CAOT Position Statement Occupational therapy and older adults (2011)

The Canadian Association of Occupation Therapist (CAOT) believes that engagement in meaningful occupations, be they leisure, social, self-care, volunteer, productive, and/or physical in nature, is important to the health and well-being of all Canadians. CAOT recognizes that there is a need to support opportunities for occupational engagement for older adults, regardless of health or disability status. Having an understanding of the dynamic relationship between the person, occupation, and environment can uniquely position occupational therapists to provide client centered, evidence-based services for the growing cohort of older adults.

Recommendations for occupational therapists

1. Occupational therapists utilize our foundations of client centered enablement that honour: choice, risk and responsibility, client participation, vision of possibility, change, justice, and power sharing (Townsend & Polatajko, 2007).

2. Occupational therapists enable older adults, including those with a disability, to age in a place of their choosing by developing partnerships with older adults, family caregivers, and community stakeholders, as well as through advocating for safe, accessible, affordable, and age-friendly living options and community environments.

3. Occupational therapists foster older adults' well-being by supporting their efforts to maintain social connectedness, adapt to and manage health/ability challenges as they arise, and engage in occupations that allow self-expression, opportunities to learn, and promote feelings of belonging and contributing.

4. Occupational therapists acknowledge the diversity amongst older adults and how this diversity influences occupation. Occupational therapists recognize that aspects such as spirituality, socio-cultural context and sexual orientation influence the occupations older adults want and need to do.

5. Occupational therapists re-evaluate the concepts of "successful aging", "rehabilitation" and "independence", as these can unintentionally promote ageist attitudes and/or therapeutic nihilism. Instead, occupational therapists focus on occupation-based goals of importance to older adults.

6. Occupational therapists should be aware of the interaction between the aging process and disability with clients who are aging with disabilities, and explore how this impacts performance and engagement in occupation for both the client and any supporters/caregivers of clients.

CAOT Initiatives

To enable occupational therapists to better support older adults' engagement in meaningful occupations, CAOT will:

1. Promote interprofessional research, and include and partner with older adults in such research, to expand the evidence-base for practice.

2. Provide occupational therapists with access to evidence-based and professional development activities on the consequences of elder abuse, age discrimination, spirituality, sexual health in older adults, socio-cultural sensitivity, aging with a disability, and interactions between resilience, occupation, autonomy, and meaning.

3. Promote interventions that enable clients to exercise control over decisions in their daily lives and enable meaningful participation in chosen occupations.

4. Develop tools and resources and, participate in advocacy activities to ensure optimal access and utilization of the occupational therapy workforce

5. Collaborate with stakeholders to facilitate, support and sponsor developments in local, regional, provincial and national contexts to enhance occupational opportunities and participation among older adults.

Background

1. Many factors influence the well-being of older adults, including social connectedness, literacy, housing, income security, activity or occupational engagement, health status, and the safety of their environments. Canadian statistics reveal that older adults are the fastest growing sector of our population, with those over age 65 projected to almost double from the 2006 level of 13.2% to 24.5% of Canadians by 2036 (Statistics Canada, 2006). The vast majority of older adults live in private residences, and 37% report their health as very good or excellent. However, chronic illness rises with age, and one in ten aged 75 and older requires assistance with basic activities of daily living (ADLs) (Statistics Canada, 2006).

2. The prevalence of dementia is also predicted to grow in the coming years, rising from 1.5% of the Canadian population in 2008 to 2.8% by 2038 (Rising Tide, 2010). With this growth and given that most dementia care is delivered by family members in the community, hours of informal care are expected to more than triple in the same period to almost 900 trillion (Rising Tide, 2010). Clearly, support and education for family caregivers are essential; in fact it is estimated that "helping caregivers develop

coping skills and build their competencies in their caregiving roles would yield a 30-year value of $63 billion" (Rising Tide, 2010, p.13).

3. There is concern that the quality of life for older adults will deteriorate if the increasing number of elderly persons is being underestimated or not addressed as the baby boomer generation starts to enter the third and fourth ages (Ontario Human Rights Commission, 2000).

4. Often individuals hold ageist attitudes and beliefs without being aware of them and how they impact their interactions with others (Klein & Liu, 2010). Such ageist attitudes and beliefs can also become integrated into health care practices and systems, as well as more broadly into designed environments and institutions(World Health Organization, 2007). There is a significant amount of literature to support the association of ageism with poorer physical and mental health, decreased community participation, and poorer emotional well-being. The belief of 'inevitable decline' can ultimately lead to increased morbidity and mortality when it produces a sense of helplessness within the older adult population. In contrast, positive self-perceptions of aging can impact longevity of life in older adults (Dozois, 2006; Nemmers, 2004).

5. Idealistic notions of positive/successful aging (such as eternal youth and beauty, consumerist leisure activity, and absence of physical or cognitive disability) are unrealistic, and tend to shift responsibility for managing the aging process solely on to individuals without acknowledging that older adults have differential resources and opportunities to be 'positive agers'. These notions can be used to justify state cutbacks in support and programs for older adults, and foster a blaming mentality against those who are perceived as failing to have lived a "healthy lifestyle" or save sufficient funds for their old age (Rudman, 2006); all of which may contribute to ageist stereotypes and therapeutic nihilism in healthcare, even among occupational therapists (Klein & Liu, 2010). Therapeutic nihilism is a form of ageism unique to health care settings, wherein health practitioners may believe that older adults cannot recover, or not as fully as younger patients, or are less deserving of or in need of health care services. Based on this skepticism, older adults may not be offered the full range of treatments, particularly intensive/expensive interventions.

6. Older adults play key roles in communities, such as volunteering, working, sharing their knowledge and experiences, and being caregivers. These occupational roles need to be supported by communities and societies, through ensuring that environments are inclusive, accessible and safe and, thus, enable older adults to engage in these roles (WHO, 2007).

7. Understanding socio-cultural diversities such as beliefs, values, and attitudes, including toward sexuality, is essential to provide safe and effective care for clients. Meeting the needs of ethnic minorities is particularly important as diversity is increasing amongst the Canadian older adult population. This requires occupational therapists to be self-reflexive regarding their own cultural and professional assumptions, and be sensitive to other ways of knowing and doing (Chevannes, 2002).

8. Life expectancy is increasing for people who are aging with a disability compared to previous generations. However, disparities between those aging with and without a disability continue to exist. For example those with disabilities are experiencing physical health changes earlier in life compared to the population that does not have disabilities (Cohen, Vahia, & Reyes, 2008; Heller, 2010; Kemp, 2005, Marks & Sisirak, 2010; Yorkston, McMullan, Molton, & Jensen, 2010), and the life expectancy for an individual aging with a severe and persistent mental illness is substantially shorter than normal (National Association of State Mental Health Program Directors, 2006).

9. Self- efficacy is associated with improved health-related outcomes, quality of life, and reduced mortality. Self-efficacy is fostered by success experiences, and thus older adults may benefit from opportunities to demonstrate their abilities to cope (Scaffa & Bonder, 2009) as well as engage in meaningful occupations.

10. Client-centred home-based interventions using a multi-component approach, which includes appropriate use of environmental adaptations and assistive technology, can improve self-efficacy in older adults and assist in aging in place (Gitlin et al., 2009; Mann & Hicks, 2009; Sanford, et al., 2006).

11. CAOT has a history of engaging in initiatives that promote the health and well-being of older adults such as; Falls prevention projects funded by Health Canada, The National Blueprint for Injury Prevention in Older Drivers: Funded by Public Health Agency of Canada and the development of strategies for managing and addressing Elder Abuse.

Definitions

Ageism: This can be defined as the discrimination of individuals based solely on age (Klein & Liu, 2010).

Clients: In occupational therapy clients may be individuals, families, groups, communities, organizations, or populations who participate in occupational therapy services by direct referral or contract, or by other service and funding arrangements with a team, group, or agency that includes occupational therapy (Townsend & Polatajko, 2007).

Occupational therapy: is the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and of enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life (Townsend & Polatajko, 2007).

Self-efficacy: This is a belief that one can successfully undertake the course of action needed to achieve a goal. Self-efficacy influences how people feel, think, motivate themselves, and behave (Bandura, 1994).

References

Bandura, A. (1994). Self-efficacy. Retrieved from http://des.emory.edu/mfp/BanEncy.html

Chevannes, M. (2002). Issues in educating health professionals to meet the diverse needs of patients and other service users from ethnic minority groups, Journal of Advanced Nursing, 39(3), 290-298.

Cohen, C.I., Vahia, I., Reyes, P., Diwan, S., Bankole, A.O., Palekar, N., et al. (2008). Schizophrenia in later life: Clinical symptoms and social well-being. Psychiatry Services, 59, 232–234.

Depp, C.A., & Jeste, D.V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. American Journal of Geriatric Psychiatry, 14 (1), 6-20.

Dozios, E. (2006). Ageism: A review of the literature. Calgary, AL: Word on the Street Consulting.

Gitlin, L. N., Hauck, W. W., Dennis, M. P., Winter, L., Hodgson, N., & Schinfeld, S. (2009). Long-term effect on mortality of a home intervention that reduces functional difficulties in older adults: Results from a randomized trial. Journal of the American Geriatrics Society, 57(3), 476-481.

Heller, T. (2010). People with intellectual and developmental disabilities growing old. Impact, 23, 2-3.

Isaac, V., Stewart, R., Artero, S., Ancelin, M-L., & Ritchie, K. (2009). Social activity and improvement in depressive symptoms in older people: A prospective community cohort study. American Journal of Geriatric Psychiatry, 17 (8), 688-696.

Kemp, B.J. (2005). What the rehabilitation professional and the consumer need to know. Physical Medicine and Rehabilitation Clinics of North America, 16(1), 1-18.

Klein, J., & Liu, L. (2010). Ageism in current practice: Experiences of occupational therapists. Physical and Occupational Therapy in Geriatrics, 28(4), 334-347.

Mann, W.C., & Hicks, E.E. (2009). Products and technology. In In B.R. Bonder & V. Del-Bello-Haas (Eds.), Functional performance in older adults (3rd ed., pp. 591-608). Philadelphia: FA Davis.

Marks, B., & Sisirak, J. (2010). Age-related health changes for adults with developmental disabilities. Impact, 23, 24-25.

Molton, I.R., & Jensen, M.P. (2010). Aging and disability: Biopsychosocial perspectives. Physical Medicine and Rehabilitation Clinics of North America, 21(2), 253-265.

Montross, L.P., Depp, C., Daly, J., Reichstadt, J., Golshan, S., Moore, D., Sitzer, D., & Jeste, D.V. (2006). Correlates of self-rated successful aging among community-dwelling older adults. American Journal of Geriatric Psychiatry, 14 (1), 43-51.

National Association of State Mental Health Program Directors. (2006). Morbidity and mortality in people with serious mental illness. Retrieved from http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Mortality%20ad%20Morbidity%20Final%20Report%208.18.08.pdf

Nemmers, T. (2004). The influence of ageism and ageist stereotypes on the elderly. Physical and Occupational Therapy in Geriatrics, 22(4), 11-20.

Ontario Human Rights Commission. (2000). Discrimination and age: Human rights Issues facing older persons in Ontario discussion paper. Retrieved from http://www.ohrc.on.ca/en/resources/discussion_consultation/DissAgeDiscrim2.pdf

Reichstadt, J, Depp, C.A., Palinkas, L.A., Folsom, D.P., & Jeste, D.V. (2007). Building blocks of successful aging: A focus group study of older adults' perceived contributors to successful aging. American Journal of Geriatric Psychiatry, 15(3), 194-201.

Rising tide: The impact of dementia on Canadian society. (2006). Toronto, ON: Alzheimer Society of Canada.

Rudman, L.D. (2006). Reflections on positive aging and its implications for occupational possibilities in later life. Canadian Journal of Occupational Therapy, 73(3), 188-192.

Sanford, J.A., Griffiths, P. C., Richardson, P., Hargraves, K., Butterfield, T., & Hoenig, H. (2006). The effects of in-home rehabilitation on task self-efficacy in mobility-impaired adults: A randomized clinical trial. Journal of the American Geriatrics Society, 54, 1641-1648.

Scaffa, M.E., Bonder, B.R. (2009). Health promotion and wellness. In B.R. Bonder & V. Del-Bello-Haas (Eds.), Functional performance in older adults (3rd ed., pp. 448-467). Philadelphia: FA Davis.

Schneider, G., Driesch, G., Kruse, A., Neben, H-G, & Heuft, G. (2006). Old and ill and still feeling well? Determinants of subjective well-being in >60 year olds: The role of the sense of coherence. American Journal of Geriatric Psychiatry, 14(10), 850-859.

Statistics Canada. (2006). A portrait of seniors in Canada. Retrieved from http://www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf

Townsend, E., & Polatajko, H. (2007). Enabling occupation II: Advancing an occupational therapy vision for advancing health, well-being and justice through occupation. Ottawa, ON: CAOT Publications ACE.

Williamson, M., & Harvey, T. (2007). Aging successfully in place. Perth: National Disability Services WA. Retrieved from www.disability.wa.gov.au/.../doc/ageing_successfully_in_place_discussion_paper.doc

World Health Organization. (2007). Global age-friendly cities: A guide. Geneva, Switzerland: WHO Press.

Yorkston, K.M., McMullan, K.A., Molton, I., & Jensen, M.P. (2010). Pathways of change experienced by people aging with disability: A focus group study. Disability and Rehabilitation, 32(20), 1697-1704.

Position statements are on political, ethical and social issues that impact on client welfare, the profession of occupational therapy or CAOT. If they are to be distributed past two years of the publication date, please contact the Director of Professional Practice Tel. (613) 523-2268 or E-mail: practice@caot.ca.