

Chapter 1

Introduction

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This introductory chapter provides a justification for why occupational therapists should be interested in working with older people and explains the structure of the book. The demands of occupational therapy practice with older people are considered, and a brief explanation is given for how the World Health Organization's [WHO] International Classification of Functioning, Disability and Health [ICF] (WHO 2001) can be used in occupational therapy practice. We also present our own reflections and that of an occupational therapy expert, Jennifer Wenborn, interspersed in boxes within the chapter, on why we work with older adults. We are not proud of our initial attitudes, but we hope that we do convey our enthusiasm for occupational therapy with older people.

Ageing is a process which occupational therapists cannot ignore, for globally there will be 1.2 billion people over the age of 60 by the year 2025 and by 2050 these figures will have doubled, with 80% of older people living in developing countries (WHO 2002). It is also worth considering why there is a global increase in the ageing population. There are three main factors – a decline in mortality, an increase in longevity and also a decline in fertility (Beard et al. 2012). It is also important to realise that the numbers of the oldest-old (or those people aged over 85 years) has doubled in the last 25 years and is predicted to more than double in the next 20 years (Wise 2010). Instead of regarding the growth in the ageing population and also the increasing life expectancy as success stories, these are often viewed with doom and gloom. This doom and gloom is often associated with the belief that old age equals indignity and dependency, as well as economic concerns of the need for more money to pay for additional health and social care. Yet healthy older people can be considered a precious resource, making important contributions to their families, communities and the economy at large, by either paid or voluntary employment (WHO 2002).

The type of service provided by occupational therapists for older people varies internationally, and it has to be acknowledged that the authors of this book speak from their own perspective. The services that occupational therapists provide to older people are not only determined by the needs of a growing older population, but also by government policy – either at a local or national level. As occupational therapists that work in England, we have seen many changes in the way that services are delivered to older people, in both the public and private sectors. Health and social care services for older people are not only provided by public services in the acute or rehabilitation in-patient settings

for older people with physical or mental health care needs, but also by community health or social care services. Occupational therapists also provide services to older people in residential and nursing home care. Increasingly, older people are receiving services provided by the commercial and also the voluntary sectors. These are exciting and challenging times for occupational therapists working with older people.

Using this book

As in the first edition of this book, we discuss the biological, psychological and social elements of health and wellbeing for older people rather than having a bio-medical focus on health conditions. There are several reasons for this; many older people are referred to occupational therapy services with multiple difficulties in occupational performance and not all of these are caused by a health condition – some may be the result of the normal ageing process, or by environmental and contextual factors. There is also an increasing emphasis within health and social care on health promotion, and occupational therapists are becoming increasingly aware of their role with the ‘well’ older age group.

Once again, we have used the World Health Organization’s [WHO] bio-psycho-social model of health, the International Classification of Functioning, Disability and Health [ICF] to provide a framework for the book, and the domains of the ICF have provided definitions for the content of each chapter (WHO 2001).

The motivation for writing a second edition of our book is our desire and wish for occupational therapists to continue to move towards an ‘active ageing’ approach (WHO 2002). Active ageing (Box 1.1) signifies an important paradigm shift: away from a ‘needs based’ approach to a ‘right based’ approach which support the rights and continued participation of older people both in the community and the political process (WHO 2002).

This chapter provides an introduction to the core issues that influence our practice as occupational therapists, including some personal reasons. Chapter 2 considers common concepts and theories of ageing, contextualising them within an occupational science perspective. Chapters 3, 4 and 9 consider other contextual factors such as social, cultural, environmental and economic factors. Chapter 5 does consider some of the more common health conditions that affect people in old age, but also directs the reader towards the evidence base for occupational therapy intervention as well as highlighting some

Box 1.1 What is active ageing?

It is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. (WHO 2002: 12)

‘Active’ refers to continued participation in society and to realise their potential for physical, social, and mental wellbeing whilst ensuring adequate protection, security and care when assistance is needed. This includes continued participation in social, economic, cultural and spiritual, and civic affairs.

commonly- used outcome measures. Chapters 6 and 7 consider the ageing body in terms of body functions and structures. Chapter 8 presents how activity and participation changes in older age.

It is hoped that this book encourages the reader to view the strengths of older people during the ageing process, to consider old age as a time of celebration and to promote occupational justice for their older clients whilst still meeting all the demands of present-day practice.

The demands of occupational therapy practice

Although policies, demands and service provision vary from country to country, there is an increasing need for occupational therapists to clearly articulate the importance of their role and the evidence base of occupational therapy interventions to other professionals who might hold the power to commission services on behalf of older people, or to older people themselves and their families. Within the UK, public health and social care service provision is being increasingly determined by guidance provided by the National Institute for Health and Clinical Excellence [NICE] and the Social Care Institute for Excellence [SCIE]. What is encouraging is the inclusion of occupational therapy research within the UK NICE guidelines (NICE 2008). This guidance refers to occupational therapy and physical activity to promote the mental wellbeing of older people. These guidelines are extremely important for supporting and developing interventions within UK clinical practice.

Interestingly, where occupational therapy is well established, there is often little or no evidence for the service provided. Indeed, a systematic review of occupational therapy practice for older adults with lower limb amputations found that research evidence with this population is limited and scarce, and yet occupational therapists are key members of the multidisciplinary team for these older adults (Spiliotopoulou and Atwal 2011). However, complacency is dangerous, as one reason for occupational therapy posts being axed or services being contracted is a lack of evidence to support interventions or to provide evidence of its cost-effectiveness.

Box 1.2 Why work with older adults? – Jennifer Wenborn.

"I left occupational therapy college in 1979 very undecided about which speciality I wanted to work in – except I was clear I was NOT going to work in 'geriatrics' (as older people were then known). This was due to a very unsatisfactory first clinical placement at a (well-known) geriatric hospital, following which I seriously considered leaving the course as I didn't think OT was the right job for me. I started a rotational post in a central London hospital but almost immediately the unit was shut to save money and I was transferred to 'slow stream geriatric rehabilitation'. Not the most auspicious start to my brand-new career! However, I soon found that I enjoyed building relationships over time with the patients and working as part of a multidisciplinary team. Senior and Head OT posts followed, and I enjoyed and developed a broad range of experience, predominantly working with older people. After 15 years in the NHS I opted for redundancy when yet another reorganisation came along.

Eighteen months at the College of Occupational Therapists establishing their consultancy service followed before becoming self-employed. Over the next ten years I provided a wide range of services: individual assessments and interventions; setting up new services – occupational therapy within a private hospital; fast-track technician to facilitate NHS discharge; long-term care insurance assessment service for a reinsurance company; Commission for Health Improvement (CHI) reviews; Department of Health and Health Advisory Service project work; NHS management and supervision; education and training. I increasingly worked in care homes – with older people and adults with severe disability – learning more about people with dementia and acquiring specialist skills such as seating provision and multisensory stimulation.

I was then asked to provide some input to a new NHS Nursing Home until appointed to the 50:50 clinical/academic post. Having caught the research bug when I completed my Masters in Occupational Therapy ten years earlier I couldn't resist applying. I went on to complete my PhD, based on a randomised controlled trial of occupational therapy intervention for people with dementia in care homes. I now work full-time for University College London, using my OT skills to evaluate non-pharmacological interventions for people with dementia and their family caregivers. My next goal is to do more occupational therapy research to add to our profession's evidence base.

I definitely ended up in the right speciality! I love meeting older people, learning from their life experience and resilience. Those we meet in our work often have a complex mix of abilities and needs and I enjoy 'unpicking' these to achieve the best 'fit' solution – not least because it utilises my full range of occupational therapy skills creatively. I enjoy working within a team – the core members being the older person and their family. The range and diversity of what I have done has made it the best job ever!"

Jennifer Wenborn

Providing an evidence base

It is encouraging that there has increasingly been some high-quality research that does provide an evidence base for occupational therapy practice. Interestingly, studies by Clark et al. (1997, 2001, 2011), Steultjens et al. (2004), Graff et al. (2006), and Logan et al. (2010) have all involved older people (and are discussed in more detail in Chapter 2). Indeed, the amount of research involving older people has increased dramatically over the last 10 to 15 years, possibly because of global emphasis of user involvement and client-centred practice as part of health promotion policy (WHO 1986).

It would be naïve to say that research with older people is easy, and research by McMurdo et al. (2005, 2011) suggests that there is still a widespread exclusion of older people from research. There are many reasons given as to why older people are still excluded from research, such as:

- Obtaining consent is too time consuming (Bayer and Tadd 2000)
- Inclusion in research often deterred by others (Zermansky et al. 2005)
- Older people are perceived as too vulnerable or frail by researchers (Department of Health 2001, McMurdo et al. 2005)
- Older people are commonly excluded if they have cognitive impairment or dementia (Wilkinson 2002)
- Older people have multiple health conditions and medications, which increase likelihood of attrition, mortality rates and confounding variables within a study (McMurdo et al. 2005, Zermansky et al. 2005)

- They may require longer explanations about the study or more time to decide in consultation with family (Harris and Dyson 2001, Davies et al. 2010)
- Screening of oldest-old could take longer because of fatigue, mobility problems, social care or transportation issues (McMurdo et al. 2005, Zermansky et al. 2005, Davies et al. 2010).

However, it is suggested that the danger of not recruiting older people to health and social care research (and especially clinical and intervention trials) is a loss of autonomy and poor scientific outcome. There is also a paradox, with those people with the greater need and usage of services and interventions being excluded by ill health and social isolation (McMurdo et al. 2005, 2011).

It is acknowledged that researching with older people as participants requires more time, planning and expertise (Owen 2001, McMurdo et al. 2011) and an understanding of, and flexibility within, the consent process within both quantitative and qualitative research studies. Harris and Dyson (2001) and Davies et al. (2010) identified that the initial approach to older people by using 'gatekeepers' such as familiar and trusted health professionals, or by family members, enhanced recruitment. Recruitment to a study can also be enhanced by the personal contact with the researcher to gain information about the study, either face-to-face or by telephone (Harris and Dyson 2001, Davies et al. 2010).

The choice of design can often influence the reliability of the data collected from older people. Atwal and Caldwell (2005) identified that older people are often reluctant to express criticism of services during face-to-face interviews, and yet could have difficulty reading and completing potentially less-intrusive postal questionnaires because of small font size or language barriers. More frail older people might also have difficulty in sustaining their participation in interviews or questionnaire-based surveys because of fatigue (Davies et al. 2010). Cross-sectional and matched pair designs are often thwarted by the heterogeneity of an older sample population, but longitudinal cohort studies commonly suffer from participant attrition (Matthews et al. 2004, McMurdo et al. 2005). Indeed, in a review of randomised control trials, McMurdo et al. (2011) identified an attrition rate of up to 37% of older participants within the studies reviewed, often due to declining cognitive functioning, admission to long-term care or mortality.

The use of one-to-one or focus group interviews in qualitative research is said to be especially appropriate when involving older participants. The use of a semi- (or unstructured) interview process following a conversational style is also advocated to facilitate an older participant to reconstruct past experiences in a relatively free and unprompted way (Gearing and Dant 1990, Montazeri et al. 1996). Researching with older people with dementia is also said to be enhanced by the use of qualitative methodologies, a flexible interview schedule (i.e. finding the right time), allowing the participant to return to the topic, being supportive and alert to non-verbal signals, and being willing to accept the person's narrative as truth (Bond and Corner 2001, Wilkinson 2002, Hubbard et al. 2003).

Although there is increasing advice and guidance on methodological factors that need to be considered when researching with older people, there remains a disappointing lack of evidence to support occupational therapy practice in many areas. For example, there is still a lack of research evidence for occupational therapy for people with long-term health conditions and to support interventions within acute care settings for older adults and yet, in

the UK, we have experienced a growth in the number of occupational therapists working within Accident and Emergency Departments. Whereas, in other more established areas of occupational therapy practice with older people (for example, dementia care, stroke, falls and Parkinson's disease), the interventions are highly rated by service users and clients, although the evidence base for intervention is ambiguous. It is important to explore both service user perspectives and the efficacy of interventions in the recently-expanding areas of occupational therapy with older adults such as those older people entering old age with disability, those with learning disability, older people using acute care and also intermediate care services.

As consumers of occupational therapy research, we need this evidence too. We also need the skills to critically appraise research articles so that we can determine the quality of the research, and to make a decision about how this research could impact upon our practice. In particular, therapists need to understand both qualitative and quantitative methods. Managers of services also have a part to play in building infrastructure to support evidence-based practice.

We write this chapter at a time of global economic recession, with public sector funding cuts and subsequent contraction and rationalisation of services. It is therefore even more important to consider the most appropriate and effective place (economically, socially, scientifically and professionally) for occupational therapists to work. As therapists, we need to start considering what our contribution is to our older clients. We have both practice experience and an interest in older people's acute care services, and the following are questions that we ask ourselves:

- What contribution do occupational therapists make to the quality of life and occupational justice of older adults in acute care settings?
- Is the role of occupational therapy in this setting simply to expedite hospital discharge or to prevent or delay a hospital admission?
- Are occupational therapy services in the acute care setting cost-effective?
- Could this service be offered by another member of the interprofessional and interagency team at a lower cost?
- Are occupational therapists working in the acute care setting carrying out their duties in an occupationally just and client-centred way?

These questions may be controversial, but we do believe that there is a role for occupational therapy for older adults in acute care settings. However, there appears to be a role dilemma for occupational therapists when working with older adults who are admitted into acute health care settings. Whilst discharge planning is an important process, perhaps it is more important for occupational therapists to focus on how they will contribute to this process rather than with the actual coordination of the discharge? Perhaps occupational therapists need to give a higher focus to preventive and rehabilitative interventions that promote optimal occupational performance and occupational justice? Likewise, community occupational therapists should also consider how rehabilitation can be integrated more into their practice, and ascertain further evidence to demonstrate how the provision of assistive technology and/or environmental adaptation support this process. This will be explored further in Chapter 9. It is therefore important for occupational therapy practitioners to continually evaluate their service provision in a methodologically robust way to add to the evidence base for occupational therapy and older people.

Box 1.3 Why work with older adults – Anita Atwal.

“At the age of 21 I had absolutely no intention of working with older adults. I had just got my first job and real taste of independence in a large teaching hospital. I was going to focus on having fun and trying to avoid ‘hard work’. On reflection, this was of course not the ideal attitude to have! Occupational therapy is more than work, it’s a commitment to certain principles.

However, after completing a mental health rotation I started my first physical rotation, which was on an acute older persons’ ward. I remember walking onto the ward and thinking that this was not for me! The ward was busy and full of commodes and people rushing by. However, I was then introduced to Rose. Rose was a dancing 70-year-old with flaming red hair who served the tea. The nurses, doctors and physiotherapists were dynamic and sociable. This was fun and, moreover, the two consultants were fantastic. On reflection, it was their attitude towards their management of the older person that changed the way I viewed older people. The older people were treated with respect and dignity. Their concerns were listened to and, more importantly, so were ours. We were given time to rehabilitate the person and given news about their progress in the day hospital. The consultants’ attitude and leadership meant that the team adopted their ethos. Moreover, whilst working with older people was challenging and thought provoking, it was not ‘hard work’, it was fun. It meant that I really was utilising my skills and each day there was a new challenge.

My advice is to gather as much experience as possible and work in lots of physical areas such as neurology and orthopaedics. This will enhance your occupational therapy skills and shape your future development as an occupational therapist.”

Anita Atwal

A new and exciting innovation has been the growth of knowledge transfer activity as there are often criticisms that academic researchers live and working in ivory towers with little application to everyday practice. Knowledge transfer (KT) describes the collaborative problem-solving and sharing of experiences, perspectives, and knowledge among caregivers, researchers and policy makers that arises through developing partnerships and exchanging information and ideas (ESCR 2010). This has the potential to prepare organisations and practitioners to receive the new knowledge resulting from research and implement it in practice. We have used this process successfully in partnership with members of the Specialist Section – Trauma and Orthopaedics of the College of Occupational Therapists, in formulating guidelines for occupational therapists working with people with lower limb amputations (Atwal et al. 2011). The success of the collaboration was the fusion of academic and expert skills in producing the guidelines. The expert clinicians received training in critical appraisal skills and on the process of producing guidelines. The academics faced the challenges of translating the research evidence into meaningful guidelines for practitioners (Atwal and Spiliotopoulou 2011).

ICF and Occupational Therapy

The International Classification of Functioning, Disability and Health (ICF; Box 1.4) is a member of the WHO’s group of classifications devised to provide a global language. It can be linked with the ICD-10 which considers diagnosis and disease, whereas the ICF considers health and wellbeing in terms of the way we function in the context of our lives.

Box 1.4 The International Classification of Functioning, Disability and Health [ICF] (WHO 2001).

The World Health Organization's International Classification of Functioning, Disability and Health [ICF] (WHO 2001) can be accessed and explained in more detail at:

<http://www.who.int/classifications/icf/en/>

The College of Occupational Therapists [COT] have also produced a guidance document on the ICF:

COT (2004) Guidance for the Use of the International Classification of Functioning, Disability and Health and the Ottawa Charter for Health Promotion in Occupational Therapy Services. London, COT.

The ICF has been adopted by occupational therapy associations and bodies in the UK, Canada, the US, Australia and Scandinavia, as well as the World Federation of Occupational Therapists (WFOT) as a model of health and disability because of its person–context interaction. It is not an occupational therapy-specific model but is a universally devised and accepted tool that involved many professions, organisations and user groups from around the world in its construction. It is not just a health and social care classification but for any agency including economic, education and transportation. Because of its universality, it is useful for interprofessional and interagency working as a ‘common ground’ or language for communication and intervention planning. Therefore, where occupational therapists work in interprofessional or interagency teams it allows for shared understanding of issues and concepts such as disability, impairment or participation (Tempest and McIntyre 2006).

The ICF is considered as a bio-psycho-social model of functioning, because of its body-person-context interaction, applying to all people throughout the world. Even though it is used as a means of classifying and collecting data on functioning and disability of populations on a global scale, it also provides a framework to consider the occupational performance of individuals and how this is impacted by extrinsic factors. It therefore fits in with the ideals of client-centred practice.

In the past, the consequences of health conditions for older people have been considered in terms of mortality rates; however, the ICF provides an opportunity to collect evidence of what older people can and cannot do. It enables us to consider the links between intrinsic factors from a health condition and also the contextual barriers or facilitators that impact upon their functioning. The ICF considers that the different elements within the classification can interact to a lesser or greater degree, rather than having a causal or hierarchical effect (see Figure 1.1). For example, an older person might not have any impairment or activity limitation but does have participation restriction because of the attitudes of their family or the society in which they live.

The main components of the ICF are body functions and structures, activity, participation and the personal and environmental contextual factors. This fits easily with occupational therapy thinking of the person-environment-occupation interaction described in models of Occupational Performance (Christiansen and Baum 1997). Each component can be described and defined in a positive or negative way (e.g. impairment of body structure or function). Each of the body functions and structures are considered by systems rather than organs because of

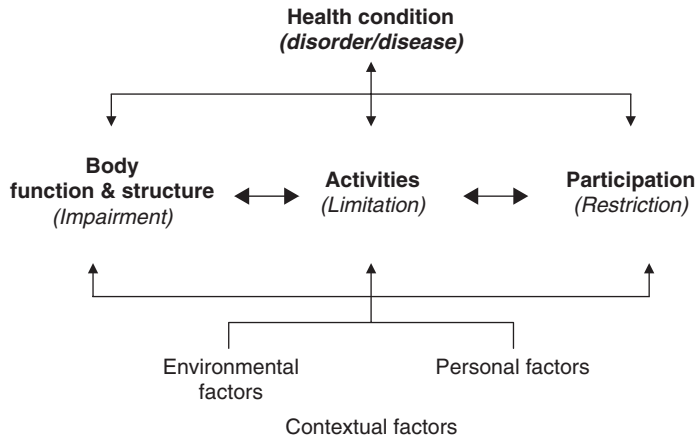


Figure 1.1 The World Health Organisation's International Classification of Functioning, Disability and Health [ICF] (Source: WHO 2001:18).

overlapping functions between many structures. Activity and participation can be considered in terms of activity limitation and participation restriction, with personal and environmental contextual factors described in terms of potential facilitators or barriers for the client's activity or participation. An example of this could be that the cessation of the local bus service acts as a barrier to an older person being able to do their food shopping independently, but the acquisition of a home computer and easy internet access can facilitate the older person to order their weekly food shopping online and have it delivered by their supermarket of choice.

Each of the components is subdivided into separate domains and these are defined within the ICF, providing much-needed universal definitions of self care and mobility, for example. The reader is advised to explore these on the ICF website mentioned in Box 1.4.

Use of the ICF as a framework

In the following chapters in this book, it will hopefully become clearer how the normal ageing process and pathological change of body functions and structures and contextual factors can interact to create activity limitations or participation restrictions for an older person. It is worthwhile considering Mrs Nowak's story in Box 1.5 and then explore how the occupational therapist has extracted relevant issues from this story using the ICF (WHO 2001) as a framework, to inform intervention (Figure 1.2). The ICF codes have also been included so that the reader can consult the classification and definitions on the ICF website.

The ICF framework is a useful tool to identify Mrs Novak's problems and potential issues. By considering these as differing concepts, it allows the therapist to consider whether the limitation in activity or participation restriction are caused by an impairment of body function or structure, or by an environmental barrier. Therefore, the occupational therapist can consider if the outcome measure of choice will focus on impairment or on contextual factors; or, indeed, necessitate the need for both types of outcome measure to be used. The most appropriate intervention can then be determined. However, the choice

Box 1.5 Mrs Novak's story.

Mrs Novak is a 96-year-old lady who left Poland 60 years ago. She has been a widow for 30 years and has no children or any near relatives. She lives alone in her own two-storey house on the outskirts of a small town in the UK. Mrs Novak went to see her general practitioner [GP] because she has been finding it increasingly difficult to walk to her local shops and becomes tired easily when carrying out her housework. She has been suffering with osteo-arthritis [OA] for many years.

Mrs Novak's GP examined her and considered that her OA had not changed, and suggested that her muscle weakness and wasting, mobility problems and generalised feelings of fatigue were due to the normal ageing process rather than a specific diagnosis.

Mrs Novak was worried by this and was adamant that she did not want help from her local social services department as she was frightened that they would insist on her moving into residential care. Although Mrs Novak is independent in self-care, she is beginning to have difficulty climbing the stairs to her bedroom and bathroom. Fortunately, she has a toilet on the ground floor of her house. Although she can cook her own meals she gets fatigued standing for long periods. Her only social contact is from attending a daily service at her local church, which she is struggling to attend. This upsets her, as her observance of her beliefs is very important to her.

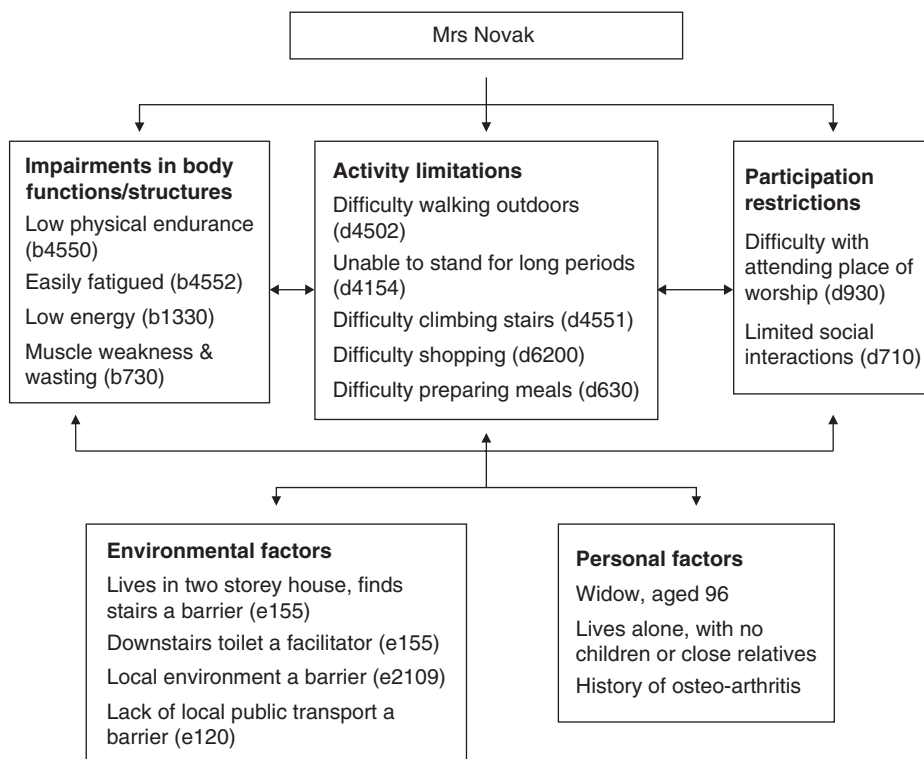


Figure 1.2 The use of the ICF as a framework for practice.

of intervention will also be determined by the beliefs, philosophy and theoretical model of the occupational therapist and the organisation.

One could suggest that, in the absence of any identifiable health condition, Mrs Novak is becoming frailer and less able to cope with her everyday tasks. As an occupational therapist, it is perhaps pertinent to consider that Mrs Novak is now 96 years of age, and that her physiological capacity is probably reduced. Therefore, it might be appropriate to consider a compensatory approach to address Mrs Novak's occupational performance difficulties. This approach may be the best option for Mrs Novak to preserve her current level of body functioning, to conserve her energy and capacity for her most valued occupations. Hence Mrs Novak's activity limitations or participation restrictions could be considered in terms of environmental facilitators and barriers to improve performance, and therefore these will be the focus of assessment and intervention. For example, the OT could discuss with Mrs Novak whether her kitchen could be organised in such a way to reduce unnecessary energy consumption, and that perhaps the provision of a perching/high stool could assist her in carrying out kitchen activities. The OT could carry out an assessment of Mrs Novak's stairs to consider if provision of extra rails would reduce the amount of effort required and improve Mrs Novak's ability to safely ascend and descend her stairs. Mrs Novak's local place of worship might also have a rota to collect and transport parishioners so they could attend services and events, and perhaps have a local community organisation that helps more frail or disabled parishioners with everyday activities such as shopping, so perhaps enabling Mrs Novak in such a way that she feels supported and empowered rather than threatened and monitored so that her sense of autonomy remains intact.

Using the ICF as a framework not only highlights the areas of importance for the client but also the type of services that could be involved. Mrs Novak's story highlights how the interagency team often involves local community services, such as voluntary organisations or places of worship, as well as the public sector. The ICF can also clarify roles and identify areas of overlap and discrepancies in service provision when working in interprofessional and interagency teams where roles seem to be blurred. Using the ICF can also assist in clinical reasoning – of the choice of intervention approach and focus of assessment. Such clarification can avoid two services working at odds with each other – one with a rehabilitative approach (working on activity capacity) and another with a compensatory one (working on activity performance) with the same client.

Why work with older people?

It is interesting that all three of our stories given in Boxes 1.2, 1.3 and 1.6 show that we all have had similar experiences. None of us wanted to work with older people initially, and fell into this area of practice by accident. What also comes across is that we all enjoy the interdisciplinary team working that is necessary when working with older people, because of the many needs and problems an older person normally faces when they are referred to healthcare services.

It is perhaps fair to say that our own early attitudes were not unusual and mirrored those explicitly expressed in health and social care at the time, with older people being excluded

Box 1.6 Why work with older people – Anne McIntyre.

“I would like to say that I had always wanted to work with older people, but this was not the case. I qualified as an occupational therapist in 1980, and, like Jennifer, was determined never to work with older people. I was ambitious and knew that if I wanted to ‘get on’ in OT, then working with older people was not the right career path to take. I hadn’t been able to decide whether I wanted to work in a physical or a mental health care setting, and for many years I specialised in neurological rehabilitation as I felt it gave me the best of both worlds. It was not until my last clinical post before becoming an academic OT that I started working in an older people’s service. The post was, I am afraid, chosen because of its proximity to my children’s school and not because of the client group. However, here my love for older people’s practice began. I worked in a community day hospital for older people with ‘physical’ health problems. I helped set up the service and worked in a very enthusiastic and supportive interdisciplinary team. Until this time, I had worked within a medical model of practice, but soon learnt that a bio-psycho-social model was more appropriate here.

I found working with older people a challenge and very stimulating, as my interventions had to be client-centred and multifaceted. No two clients (or, indeed, interventions) were alike, because of the differing personal and environmental contextual factors. I listened to people’s stories of their past lives – of their struggles and losses during WWII, and the hardships faced during their childhood in the 1920 and 1930s. I realised that these past experiences influenced the older person that they had become. I became aware that even the most affluent client suffered deprivation of some kind – as they were often socially isolated and looked after by a succession of paid carers, with little opportunity for developing any kind of relationship. Unfortunately, we also had to address incidences of physical, emotional or financial abuse, and co-existing mental health problems, so I was fully aware of the vulnerability of our older clients. I became interested in falls prevention whilst at the day hospital, and this interest has continued until today. My PhD research explored the experiences of older people with dementia and their carers of falling. Once again, I listened to peoples’ stories and realised how these participants were struggling to maintain their autonomy and identity whilst dealing with the consequences of falls, dementia and ageing.

So what do I enjoy about working with older people? I enjoy the challenge of enabling each individual, to maintain their optimal health and wellbeing in a holistic way. I relish that my clinical reasoning skills are continually challenged, my ‘tool box’ of interventions is constantly added to, and my negotiation skills are honed. I have a hatred of being bored, and one thing I have never been, when working with older people, is bored.”

Anne McIntyre

from services and interventions because of their age. These beliefs are no longer explicitly expressed; however, it is worth reflecting whether these attitudes still prevail but are implicit in current practice.

One of the reasons why we are so passionate about working with older adults is because we believe occupation can enhance the lives of everyone in society. What all three of us enjoy is the challenge and complexity of practice with older people. We have developed skills and a greater awareness of the need to manage interrelated health, social, environmental and political factors to ensure occupational justice for our older clients.

Summary

This chapter has introduced the structure of this book and the concept of active ageing. Current challenges to the occupational therapy profession and the need for evidence base practice have been discussed. An understanding of the underlying issues and potential solutions to researching with older people have also been presented. The WHO (2001) ICF has also been presented, along with a suggestion for its use in occupational therapy to assist clinical reasoning and service provision. We have also presented our own stories of how we came to work with older people, how our initial prejudices were changed and why we find working with older people enjoyable, challenging and stimulating. This chapter provides a background to the chapters that now follow. We hope that this book will inspire you to adopt an active ageing approach to older adults and for you to reflect on current and future practice. We also hope you enjoy our colleagues' contributions.

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