The aim of this feasibility study was to see if an occupation-based health-promoting intervention for community-living older people could be delivered successfully and also to provide some information to guide a future trial of clinical effectiveness. The participants’ ages ranged from 60 to 92 years. Twenty-eight participants commenced the 8-month programme and 26 completed it; they have continued to meet independently following facilitator withdrawal.

The participants were interviewed qualitatively before and after the 8-month programme. Additionally, pre-programme and post-programme measurements of cognition, depression, functional dependency and quality of life were conducted with each participant before and after the intervention.

The post-intervention interviews illustrated the individualised benefits experienced by the participants, with greater self-efficacy being a significant theme. A comparison of the pre-intervention and post-intervention scores on the quantitative measures showed an upward trend on all dimensions of quality of life. The measurement of cognition, depression and dependency proved useful for screening purposes and for identifying individuals at risk, but not as an outcome measure.

The delivery of the programme was feasible and its benefit to participants was observed, but there is a need for further research to test the intervention rigorously and to explore applicability in a range of settings.

Occupational Therapy Led Health Promotion for Older People: Feasibility of the Lifestyle Matters Programme

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Introduction

This paper reports a feasibility study of health-promoting interventions for community-living older people, conducted during 2004/5 in one city in the North of England. The Lifestyle Matters project was inspired by the United States (US) Well Elderly study (Mandel et al 1999), which involved the delivery of a health-promoting intervention called Lifestyle Redesign®. Based on an occupational approach to healthy ageing, Lifestyle Redesign® helps older people to improve their quality of life and to avoid the negative spiral of decline (Mandel et al 1999). Participants meet in a weekly group over several months and have monthly individual sessions with one of the facilitators. The emphasis throughout is on the identification of participants’ own goals and their empowerment through sharing the strengths and skills possessed by group members.

Lifestyle Redesign® was found to be effective in enhancing the physical and mental health, occupational functioning and life satisfaction of community-living older adults in Los Angeles (Clark et al 1997, 2001, Hay et al 2002). Given the prevailing policy focus upon the provision of health-promoting interventions for older people (World Health Organisation 2002, Godfrey et al 2004, Social Exclusion Unit 2005, Age Concern 2006, Windle et al 2007, National Institute for Health and Clinical Excellence [NICE], in press), it was considered to be an opportune time to test a similar approach in the United Kingdom (UK). It was realised that an intervention developed for use in a US context would not necessarily transfer to a UK population of older people, so the feasibility study sought to establish:

- Whether older people living in the UK would wish to participate in a programme of this nature and, if so, how they might be recruited.
What the preferred structure and content of the intervention programme would be
Whether, given the national shortage of positions for occupational therapists in the UK, other facilitators could deliver the intervention with occupational therapy supervision
How health outcomes and other potential outcomes can be most appropriately measured in this population.

Literature review

Occupation, defined as activity that is meaningful for individuals and for groups of people, is essential for the maintenance of quality of life at all stages of the life course (Clark et al 1991, Law et al 1998, Yerxa 1998). However, in older age, maintaining engagement in chosen as opposed to essential activities can be challenging. Life events, such as the onset of illness, a fall, a bereavement or the loss of a recognised life role, often signal the beginning of a negative spiral of disengagement, expressed by diminished confidence and a reluctance to venture beyond the security of set routines or the comfort of the home (Mountain 2004). Essential daily activities can be more difficult, take longer and require more energy; leaving diminished resources for non-essential activities (Borell et al 2001). If undertaking occupations requires external support, the older person may experience a reduced sense of control and a loss of spontaneity. Additional difficulties can be posed by a lack of financial resources, inaccessible amenities and the unavailability of cheap and reliable transport (Age Concern 2006). A combination of adverse circumstances can severely compromise mental wellbeing (Age Concern 2006, Bowers et al 2006).

There is growing evidence of an association between physical activity and the maintenance of health at all ages. In older age, an active lifestyle, with a moderate amount of exercise, can reduce the risk of falls (Province et al 1995, Campbell et al 1997); help to maintain independence (Penninx et al 2001); contribute to positive mental health (Singh et al 2001, Strawbridge et al 2002); and possibly reduce the risk of cognitive decline (Yaffe et al 2001). Additionally, a small but robust evidence base demonstrates that participation by older people in activities to promote social engagement is strongly associated with life satisfaction (Warr et al 2004) and with survival (Glass et al 1999).

Method

Necessary ethical and governance approvals were obtained prior to the commencement of data collection. A steering group, comprising voluntary sector representatives, two older people involved in voluntary sector services, operational managers from health services and the researchers, met at monthly intervals to advise on the practicalities of intervention delivery. Academic advisers were also recruited to scrutinise progress and to ensure research credibility. A launch event was facilitated to showcase the beginning of the project, to which key stakeholders were invited. The sequential steps taken during the preparation and subsequent delivery of the intervention are described below.

Developing the intervention

The US Lifestyle Redesign® manual (Mandel et al 1999) was given to five older people who had volunteered to scrutinise the contents in their own time. They then participated in a focus group to give their views. During the discussion, the volunteers emphasised the importance of language and cultural appropriateness and suggested the need for a greater focus on family relationships and spirituality. Their views were incorporated within the development of a draft UK intervention programme, which included the overarching themes of ‘beginnings’, ‘activity and health’, ‘maintaining physical and mental wellbeing’, ‘activities in the home and community’, ‘safety in and around the home’, ‘managing personal circumstances’ and ‘ endings’. Themes were expanded into topics; for example, the theme ‘maintaining mental wellbeing’ included the topics ‘sleep as an activity’, ‘keeping mentally active’ and ‘memory’. Methods of exploring topics were identified to provide the participants with opportunities to put their ideas into practice. Feedback from the participants and facilitators during intervention delivery was incorporated into the draft programme, with a final version being agreed and published at the end of the project (Craig and Mountain 2007).

Participant recruitment

The intention was to recruit older people ‘on the cusp’ of wellbeing and frailty, as defined in the National Service Framework (NSF) for Older People (Department of Health 2001). Recruitment was restricted to residents within two coterminous communities. District nurses covering these populations agreed to stimulate the interest of the individuals that they thought might benefit. Posters and flyers were placed in locations frequently visited by older people, such as the general practitioner surgery, post office, library and local supermarket, and information was also broadcast on local radio and published in local newspapers. The aim was to recruit 24 participants, 12 for each group. Some over-recruitment was considered appropriate to compensate for anticipated attrition.

Pre-group screening and interview

Prior to programme commencement, each volunteer was invited for interview at a venue of his or her choice by a researcher not involved in programme delivery. Following signed consent, the Mini-Mental State Examination (MMSE) (Folstein et al 1975) was used to screen for cognitive impairment (a score of 18 or under was an exclusion criterion). Other standardised instruments were applied to measure the following: activities of daily living (Mahoney and Barthel 1965), depression (Yesavage et al 1983) and quality of life (Hays et al 1993). Basic data
about the individual and his or her living circumstances were obtained through a questionnaire. Each person was also asked to describe any health problems about which he or she considered that the facilitators should be aware. Each volunteer who met the inclusion criteria was then visited a second time and interviewed before being invited to enter the programme. Qualitative methods of inquiry were employed (Ritchie and Spencer 1994). Topic guides for interviews with participants were created out of the existing knowledge and evidence base, and included questions and probes to elicit views about their quality of life, their lifestyle and concerns and what they hoped to gain from participation.

**Intervention delivery**

Two Lifestyle Matters groups were convened. The delivery of the intervention mirrored that in the US, with each participant attending the same group weekly as well as receiving a 2-hour individual monthly session.

One group was facilitated by two occupational therapists and the other by two occupational therapy technical instructors. Prior to the commencement of the programme, all the facilitators were provided with the same 2-day training together, with the training having a significant group work component. Each individual was supervised throughout by an academic occupational therapist. All facilitators maintained weekly records of participant attendance and involvement, as well as personal reflective diaries.

**Post-intervention interviews**

At the end of programme delivery, the participants were again asked to complete the battery of measures by interviewers who visited them at home. They were also interviewed qualitatively about their perceptions of the experience of participation.

**Results**

**Recruitment**

District nursing did not signpost any older people to the programme. The other described methods of recruitment resulted in three volunteers only. Following advice from the voluntary sector, a strategy of direct community engagement was adopted; this proved successful, with 42 older people expressing interest in taking part. Thirteen volunteers subsequently withdrew because they were unable to commit themselves to attendance at the same time every week over several months, leaving 29 who were screened for involvement in Lifestyle Matters. One person was found to be too cognitively impaired for inclusion (MMSE score <18) and was referred to other voluntary sector services.

**Participant profile**

The ages of the 28 people who commenced the programme ranged from 60 to 92 years, with a mean of 78.5 years. Only three were male (two men accompanied their wives). Ten were married, 17 widowed and one divorced. Nineteen were living alone. The majority (20) were owner-occupiers, six lived in rented housing and two lived in sheltered accommodation. Four received district nursing or home care services and 26 were already attending at least one community group. The numbers of cited health problems that they reported ranged from nil (one person) to seven.

**Attendance and participation**

Two groups met weekly for 8 consecutive months, one group with 16 participants and the other with 12. Two people were lost to the study at an early stage due to ill health. The remaining 26 completed the programme, despite 5 being significantly compromised by illness and/or life events during the 8 months. An unexpected result was that following facilitator withdrawal, both groups have continued to meet independently with assistance from community resources.

Each of the groups selected the themes and topics that they wanted to pursue, with ideas from the manualised programme (Craig and Mountain 2007) being suggested by the facilitators. The group setting enabled participants to have their views listened to and common experiences were identified. The groups also provided a place where new skills could be rehearsed in a supportive atmosphere and where problem solving could occur, particularly through modelling when group members learnt from each other. An important aspect was the trips into the community, where ideas could be put into practice with support and encouragement from peers. Each participant was also offered a monthly individual session with one of the facilitators during the 8 months, where their own, often complex, needs might be explored and clarified and individual goals identified and worked on.

**Results of data analysis**

The results of the application of the pre-intervention and post-intervention measures were correlated using the Wilcoxon Signed Ranks test for non-parametric data. Score distribution was examined using box plots.

Framework Analysis facilitated by Nvivo software was employed to analyse the qualitative data (Ritchie and Spencer 1994). This method is particularly suited to applied studies of policy or practice that have clearly defined aims at the start (Green 2005). Framework Analysis employs a well-defined sequence of five analytical steps (familiarisation, identifying thematic framework, indexing, charting, and mapping and interpretation), which is intended to make the process of analysis accessible and verifiable.

Table 1 shows the extent of quantitative and qualitative data obtained from the participants pre-intervention and post-intervention. This demonstrates that there were some partial refusals, so a full data set was not achieved (particularly post-intervention). The major reason for the incomplete data sets was that the participants did not wish to complete a number of questionnaires.
Quantitative analyses

The results were examined to look for any trends and to consider their value for use in a future trial.

On the Geriatric Depression Scale (GDS), scores >5 are generally considered to indicate the probable presence of ‘case’ level clinical depression. One participant scored particularly highly (13) pre-intervention and was referred for treatment, but also embarked upon the programme. All other participants scored less than 5, the mean scores being 3.2 pre-intervention and 1.5 post-intervention. This apparent post-intervention improvement was not statistically significant.

The Barthel Index is scored 1-100, with 100 indicating no problem with specific basic activities of daily living. Only three participants had pre-intervention scores lower than 90, one of whom subsequently entered residential care. Scores were not significantly different post-intervention.

The SF36 is scored in eight sections, with a score of 100 representing the highest level of functioning possible and a score of 0 the lowest. As Fig. 1 shows, post-intervention scores demonstrated an upward trend in all sections.

Results of analysis of pre-intervention and post-intervention interviews

The 27 participants who were interviewed qualitatively pre-programme all described health as being a significant contributor to their quality of life. Some were stoical about ill health and accepted this as part of growing older. For others, the sudden impact of ill health had come as a shock.

It was noteworthy that, although the majority talked about the importance of maintaining physical health, mental wellbeing was not discussed, with only one person mentioning memory problems. Those with physical health related problems described how the consequences permeated every aspect of their lives.

Most of those interviewed expected to continue with an active life, with walking being an important part of the daily routine. However, the hilly nature of the local environment meant that mobility was challenging for some. The insidious erosion of confidence due to the combined effects of age, illness and disability was fully described by 11 participants. The effort required to continue activities combined with the lack of practice meant that it could be easier not to try.

The participants had varied hopes and expectations of the programme. The more disabled participants saw it as an opportunity for socialising, whereas those who were more mobile expressed the view that the programme might be more appropriate for other, more needy older people. Some had quite specific educational aims, such as acquiring skills in technology use. The complete analysis of the pre-programme interviews is provided within the project report (Mountain et al 2006).

The 26 participants who completed the programme were interviewed within 2 weeks of cessation. (Pseudonyms are used.) The majority reflected upon their engagement in activities and the enjoyment that they had obtained from participation. Taking part in new activities led some individuals to achieve things that they had not considered themselves to be capable of:

Fig. 1. Box plot distribution of scores for overall physical and mental health pre-intervention and post-intervention as measured by the SF36.

Cumulative scores for both physical and mental health improved post-intervention, but not significantly. The range of cumulative physical health scores increased post-intervention, whereas the range of cumulative mental health scores narrowed, with the minimum score rising from 60 to 75. One outlying case had a low score for mental health post-intervention, which could be attributed to the ill health experienced by this person during the programme. Even though the changes in scores for role limitation were not statistically significant, changes occurred that, with a larger sample, could prove significant; for example, the mean score for role limitation due to emotional health remained consistent post-intervention but the spread of scores markedly improved, with only two participants reporting limitations. Although the spread of scores for social functioning remained unchanged, the mean score improved by 10 points post-intervention.

Table 1. Standardised tests completed during the Lifestyle Matters study

<table>
<thead>
<tr>
<th>Test</th>
<th>Number completed pre-intervention</th>
<th>Number completed post-intervention</th>
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| Mini Mental State (MMS)…………………28…………………23…………………
| Geriatric Depression Scale (GDS)………28…………………23…………………
| Barthel Activities of Daily Living     |                                    |                                    |
| Index (Barthel)                        | 27…………………20…………………      |
| Rand 36 Item Health Survey             | 25…………………..22………………….|
| Questionnaire (SF36)                   |                                    |                                    |
I came back home and I said I bet you don’t know what I’ve been doing. I brought a picture home of it and I said look at that. I’ve done that on the computer and they said ‘Oh my God, she’ll be wanting a computer next!’ I was quite pleased with my little self … I know that there was someone there showing me, but you have got to be able to take it in to do it haven’t you? (Letitia Jones.)

The opportunity to participate in a meaningful group discussion was a much valued aspect, described as being rarely available in other settings:

Well the lifestyle group talks about different things; things that were interesting. Whereas this women’s group; it’s just gossiping. (Elizabeth Peters.)

Discussions provided opportunities to appreciate the qualities and skills of others, as well as providing a safe forum in which to express personal opinion. The participants were pleasantly surprised at what they learned from each other:

I would say that even the ones who were much quieter than me joined in and gave as much as everybody else did, we all gave equally I would think our opinions … I would think this is what was good about the group – we all gelled. (Eunice Smallwood.)

It is significant that even though the facilitators were mentioned in very positive terms, the participants focused upon what they had gained from each other’s knowledge and experience. One aspect that was particularly important was the encouragement that they received to talk freely about circumstances and feelings, without prejudice, in a safe and supportive but also structured environment:

Well I appreciated someone taking an interest in me, someone outside the family and outside normal friends. That’s lovely to have someone else take an interest in you. And your welfare, because that’s what it boils down to isn’t it? We are talking about your welfare from all sorts of aspects. And I suppose because it gave me the opportunity to talk about what you were offering and what I got out of it. (Edith Wood.)

The depth of discussion that took place during the group meetings was not something that some of the older people were familiar with, even within their families. One person was able to describe the challenging family dynamics that she had to try to manage in order to retain some independence:

How you feel about say, how you feel about life at the present time. What you can do, what you can’t do, what you did in the past and if you worry about it that you can’t do now and then what your family treat you like. I mean in my case my family’s a bit don’t want you to do much if you know what I mean. A bit over protective. So it was a bit of trying to stand on one side away from them. (Freda Barratt.)

Another valued aspect was the contribution by external speakers, and the benefits of obtaining clear and factual information on subjects like medication, diet and home safety:

They gave you a lot of information, the pharmacist because what we didn’t realise was that you could go to your own doctor and actually speak to a pharmacist. Practice pharmacist I think they call it and you could actually go and make an appointment and then he will advise you on all these pills that you don’t take! (Jack Smallwood.)

Outings during the programme gave the participants the opportunity to put their experiences into practice. For this widow, a personal challenge was to use public transport, a skill that she had never had to put into practice while her husband was alive:

I think I’ve told you before that me and my husband always went everywhere together and he drove. And so it was just jump in the car and go. So I had to start right from scratch again. Even enough confidence to go and get on a bus, ’cos I’d never done it. (Christine Blunt.)

Five participants stated explicitly that their confidence had improved and all gave examples of how the programme had benefited their overall wellbeing, for instance:

I’ve gone for things. Done dancing and active things. But since Jack died you see I didn’t keep it up. Because it takes you a while, it’s just not the same. But it’s got me going again, you see. It’s got me meeting more people. And that’s what it’s all about, friendship isn’t it? (Christine Blunt.)

But I find it easier now to talk to people I don’t know whereas before I used to let my husband do all the talking because he was very extrovert and never stopped talking really and always got on well with anyone he met. And so I used to chip in now and again. But I’ve found now that I’ve got the confidence to approach other people. (Edith Wood.)

I think that the Lifestyle group has brought me out more. It’s made me realise that I’m still of worth … Not just a pot washer, a granny, a babysitter. (Dora Brown.)

When I went to school, I wasn’t well educated … but I learned a lot and I have enjoyed it. It hasn’t made me as shy, because usually I am a shy person and it has brought me out a little bit. (Peter Franklin.)

Discussion

The process of establishing and delivering this intervention programme raises a number of issues, both for practice and for any future research into this programme. The programme is reliant upon older people volunteering their involvement. It proved difficult to find and engage older people dispersed in the local community, requiring consideration of how to attract people when participation is not mandated and how to reach those in need. The lack of involvement of district nurses was disappointing, particularly as health service policy is moving increasingly towards health promotion and disease prevention models. Owing to the small scale of the study, this could, however, be attributed to the specific service approached and, therefore, may be worth testing again.
Meeting with community activists and giving taster workshops and talks to small groups was the key to successful recruitment, but in engaging older people who were already linked to groups of various kinds it did not necessarily reach isolated older people. Further work is indicated to explore how older people disconnected from community life can be successfully reached and involved. However, it should also be noted that the analysis of pre-programme interview data suggests that those *in transition* (Department of Health 2001) have a wide range of coping abilities, extending from those with early signs of diminishing confidence and capacities to those who are dependent upon others for certain activities of daily living.

The lack of attrition from the programme was unexpected, given that delivery took place over the winter months. That the intervention was able to meet the needs of older people aged from 60 to 92 years was also unexpected. It appeared to have relevance and be beneficial for those in early retirement as well as for individuals who were very old, which was also evidenced by the continuance and growth of both groups. This example of the development of community capital (Godfrey et al 2004, Social Exclusion Unit 2006) is striking. Nevertheless, the population of older people who volunteered for *Lifestyle Matters* was homogeneous in that only one person of mixed race participated; the rest were white British. Further work is required to explore the adaptability of the *Lifestyle Matters* programme to different populations of older people.

The qualitative findings revealed that the qualified staff and those without an occupational therapy qualification were equally competent as facilitators. However, qualified staff involvement resulted in timely responses to problems resulting from ill health and disability; for example, arranging for assistive technologies to be made fit for purpose and suggesting ways of adapting activities. All facilitators took time to adjust to working in the absence of a service infrastructure, where case records can be accessed to obtain information. Another challenging aspect for all facilitators was allowing individual older people to take personal decisions about their level of risk taking. The older people particularly valued the opportunity to learn from each other, the time to engage in thoughtful discussion and the opportunities to put ideas into practice. This meant that the facilitators had to step back and relinquish the role of expert to the older people themselves. Thus the established professional role was challenged.

At the end of the project, all facilitators reported obtaining personal benefit from their involvement. The obtained results suggest that staff other than occupational therapists are able to deliver the programme, provided that they are adequately supported by occupational therapists. The intervention may therefore be appropriate for use by other community staff, such as health trainers and community matrons, but this assumption warrants further testing.

In common with the results obtained from many previous studies, the findings obtained from the qualitative interviews echoed the significance of health and related issues in determining independence and continued participation (World Health Organisation 2003). The interplay of health with other factors, such as bereavement and other losses, living arrangements, personal resilience and available networks of support in determining coping abilities, was confirmed (Mountain 2004). The findings also raised questions about the sensitivity and relevance of some current services for older people, and the need to recognise the potentially limiting as well as the helpful and supportive nature of some family relationships.

The post-programme interviews revealed the very individualised benefits received by the participants. The greater self-efficacy that they experienced was a significant theme (Bandura 1997). It has been previously observed that self-confidence, which arises from the interaction of personal, behavioural and environmental factors, can result in positive health outcomes (National Chronic Care Consortium 1999). Therefore, self-efficacy could be an outcome measure in a future trial. The improvements to wellbeing that all participants reported were in the main related to improved engagement and mental wellbeing, and not directly to physical health. In order to engage in a more fulfilling lifestyle, many participants did, by default, become more physically active, a fact that was not acknowledged during the interviews. The range of activities pursued by the participants and the varied benefits that they described illustrate the flexibility of the programme and its appropriateness for active older people, as well as for those who are more frail and dependent. The extent to which the older people took forward the activities pursued during *Lifestyle Matters* into their lives is a further positive outcome.

The prime reason for this study was to explore the feasibility of implementing a programme inspired by *Lifestyle Redesign* in a UK setting. The extent of uncertainty regarding the success of this intention (for example, the extent of anticipated attrition from the programme) did not lend itself to a research design where numbers of participants are identified to power a future study of clinical and cost effectiveness. Furthermore, the extent of project funding limited the remit of the project to two groups. So even though the phase 1 (modelling) of the Medical Research Council (2000) complex interventions framework was adhered to, phase 2 requirements could not be fulfilled through this small study. Therefore, the results obtained from analysis of the pre-intervention and post-intervention measurement have to be viewed with caution, and the numbers required to power a future trial will be identified through the results obtained by Clark et al (1997) from application of the SF36. However, in common with the findings of previous studies (Livingston et al 1998, Murray et al 1998), the problems of applying existing quality of life scales to an older population were apparent, emphasising the urgent need to develop more appropriate measures.
The results from the instrument application suggest that outcome measures, such as the Barthel Index and Geriatric Depression Scale (GDS), are of limited value when the aim is to work with older people to maintain quality of life and wellbeing. However, the GDS did prove to be valuable as a screening tool for identifying individuals who are clinically depressed and undetected in the community and require the attention of specialist services. The SF36 proved more sensitive to the changes reported qualitatively by participants and would therefore be appropriate for further use. The results obtained indicated the need to measure activities of daily living, health and mental wellbeing, overall health, self-efficacy, social participation and social resources, in addition to quality of life through the SF36.

Possible other measures for use in a future trial include the Functional Status Questionnaire (Jette et al 1986); the Diener Satisfaction with Life Questionnaire (Diener et al 1985); the General Health Questionnaire (Goldberg and Williams 1978); the Generalised Self-Efficacy Scale (Schwarzer and Jerusalem 1995); and the Multidimensional Functional Assessment of Older Adults (Fillenbaum 1988). This list may need to be revisited owing to the previously stated completion tolerance of participants. It will also be important to add a cost evaluation, similar to that undertaken through the Clark et al (1997) study (Hay et al 2002).

Conclusion

The value of participation in meaningful activity for mental wellbeing was underscored by the first output of the UK Inquiry into Mental Health and Wellbeing in Later Life (Age Concern 2006). As a result of its findings, this inquiry recommends the introduction of healthy ageing programmes by local authorities in partnership with other agencies. The results of the feasibility study of Lifestyle Matters confirm the tangible benefits that older people can obtain from a health-promoting, occupation-based intervention delivered over time. It also illustrates the complexity that underpins successful provision. Health-promoting services, where older people can choose to be involved, need to be embedded into communities and even then questions remain regarding how to reach the most isolated.

To date, there are few tools available to assist service providers to develop health-promoting services for older people and little available research to underpin service innovation. Lifestyle Matters was demonstrably able to fulfil the service gap, but there is a need for further research to test the programme rigorously and to explore applicability in a range of settings. This includes how to measure accurately the range of outcomes that the older people described. Finally, it is becoming apparent that this programme may well have significant implications for the UK occupational therapy profession, particularly when guidelines on health promotion for older people are published by the National Institute of Health and Clinical Excellence in October 2008.

Acknowledgements

The authors would like to acknowledge the funding support received from the Sheffield Health and Social Research Consortium, which enabled this project to be conducted. They would also like to thank the occupational therapists and technical instructors – Julia Clifford, Kate Lipka, Angela Miller and Julie Barham – who delivered the intervention so effectively.

Key findings

- Participants were able to describe the benefits that they experienced but robust evidence of effectiveness is required.
- Improved self-efficacy was described by all participants.
- An unexpected outcome was the continuing community capital that the programme stimulated.

What the study has added

This modest study has stimulated national and international interest. It is cited within an evidence review conducted for NICE (Windle et al 2007) and has been incorporated into forthcoming guidelines (NICE, in press). It has also stimulated an occupational therapy European network under the auspices of ENOTHE (European Network of Occupational Therapists in Higher Education) (www.hva.nl) and has attracted the attention of the gerontological research community.

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