR).	Explore the experiences of physiotherapists and occupational therapists.	Therapists enabled patients to feel connected with the natural environment.	COPM and Crepeau Activity Analysis.	Therapists used outdoor environments for training and creative activities.
Shimizu et al., 2022	22 people with ABI with difficulty using public transport.	Report the progress of a behavioural approach enabling people with ABI to travel independently using public transport.	Two patients with ABI were intervened to use public transport.	MMSE, TMT, RBMT, Rey Figure, FAB, BADS.	Improvements in the use of public transport were observed, and the effects were maintained during follow-up.
Rohrer-Baumgartner et al., 2022	School-aged children with ABI and their families	Improve the daily functioning of children with ABI in the chronic stage.	Psychoeducation and classroom observation.	HBI, TOPSE, BRIEF-2, PedsQL, FNQ-P, PHQ-9, GAD-7, Likert Scale, CICI, Goal Ladder 1 to 5, SMART goals, and GAS.	Health, behaviour, parental self-efficacy, quality of life, family needs, depression, and anxiety in parents were assessed.

Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale "Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen" (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Objective (PART-O), Participation Assessment with Recombined Tools-Satisfaction (PART-S), Enfranchisement Scale, Customer Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Christie et al., 2021	78 people from community services and 39 family members.	Implement an approach encompassing the data collection service to evaluate client experience in ABI rehabilitation.	Evaluate the experience of clients and their families in rehabilitation programs addressing residential, community, vocational, and transitional support needs.	CSQ-8 and PES-BIR.	A total of 118 questionnaires were completed with high satisfaction. Staff technical competence and teamwork were highlighted, while communication and continuity were identified as areas for improvement.
Owolabi et al., 2023	6 people with TBI and 7 healthcare professionals.	Describe barriers to accessing care for people with TBI.	Evaluate barriers to accessing healthcare in a South African municipality.	Questionnaire designed by the authors, semi-structured individual interviews, and focus group discussions.	Lack of safety, family support, and clear and effective communication were identified as barriers.

Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale "Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen" (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADs), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Objective (PART-O), Participation Assessment with Recombined Tools-Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Zarshenas et al., 2021	47-year-old woman with severe stroke	Investigate the feasibility of an assistive technology for meal preparation called COOK within an assisted community residence.	Use of COOK technology for meal preparation.	COPM, IADL Profile, BDI-II, BAI, OBS, FSS, SAD, QOLBRI, CIQ.	The intervention with COOK improved independence, safety, and supported the participant's memory during meal preparation.
Bottari et al., 2020	91 people with severe TBI aged 16 to 40 years.	Investigate the structural validity of the ADL Profile.	Direct observation of independence in daily tasks in real-life environments.	ADL Profile.	The ADL Profile measures independence in 17 items within personal, home, and community contexts, showing excellent internal consistency.
Layton & Cerf, 2023	Person with ABI living at home with assistive technologies.	Report on the use and tools of MyATOF in a case study and assistive technology-enabled home.	Use of MyATOF to articulate supports, outcomes, costs, and service delivery experiences.	Interview conducted by occupational therapy students.	MyATOF allowed the user to provide data using five tools; one related to costs required language adaptation.

Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale "Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen" (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Bogner et al., 2019	People older than 14 years with severe, moderate, or mild TBI.	Evaluate the effect of providing a higher percentage of therapy as contextualized treatment on acute traumatic brain injury (TBI) rehabilitation outcomes.	ContextTx: real-life activity that the individual would perform at home or in the community. DeContextTx: clinical activity not directly associated with a real-life activity.	PART-O-17, FIM, Satisfaction With Life Scale, and PHQ-9.	Increased ContextTx improved PART-O and FIM scores, with advances in productivity, cognition, and motor skills. ContextTx favours community participation in patients with TBI.
Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale "Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen" (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Objective (PART-O), Participation Assessment with Recombined Tools-Satisfaction (PART-S), Enfranchisement Scale, Customer Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).					

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Juengst et al., 2023	408 people older than 16 years with moderate or severe TBI.	Develop multidimensional profiles of societal participation for people with TBI.	Analyse patterns of community participation in people with ABI.	PART-O, PART-S, Enfranchisement Scale.	Four participation profiles were identified: 1) Low frequency and moderate dissatisfaction (27.2%), 2) Limited participation and moderate dissatisfaction (12.3%), 3) High frequency and satisfaction (48.5%), and 4) Moderate participation, especially social, with varied satisfaction (12%).

Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale “Hilfbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen” (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Objective (PART-O), Participation Assessment with Recombined Tools-Satisfaction (PART-S), Enfranchisement Scale, Customer Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Kettlewell et al., 2022	10 people with ABI aged 18 to 65 years, at least 3 months after ABI.	Evaluate the potential use and effectiveness of Brain-in-Hand for adults with ABI.	The implementation of Brain-in-Hand in ABI focuses on independence through the analysis of contextual and personal factors.	Semi-structured interview.	Over 6 months, Goal Attainment Scale scores increased and participation decreased.
Kurihara et al., 2024	20 Japanese occupational therapists with more than 10 years of experience in the area of work inclusion.	Clarify specific occupational therapy content in employment support for clients with ABI.	Role of occupational therapists in the work inclusion of people with ABI.	Structured interviews, neuropsychological tests, and training in daily activities.	Six concepts of work support were identified: vocational life, interpersonal skills, work, illness and disability, compensatory measures, and goal setting.

Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale "Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen" (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Objective (PART-O), Participation Assessment with Recombined Tools-Satisfaction (PART-S), Enfranchisement Scale, Customer Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
D'Cruz et al., 2020	Narrators: Adults (19–65 years) with ABI. Facilitators: People with experience in storytelling workshops.	Explore storytelling and the intersection of experiences.	Facilitated storytelling program.	Interview.	Two relationships in storytelling were identified: reciprocal collaboration between narrators and organization to achieve advocacy impact, and the relationship with the relationship with facilitators.
Hocking et al., 2023	Adults with TBI in rehabilitation and clinicians providing this care.	Evaluate the feasibility, acceptability, and usability of RehabChat.	RehabChat helps patients with TBI set goals and carry out activities between care sessions.	Pre-post Likert Scale, MOT-Q, BMQ-S, BMQ-R, RTES, SUS, and semi-structured interview.	RehabChat demonstrated good usability, with a SUS score of 76.25, exceeding the threshold of 68.

Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale "Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen" (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Satisfaction Questionnaire (PART-S), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Kessler et al., 2021	6 adults at least 3 months after stroke who were not currently receiving occupational therapy services.	Evaluate the feasibility and acceptability of Tele-OPC in adults with stroke.	Tele-OPC promotes participation in meaningful activities.	COPM, CSS, HAq-II.	Occupational performance coaching through telerehabilitation was feasible, with high completion and satisfaction rates.
Simpson et al., 2022	73 participants with upper limb weakness.	Examine the trajectory of scores on the REACH Scale during the first year after stroke.	The REACH Scale is a self-assessment that captures the use of the affected arm in real-life situations.	REACH Scale, FMA-UL, SULCS, GRCS, Accelerometers.	Eighty-seven percent of participants improved by at least one level on the REACH Scale within one year.
Lipson-Smith, 2019	30 experts from different disciplines.	Describe priorities in rehabilitation facilities for hospitalized patients.	Priorities in the design of facilities for hospitalized patients.	Previous reading on stroke rehabilitation background.	Prioritize efficient and safe centres that provide emotional well-being and promote physical, cognitive, and social outcomes.

Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale "Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen" (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Objective (PART-O), Participation Assessment with Recombined Tools-Satisfaction (PART-S), Enfranchisement Scale, Customer Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).

Table 1. Continued...

Author and year	Population	Study objective	Community intervention	Assessment tools	Main findings
Stockley et al., 2024	Stroke survivors, caregivers, and experts.	Identify measurable criteria for Clinical Centres of Excellence in stroke rehabilitation.	The importance of involving patients, caregivers, and key stakeholders in a person-centred approach is mentioned.	Not applicable.	Criteria for designing facilities include optimal outcomes, research, collaboration with patients, knowledge exchange, leadership, education, and advocacy.
Note: Geriatric Depression Scale (GDS), Dysexecutive Questionnaire (DEX), Barthel Index (BI), German Scale "Hilfsbedarf von Menschen mit Behinderung für den Lebensbereich Wohnen" (HMBW), Rehabilitation Therapy Engagement Scale (RTES), Trail Making Test Part A/Part B (TMT), Rivermead Behavioral Memory Test (RBMT), Frontal Assessment Battery (FAB), Behavioural Assessment of the Dysexecutive Syndrome (BADS), Brain Injury Rehabilitation Motivation Questionnaire-Relative (BMQ-R), Brain Injury Rehabilitation Motivation Questionnaire-Self (BMQ-S), Traumatic Brain Injury Rehabilitation Motivation Questionnaire (MOT-Q), Health and Behavior Inventory (HBI), Tool to Measure Parenting Self-Efficacy (TOPSE), Behavior Rating Inventory of Executive Function 2 (BRIEF-2), Pediatric Quality of Life Inventory (PedsQL), Family Needs Questionnaire (FNQ-P), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder Assessment Scale (GAD-7), Likert Scale, CICI Assessment, Goal Ladder 1–5, SMART Goals and Goal Attainment Scaling (GAS), Participation Assessment with Recombined Tools-Objective (PART-O), Participation Assessment with Recombined Tools-Satisfaction (PART-S), Enfranchisement Scale, Customer Satisfaction Questionnaire (CSQ-8), Patient Experience Survey in Brain Injury Rehabilitation (PES-BIR), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), Overt Behaviour Scale (OBS), Fatigue Severity Scale (FSS), Self-Awareness Deficits Interview (SAD), Quality of Life after Brain Injury (QOLIBRI), Community Integration Questionnaire (CIQ), Functional Independence Measure (FIM).					

Regarding the population, 19 studies focused on adults with stroke or traumatic brain injury (TBI). Seven included family members/partners, four included healthcare professionals, and one included children with acquired brain injury.

From the included studies, we identified community-based interventions such as: (a) functional training in natural environments (e.g., planning and executing journeys on public transport, shopping and managing money in local businesses, managing time and routines at home), which was the most frequent ($n = 9$); (b) followed by environmental adaptation and assistive technologies (home modifications, prescription/training in the use of assistive technologies in context) ($n = 3$); and (c) telerehabilitation with tasks anchored in community activities ($n = 3$). The other interventions identified are: (d) metacognitive and compensatory strategies in situ (e.g., CO-OP, Goal Management Training, errorless learning applied to community tasks); (e) promotion of social participation and networks (peer groups, community activities, leisure and citizenship); (f) return to supported roles (supported employment/education, on-site practice); (g) education and training for caregivers/families at home and in the community; and (h) intersectoral coordination/case management with local services.

A variety of assessment tools were found aiming to measure functional outcomes, participation, and the perceptions of users and their support networks. In this regard, recent literature from the region shows that hospitalization and family reorganization processes can affect mental health, routines, and caregiving roles, reinforcing the need for occupational therapy interventions sensitive to the family context (Faúndez et al., 2024). In general, the studies reported improvements in daily functioning, greater social engagement, and positive evaluations of the effectiveness of community interventions.

Facilitators and barriers

Several facilitators and barriers were identified in community interventions (see Figure 2). The main findings are detailed below.

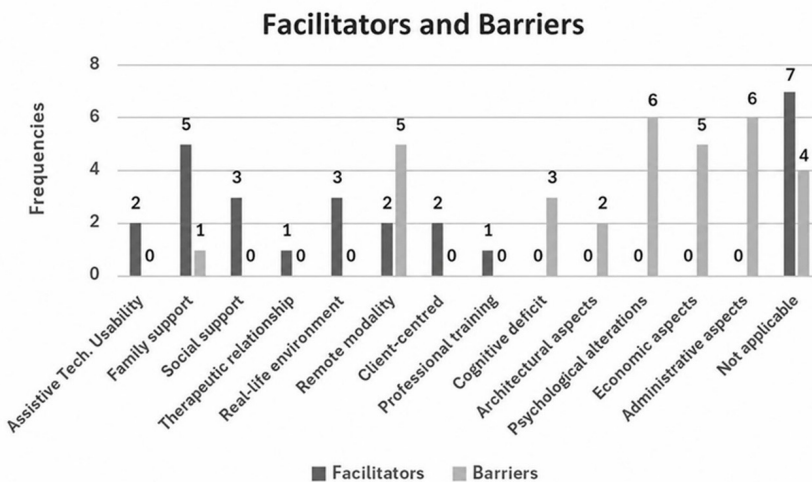


Figure 2. Facilitators and Barriers Reported in the Interventions.

Facilitators

Family and partner support was the most frequent facilitator, identified in five studies as key to the continuity of rehabilitation (Beit Yosef et al., 2019; Christie et al., 2021; Bogner et al., 2019). This support was associated with lower anxiety levels (Shimizu et al., 2022) and greater adherence to therapies (Rohrer-Baumgartner et al., 2022). Educating family members about the condition and encouraging participation outside the clinical setting were also documented (Shimizu et al., 2022).

Social support was also relevant, especially in collaborative group activities involving other individuals with ABI (Vibholm et al., 2023) and in the increased time spent socializing with friends after the interventions (Bogner et al., 2019).

Three studies highlighted the use of real-life environments to promote the generalization and sustainability of learning (Schrader et al., 2024; Vibholm et al., 2023; Kessler et al., 2021). Assistive technologies were also valued for their ease of use and usefulness in improving occupational performance (Hocking et al., 2023; Zarshenas et al., 2021).

Regarding telerehabilitation, two studies reported that it facilitated access to services by overcoming geographical and mobility barriers (Beit Yosef et al., 2019; Kessler et al., 2021).

Other facilitators included the client-centred approach (Prescott et al., 2019; Shimizu et al., 2022), professional training (Kettlewell et al., 2022), and the quality of the therapeutic relationship (Beit Yosef et al., 2019).

Barriers

Psychological barriers were the most frequent, reported in six studies. These were related to depression, anxiety, and low mood, hindering participation in interventions (Christie et al., 2021; Shimizu et al., 2022; Zarshenas et al., 2021; D'Cruz et al., 2020; Kessler et al., 2021; Simpson et al., 2022).

Five studies mentioned administrative barriers, including difficulties in accessing outpatient services and a lack of coordination between levels of the health system (Owolabi et al., 2023; Prescott et al., 2019; Schrader et al., 2024; Tsow et al., 2024; Shimizu et al., 2022).

Economic barriers were also recurrent, such as limitations in affording treatments or accessing specialized services (Schrader et al., 2024; Tsow et al., 2024; Owolabi et al., 2023; Zarshenas et al., 2021; Stockley et al., 2024).

Three studies identified cognitive barriers, especially difficulties with memory and attention, which affected participation and learning (Kurihara et al., 2024; Hocking et al., 2023; Simpson et al., 2022). Architectural barriers were linked to physical restrictions in the environment that limited rehabilitation activities (Christie et al., 2021; Stockley et al., 2024).

Although telerehabilitation was identified as a facilitator, other studies reported technical and connectivity obstacles that limited its effectiveness (Beit Yosef et al., 2019; Rohrer-Baumgartner et al., 2022; Zarshenas et al., 2021; Hocking et al., 2023; Kessler et al., 2021).

Seven studies did not report explicit facilitators, focusing instead on the assessment of participation levels (Beit Yosef et al., 2022; Layton & Cerf, 2023; Juengst et al., 2023; Simpson et al., 2022) or on the identification of barriers to implementation (Owolabi et al., 2023; Tsow et al., 2024; Stockley et al., 2024). Four studies did not

describe specific barriers, as their objective was not focused on contextual factors (Lipson-Smith et al., 2019; Juengst et al., 2023; Layton & Cerf, 2023; Beit Yosef et al., 2022).

Assessment tools

We classified the assessment tools into 16 categories (Figure 3). We observed a greater prevalence of instruments assessing cognitive functions; however, assessment alone does not constitute a community intervention nor determine its nature. In this review, the instruments are considered inputs that guide the planning of interventions focused on performance and participation in real-life contexts.

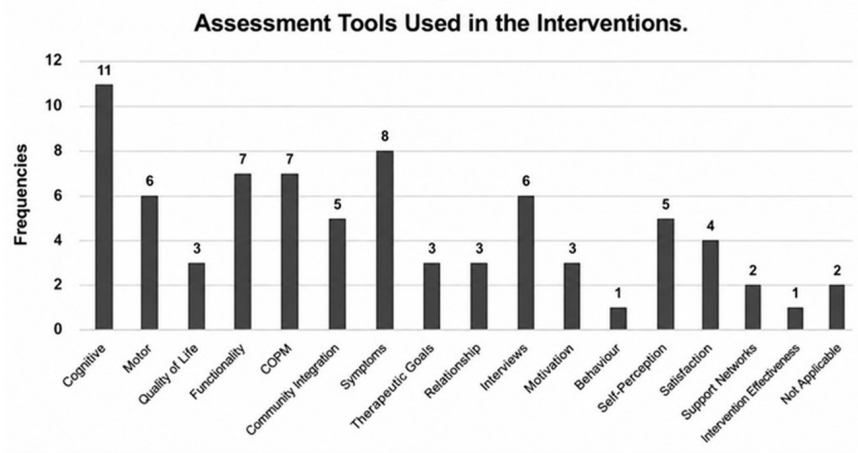


Figure 3. Assessment Tools Used in the Interventions.

Eleven cognitive tools were identified: MMSE (Beit Yosef et al., 2019; Shimizu et al., 2022), MoCA, MPAI-4-P, DEX (Beit Yosef et al., 2019), HMBW (Schrader et al., 2024), TMT, RBMT, FAB, BADS (Shimizu et al., 2022), BRIEF-2 (Rohrer-Baumgartner et al., 2022), and SAD (Zarshenas et al., 2021). These tools assessed executive functions, memory, attention, and functional awareness.

Secondly, eight tools measured emotional and psychological symptoms: MPAI-4-P (Beit Yosef et al., 2019), PHQ-9 (Bogner et al., 2019; Rohrer-Baumgartner et al., 2022; Beit Yosef et al., 2022), GDS (Beit Yosef et al., 2022), HBI, PedsQL, GAD-7 (Rohrer-Baumgartner et al., 2022), BDI-II, and BAI (Zarshenas et al., 2021), focusing on depressive and anxiety symptoms and health-related quality of life.

Seven studies incorporated functional tools, such as the ADL Profile (Bottari et al., 2020), to assess independence in daily activities. The COPM was used in seven studies (Beit Yosef et al., 2019; Prescott et al., 2019; Beit Yosef et al., 2022; Schrader et al., 2024; Vibholm et al., 2023; Zarshenas et al., 2021; Kessler et al., 2021), highlighting its person-centered approach and collaborative goal setting.

To assess community participation, we identified five tools: MPAI-4-P, PedsQL, GAS (Rohrer-Baumgartner et al., 2022), PART-O (Bogner et al., 2019; Juengst et al., 2023), and the Enfranchisement Scale (Juengst et al., 2023), which explore the frequency, quality, and significance of social and occupational participation. In the rehabilitation

process, these measures serve complementary functions: (i) they establish a baseline of participation restrictions (e.g., PART-O, MPAI-4-P); (ii) they allow these restrictions to be translated into functional and role goals (e.g., GAS); and (iii) they enable the monitoring of clinically significant changes related to reintegration into roles, collective activities, and the exercise of citizenship (e.g., Enfranchisement Scale, PedsQL). This aligns with our research objective, which is to characterize not only which instruments are used, but also how they inform clinical decisions aimed at participation in real-life contexts.

Finally, two studies did not report the use of standardized tools.

Models and frameworks

Of the 23 articles analysed, 12 different models and frameworks were identified (see Figure 4). The International Classification of Functioning, Disability and Health (ICF) was the most frequently used, reported in seven studies (Beit Yosef et al., 2019; Beit Yosef et al., 2022; Schrader et al., 2024; Vibholm et al., 2023; Layton & Cerf, 2023; Juengst et al., 2023; Kettlewell et al., 2022), indicating its broad acceptance as a basis for community interventions.

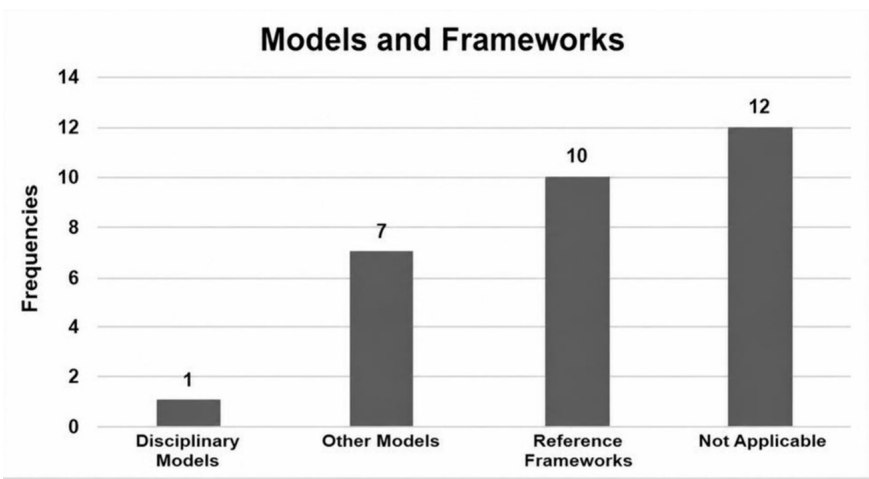


Figure 4. Models and Frameworks Used in the Interventions.

Other specific frameworks mentioned include the UK Medical Research Council Framework for the Development of Complex Interventions (Rohrer-Baumgartner et al., 2022), the Didactic Framework for Nature-Based Rehabilitation (NBR) (Vibholm et al., 2023), and a generic approach such as the “Reference Framework” (Kettlewell et al., 2022).

Seven non-disciplinary models were identified, including the Preventive Assistance Model, the Preventive, Communicative, and Visual Assistance Model (Zarshenas et al., 2021), the Human Development–Disability Creation Process 2 (RIPPH) Model, Luria’s Model of Brain Functioning, the Environmental Continuum Model (Bottari et al., 2020), the Vocational Readiness Model, and the Hierarchical Structure and Support Model for the Overall Picture of Individual Characteristics (Kurihara et al., 2024).

Only one study mentioned a disciplinary Occupational Therapy model: the Canadian Model of Occupational Performance.

Finally, 12 articles did not mention any model or framework in the design or analysis of their interventions (Prescott et al., 2019; Tsow et al., 2024; Shimizu et al., 2022; Christie et al., 2021; Owolabi et al., 2023; Bogner et al., 2019; D'Cruz et al., 2020; Hocking et al., 2023; Kessler et al., 2021; Simpson et al., 2022; Lipson-Smith et al., 2019; Stockley et al., 2024).

Discussion

This review reveals the diversity of community-based occupational therapy interventions for ABI. These range from holistic approaches to physical strategies and various outcome measures related to function, participation, and quality of life (Hauger et al., 2022). However, the reviewed studies often do not explicitly describe the specific type of community-based intervention, and the standardized assessments used may also be applicable to other contexts. Although most studies report benefits, these tend to be modest and heterogeneous, with slight improvements in social participation, occupational performance, and well-being (García, 2002; Tejada & Burgos Flores, 2020). Other studies report no significant effects due to high variability and methodological limitations across studies (Hauger et al., 2022; Arechabala-Mantuliz et al., 2022). While the potential of interventions in the chronic phase of ABI is recognized, the lack of a consistent description of the type of community intervention in many studies, together with the fact that the standardized models and instruments used are transferable to multiple settings (not exclusively community-based), limits the possibility of proposing a single intervention type as a standard. Therefore, rather than recommending a specific protocol, our results support operational principles (goals oriented towards participation, implementation in natural environments, co-design, and intersectoral coordination) and underscore the need for more detailed reporting of components and dosage (e.g., TIDieR/MRC) to improve comparability across studies.

A critical aspect is the limited use of theoretical frameworks to support interventions. Although rehabilitation goals are consistent with occupational therapy principles, few studies refer to conceptual models. This reflects a lack of explicit conceptual articulation between theory and practice, previously identified by Muñoz Gómez et al. (2015) regarding the lack of clarity surrounding the role of the occupational therapist in community contexts.

The implementation of community interventions is influenced by multiple facilitators and barriers. These barriers are primarily conceptualized as environmental factors that limit participation; however, several studies have reported psychological difficulties, including depression and anxiety, as barriers among people with acquired brain injury (Christie et al., 2021; Shimizu et al., 2022; Zarshenas et al., 2021; D'Cruz et al., 2020; Kessler et al., 2021; Simpson et al., 2022). These internal barriers affect motivation and performance in meaningful activities, highlighting the need for community-based interventions that consider both environmental adjustments and emotional and psychological support.

Among the barriers hindering the intervention process is the lack of stable funding, which threatens the sustainability of these programs and compromises their long-term continuity (Kotzur et al., 2024). At a structural level, the fragmentation of health services and the lack of coordination hinder the transition from hospital to community settings (Arechabala-Mantuliz et al., 2022). The cognitive and behavioural sequelae of traumatic brain injury (TBI) also represent significant obstacles to participation,

requiring specialized interventions and flexibility from the therapeutic team (Texas Health and Human Services, 2016; Jacobs-Nzuzi Khuabi et al., 2021). Finally, low institutional prioritization and the absence of public policies limit the expansion of these interventions (Owolabi et al., 2023; Prescott et al., 2019; Schrader et al., 2024; Tsow et al., 2024; Shimizu et al., 2022).

On the other hand, the inclusion of family and social support as facilitators within intervention plans is essential, as these are considered fundamental for adherence and the generalization of achievements (Clasby et al., 2018).

The evaluation of outcomes also presents challenges due to the heterogeneity of the instruments used, which range from functional independence scales to measures of social participation and subjective quality of life. This diversity hinders the comparison and synthesis of evidence (Hauger et al., 2022).

Our findings suggest that measuring participation is not an end in itself, but rather a framework for decision-making throughout the rehabilitation continuum: identifying barriers relevant to daily life, formulating client-centred goals, and monitoring meaningful activity and participation outcomes (consistent with the ICF). Consequently, programs that systematically integrate PART-O/MPAI-4-P for baseline assessment, GAS for goal setting, and Enfranchisement/PedsQL for outcome evaluation offer clear traceability between assessment, intervention, and community engagement.

Client-centred tools such as the COPM have proven sensitive to changes from the user's perspective (Beit Yosef et al., 2019; Prescott et al., 2019; Vibholm et al., 2023). However, the limited standardization of measures restricts the possibility of conducting meta-analyses and establishing evidence-based clinical recommendations. The literature points to the need for core sets of measures to facilitate comparisons across studies (Hauger et al., 2022; Eliassen et al., 2023).

In practice, this review underscores the need to design more comprehensive and client-centred interventions. Given the variability of ABI profiles, strategies must be tailored to users' goals, occupational roles, and life contexts. Occupational therapists can play a key role in coordinating care transitions and facilitating access to resources and support. Clinical practice should include interventions focused on meaningful participation in return to work, leisure activities, and civic engagement, going beyond functional training (Kurihara et al., 2024; Jacobs-Nzuzi Khuabi et al., 2021).

From a public policy perspective, it is vital to advocate for sustainable funding models that integrate community-based services into healthcare systems, especially in middle-income contexts such as Latin America. Investment in community-based rehabilitation can generate long-term clinical, social, and economic benefits by reducing rehospitalizations and functional dependence (Kim & Colantonio, 2010).

Strengths and limitations of the study

A key strength of this review is its comprehensive and up-to-date perspective. It integrated 23 studies from diverse designs and contexts, allowing the mapping of a broad spectrum of community interventions for people with ABI. This cross-sectional approach revealed patterns such as methodological heterogeneity, limited use of theoretical frameworks, and diversity in assessment tools. Furthermore, by focusing on interventions led by occupational therapists, the review highlights the role of the profession within a predominantly interdisciplinary field.

However, there are several important limitations. First, the methodological quality of the studies was not assessed, which may affect the validity of the findings, considering that several studies presented a high risk of bias, small sample sizes, or lacked control groups. Second, the wide variability in intervention characteristics, contexts, and populations introduces potential confounding factors, making it difficult to establish clear causal relationships. In addition, some reported improvements may reflect the natural course of recovery rather than the direct effect of the interventions.

A major limitation of the corpus is the under-specification of the type of community intervention (components, dosage, agent, and delivery setting), together with the use of instruments and frameworks transferable to other contexts. We recommend adherence to intervention reporting guidelines (e.g., TIDieR/MRC) in future research to strengthen comparability.

The predominance of English-language studies limits transferability to the Latin American context. To contextualize the findings, the discussion was framed using contributions from Latin American experts in community occupational therapy and community-based rehabilitation (CBR), who emphasize participation, territoriality, co-design, and intersectoral collaboration. This suggests that implementation requires contextual adaptations and that future syntheses should broaden the regional scope and report participation and citizenship outcomes relevant to Latin American contexts.

Relevance and implications for future research

The findings of this review provide guidance for future research in community occupational therapy following stroke. More methodologically rigorous studies are needed, such as controlled trials or longitudinal cohort studies, that minimize bias, include larger samples, and allow the evaluation of sustainable effects.

It is key to incorporate explicit theoretical frameworks to strengthen coherence and facilitate replication, as well as to compare interventions grounded in occupational models with those lacking a theoretical foundation.

It is also necessary to standardize outcomes using indicators focused on participation, quality of life, and autonomy, which would facilitate comparisons and future systematic reviews. Furthermore, contextualized evidence should be generated, especially in Latin America, and greater emphasis should be placed on qualitative or mixed-methods studies that explore subjective experiences in depth.

Finally, participatory approaches integrating people with acquired brain injury and their support networks into the design and implementation of research should be promoted in order to improve the relevance and effectiveness of interventions.

Conclusion

This review maps the current state of knowledge on community-based occupational therapy interventions for individuals with traumatic brain injury (TBI). A variety of therapeutic strategies implemented in community settings were identified, aiming to promote participation, functional autonomy, and social reintegration. These interventions reflect a growing interest in the continuity of rehabilitation following hospital discharge.

However, the review also revealed several challenges. The inconsistent application of theoretical models, the heterogeneity of assessment tools, and the scarcity of studies conducted in Latin American contexts limit the comparability and generalizability of the

findings. Furthermore, the limited explicit reference to specific conceptual frameworks weakens the visibility and replicability of the occupational approach.

The analysis of facilitators and barriers highlighted the central role of the social and family environment in sustaining interventions. In contrast, barriers such as the fragmentation of healthcare systems and users' cognitive limitations hinder access to and continuity within community programs.

The results also revealed a wide dispersion in the use of assessment instruments, with a predominance of functional measures and a lower representation of measures focused on participation and quality of life.

This review provides a descriptive basis for understanding the scope and characteristics of community-based interventions for people with ABI led by occupational therapists. By highlighting existing strategies, as well as their gaps and opportunities for improvement, it contributes to the development of more coherent and contextualized practices grounded in the discipline's own models. This review also provides a foundation for advancing practices and research that are more coherent and better adapted to diverse realities.

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Data Availability

The data supporting the results of this study are available from the corresponding author upon reasonable request.

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