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Enabling social participation for older people: The content of reablement by age, gender, and level of functioning in occupational therapists' interventions

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ABSTRACT

Background: Social participation and the ability to build and maintain social relationships is emphasized as important for older people's health and well-being.

Aim: To explore if social participation is addressed and whether age, gender and level of functioning are associated with the composition of occupational therapy interventions within the context of reablement.

Method: In this cross-sectional study, invitations to participate were sent to 60 municipalities in Sweden. 318 occupational therapists participated and described the character of initiated interventions made during 3 weeks through web-based surveys.

Result: 1392 cases were reported in the age span of 19–103 years, 61.7% were women. A higher proportion of persons having no home care and minor functional dependency got interventions with a focus on social participation to a higher extent than persons with major functional dependency. Occupational therapists' interventions vary as related to functional limitation, age, and gender.

Conclusion: The results indicate that the severity of functional limitation impacts the focus of the intervention whereas age and gender do not. There is a need for social participation to be more clearly addressed within the context of reablement.

Significance: To develop a person-centred intervention, one needs to consider aspects of age, gender, and functions.

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Ageing; activity; every-day rehabilitation; restorative home care services; social health; social care; community participation

Background

The importance of social participation and the ability to build and maintain social relationships is emphasized by the WHO in their report Ageing and Health [1]. Likewise, participation has been emphasized in WHO's policy framework [2], by defining active ageing as 'the process of optimizing opportunities for health, participation and security to enhance the quality of life as people age'. Further, social health and social services are among others, identified as key determinants in the same policy framework. Thus, in line with earlier research [3–5], social participation and social relationships are of importance and warrant attention when implementing health and social care services. According to Levasseur et al. [6], social participation is a complex concept, focuses mostly on interaction in society and community, and

recommends researchers to identify a specific definition of social participation. Therefore, our focus in this paper is on having the possibility to participate in key out-of-home activities, important elements of well-being in later life [7] and considered as a central aspect of active and healthy ageing [8,9]. For older people being allocated home help, leisure, social participation and activities outside the home are areas of engagement that are considered important but also the ones more likely to be unmet [10]. Further, the ability to move around in the community is an important part of participating in leisure, social, and other activities [11], and for health and well-being [12]. Therefore, our assumption is that aspects such as outdoor mobility, leisure, social contacts, and communication are related to social participation. Even if increasingly more time is spent at home as people age [13], social relations and activities outside the home

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are emphasized as important for independence and social participation among older people, as noted by for example Wilde and Glendinning [14].

One way to promote social participation is through reablement. Reablement is defined as an 'inclusive approach irrespective of age, capacity, diagnosis or setting' [15]. The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Reablement supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications and assistive devices as well as the involvement of their social network. Reablement consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team. This team includes professionals such as occupational therapists, physiotherapists, nurses, and home trainers [15]. Occupational therapists have specific knowledge of occupational theory and meaningful everyday occupations [13]. Due to their unique core skills, occupational therapists have a central role within the reablement team. Therefore, in this paper, the focus is on occupational therapy interventions within the context of reablement.

With regard to existing research on reablement, a recently published critical review [16] focussed on the concept of reablement and the practice of reablement. Largely, found that outcome measures focussed on functional independence and that more emphasis on social connectivity, that is, helping clients to re-establish community and other social relationships, is needed in the current reablement approach. In a Norwegian study, Witsø, Ejde, et al. [17] came to similar conclusions and in another study on older people receiving home care, Vik and Eide [10] found that in addition to indoor mobility and self-care, leisure and social activities were identified as important activities but also that these activities were the ones with which respondents were least satisfied.

Some factors are important for social participation among older people. From the perspective of older people themselves and their experiences of receiving reablement interventions, reablement services were effective regarding regaining independent living skills related to personal care [14], however, the older persons in that study reported that they did not acquire help to realize goals focussing on social relations nor on social and leisure activities. For example, the interviewees reported 'expressed distress at being confined to the house'. Lee et al. [18] examined social participation and how it might be influenced by self-rated health, gender and age. The results showed that the

influence of social participation on health status increases with age, and the effect on social participation is greater for women. Thus, social participation should be considered in community interventions, but this is scarcely investigated [19]. In addition, Tuntland et al. [20] found in one study that gender and level of functioning had an impact on reablement outcomes such as activity performance and satisfaction with performance. However, it has not been explored whether such baseline factors impact how interventions are composed. Therefore, in this paper, we aimed to explore if social participation was addressed and whether age, gender and level of functioning were associated with the composition of occupational therapy interventions within the context of reablement.

Method

This is a cross-sectional study, utilizing data from a national survey on the role of occupational therapists and physiotherapists in reablement context which included 43 municipalities and was conducted in 2017–2018 [21]. There is a growing global interest in reablement services, and the national survey is the first comprehensive study investigating reablement services in Sweden. To address the purpose of the survey, four different web-based surveys, specifically developed to collect data on organizations, target groups, content, and focus of intervention, use of assessments, and collaboration with other professionals were used. Data on occupational therapists' characteristics such as gender, age, education, and experience from working with reablement were also collected, described in our earlier publication [21].

Sample

In Sweden, 60 of the 290 municipalities have a Local Authority Senior Rehabilitation Advisors (LASRA) employed. The LASRA is responsible for quality assurance in relation to rehabilitation within the context of municipality home health care. All Local Authority Senior Rehabilitation Advisors from a national network constituted the recruitment base for this study.

Procedure and data collection

In the first step of recruitment, an invitation letter was distributed through the national network of LASRAs. To clarify the focus of the study, the

following characteristics were used to describe reablement: (1) occupational therapists and physiotherapists were coordinators of the reablement work, (2) interventions were implemented in ordinary housing, (3) the main focus was on daily activities important for the person, (4) interventions included collaboration with home care staff, (5) interventions were organized within a municipality context (also including private companies), (6) interventions included collaboration with other professionals, for example, district nurses, social workers, managers for home care staff.

A total of 43 LASRAs replied to the invitation answering the first survey concerning the organization of reablement in each municipality. Out of these, 38 stated that their municipality was willing to participate. In the second step of recruitment, OTs and PTs in 38 municipalities willing to participate were informed about the aim, content and procedure of the study and that participation was voluntary. The information was provided by e-mail from the second author and further distributed by the LASRAs. At this step, four municipalities decided that they were unable to participate. Thus, a total of 34 municipalities participated in the study meaning that both OTs and PTs answered the profession-specific web-based survey.

Participating occupational therapists ($n = 318$) were instructed to describe cases for which interventions were initiated during 3 weeks through a web-based survey. Eligible cases included all persons for which interventions addressed a 'new need' during this period. The actions included in the intervention for each case were followed for as long as the intervention was ongoing but no longer than 3 months after the start of data collection. To address frequently asked questions raised by the occupational therapists during the study period a document was constructed, regularly updated, and distributed by e-mail to all participants. A final survey was focussed on demographic characteristics of the participating occupational therapists and physiotherapists including, for example, level of education, time in current position and experience working with reablement.

For more information on the context, data collection and procedure, see Zingmark et al. [21].

Ethics

The participants were LASRAs, occupational therapists and physiotherapists. At the start of the study, the LASRAs received information about the study, that participation was voluntary and was asked

whether the municipality they represented wanted to participate. For municipalities that agreed to participate, written information about the study was sent by e-mail to the occupational therapists and physiotherapists in the municipality. Each municipality decided to what extent, that is, how many of their occupational and physiotherapists took part in the study. The study was approved by the Ethical Board at Umeå University, Dnr: 2015/268-31Ö.

Analysis

Data were analyzed and presented descriptively. Chi² tests were used to analyze if there were differences in relation to age, gender and level of functioning regarding (i) the focus on a basic need vs. social participation, (ii) the number of contacts and (iii) the duration of the intervention. A basic need was defined as including one or more of the variables body functions, walking indoors, self-care and domestic life. Social participation was defined as including the variables walking outdoors, social contacts, communication, and leisure. This is based on earlier research, stating that activities outside the home are important [10–12]. In addition to including all response options for a number of contacts and duration of the intervention in Chi² tests, these variables were also dichotomized. The number of contacts was dichotomized comparing cases that included a maximum of five contacts versus cases that included six contacts or more. The duration of the intervention was dichotomized comparing cases including a maximum duration of 6 weeks versus cases including duration of 7 weeks or longer. To evaluate differences in relation to age, the median, 81 years, was used as a cut-off resulting in the two groups: those younger than 81 and those 81 years and older. Gender was analyzed in relation to the female or male sex. Functioning was defined in relation to three levels of dependency, that is, no home care; minor functional limitation including those allocated safety alarms and/or help with domestic tasks e.g. shopping, cleaning; major functional limitation including those allocated home help for with personal activities of daily living.

Result

In all, there were 1392 cases; 859 (61.7%) were women; the age span was between 19 and 103 years, the mean age was 78 years and the median 81 years. 12.5% were younger than 65 years, 33.9% were in the span 65–79 years, 40.5% in the span between 80 and

90 years and 13.1% were 90 years or older. In all, 359 cases (25, 8%) were not allocated any home help, 230 cases (16.5%) were categorized as having minor functional limitations and 803 cases (57.7%) as having major functional limitations. Regarding the proportion of cases in each level of functional limitation, there were no significant differences in relation to gender between men and women ($p = 0.915$). In relation to age, there were significant differences regarding the proportion of cases for each level of functional limitation ($p < 0.001$); a larger proportion among those older than 81 years had a major functional limitation (68.3%) compared to those younger than 81 years (44.1%) whereas a larger proportion among those younger than 81 years was not allocated any home help (39.4%) compared to those older than 81 years (15.3%). The focus for the OT interventions (assessment, goalsetting and/or specific intervention included) could be within seven different life areas: body function, walking indoors, walking outdoors, self-care, domestic life, social contacts, and communication.

The focus of the intervention

The intervention focussed on social participation only in 94 cases (6.8%). In 1298 cases (93.2%), the assessment, goal setting and intervention were focussed on basic needs, whereas in 94 cases (6.8%) the intervention was focussed on social participation. There were no significant differences regarding the foci of intervention in relation to age ($p = 0.81$) or gender ($p = 0.78$). For a higher proportion of cases with no

home care (9.5%) and minor functional limitation (10.9%), the intervention included a focus on social participation compared to cases with major functional limitation (4.4%), ($p \leq 0.001$).

Number of contacts

In most cases, the intervention included a maximum of 5 contacts; 797 cases (57.3%) included a maximum of 1–2 contacts, 459 cases (33.0%) included 3–5 contacts. In 95 cases (6.8%) the intervention included 6 to 9 contacts and in 41 cases (2.9%) the intervention included 10 contacts or more. There were no significant differences regarding the number of contacts in relation to age ($p = 0.124$) or gender ($p = 0.112$).

When the number of contacts was dichotomized, a larger proportion of those 80 years or younger (11.4%) received more contacts (six or more) compared to those 81 years or older (8.0%), $p = 0.037$, Table 1. In relation to gender, a larger proportion of men received six contacts or more (12.2%) compared to women (8.3%); the difference did not reach the level of significance ($p = 0.052$). In relation to the level of functioning, the proportion of cases receiving six contacts or more differed between those with no home care (6.1%), those with minor functional limitation (8.3%) and those with major functional limitation (11.8%); ($p = 0.007$).

The duration of the intervention

In 1108 cases (79.7%), the intervention was implemented over a period of 6 weeks or shorter: for 385

Table 1. Focus of the intervention, number of contacts and duration in relation to age, gender and level of functional limitation.

	≤ 80 $n = 694$	≥ 81 $n = 697$	Women $n = 859$	Men $n = 532$	No home care $n = 359$	Minor functional limitation ^a $n = 230$	Major functional limitation ^a $n = 803$
Focus	$p = 0.814$		$p = 0.781$			$p \leq 0.001$	
Basic need	93.1	93.4	92.9	93.8	90.5	89.1	95.6
Social participation	6.9	6.6	7.1	6.2	9.5	10.9	4.4
No. of contacts	$p = 0.124$		$p = 0.112$			$p \leq 0.001$	
1–2	56.5	58.1	56.8	57.9	65.7	61.7	52.2
3–5	32.1	33.9	34.9	29.9	28.1	30.0	36.0
6–9	7.5	6.0	6.2	7.9	3.6	6.1	8.5
≥ 10	3.9	2.0	2.1	4.3	2.5	2.2	3.4
Duration (weeks)	$p = 0.443$		$p = 0.195$			$p = 0.265$	
≤ 1	26.9	28.4	26.7	29.2	30.6	32.6	24.9
1–3	31.8	33.9	33.3	32.4	34.0	30.4	33.2
4–6	19.9	18.2	20.1	17.3	18.4	17.8	19.7
7–9	7.9	8.8	9.3	6.8	7.2	7.4	9.1
≥ 10	13.4	10.6	10.6	14.3	9.7	11.7	13.1

Note: all numbers are in percentages (%).

^aMinor functional limitation includes home help limited to safety alarms and or help with domestic tasks. Major functional limitation includes home help for PADL.

Table 2. Focus for the intervention ($n = 1392$).

Number of foci for the intervention Focus for the assessment, goalsetting and/or intervention ^a	Number of cases (%)
1	638 (45.8)
2	485 (34.8)
3	167 (12.0)
4	69 (5.0)
5	22 (1.6)
6	7 (0.5)
7	4 (0.3)
Walking indoors	876 (62.9)
Self-care	779 (56.0)
Walking outdoors	331 (23.8)
Body function	188 (13.5)
Domestic life	295 (21.2)
Social contacts	69 (5.0)
Communication	31 (2.2)
Leisure	1 (0.1)
Other foci ^b	8 (0.6)

^aMore than one answer could be reported.

^bOpen-ended question including, for example, palliative care, fall prevention, safety alarm, assessment dementia, information about technical aids.

cases (27.7%) the intervention lasted for a maximum of 1 week; for 485 cases (32.9%) the intervention lasted between 1 and 3 weeks; for 265 cases (19.1%) the intervention lasted between 4 and 6 weeks; for 116 cases (8.3%) the intervention lasted between 7 and 9 weeks; and for 167 cases (12.0%) the intervention lasted 10 weeks or more. There were no significant differences regarding the duration of the intervention in relation to age ($p = 0.443$), gender ($p = 0.195$), or level of functioning ($p = 0.265$), Table 1. When the duration of the intervention was dichotomized, there was no difference in relation to age ($p = 0.372$), gender ($p = 0.763$) or functional limitation ($p = 0.111$). However, a larger proportion of cases with major functional limitations tended to receive the intervention over a period of 7 weeks or more (22.2%) compared to those with no home care (16.9%) and those with minor functional limitations (19.1%).

Discussion

As aimed to be explored by the present study, the results reveal that the composition of the occupational therapists' interventions in the context of reablement varies in relation to age, gender, and level of functioning. The level of functional limitation was the only factor that could explain differences related to the focus of interventions.

In a recent study, Zingmark, Evertsson and Haak [21], the results show that the foci of interventions mainly were on needs related to indoor mobility and self-care whereas needs related to social participation were addressed for only a small proportion of all cases. In the present study, there were several

important results that show the importance of thinking about aspects of age, gender, and level of functioning.

Age

Clients 80 years or younger received more contacts than clients of higher age. Even though the difference was small, it is relevant to discuss the impact of age on the composition of occupational therapy interventions. Adding to this discussion, a larger proportion of older clients also had major functional limitations which could potentially require a more extended intervention. Based on our data, we cannot draw any conclusions on why this difference exists or what impact it might have. Fewer contacts, however, indicate that the opportunity to address a wider range of activities such as a focus on social participation and activities outside the home is limited. It has also been shown that people value participation in social activities while growing older [22]. Further, Lee et al. [18] show that the older you are, the more important social participation is for health. Thus, the older you are, the more important it is to think about social participation, but our results do not show this. Reablement is often described as targeting people at risk of functional decline and at risk of losing independence [23]. Thus, by being sensitive to older persons' own goals with maintained physical functions such as walking outdoors the overarching long-term goal should include enhanced possibilities for social participation. Accordingly, a limited number of contacts challenges possibilities to enable social participation. Our results indicate that the OT must reflect on the number of contacts in relation to which type of goals can be addressed. While the initial goals mainly seem to be focused on ADL, subsequent goals could address other facets of occupational engagement such as leisure and social participation [23]. A stepwise approach towards participation in out-of-home contexts is well in line with what older people consider important [8,10]. In addition, the link between occupational engagement and positive effects on a range of health outcomes [24,25] further underlines the importance that occupational therapists' interventions acknowledge the potential to extend their focus beyond basic needs. A health economic modeling study provides further support that a more extended intervention, that potentially addresses a broader range of needs and resulting in larger effects, can be justified given the relatively small cost of the

intervention compared to other societal costs affected by the intervention [26].

Gender

In 88–92% of all cases, the intervention included a maximum of 6 contacts for men as well as for women. Tuntland et al. [20] found that gender and level of functioning had an impact on reablement outcomes such as activity performance and satisfaction with that performance. In Tuntlands' study, women seemed to benefit more than men from reablement interventions. Also, Lee et al. [18] found that the influence of self-related health on social participation, defined as taking part in group activities or other social activities the past year, is more notable among people 65 years or older, especially among women. Even though our results might be a sign of that men and women are equally treated in the Swedish context. Our results reveal that a larger proportion of men received more contacts (12.2%) than women (8.3%) ($p=0.052$) (Table 1). Thus, our results indicate a further emphasis on women's needs and wishes for interventions focussing on social participation.

Functioning

Our results show that most interventions in the context of reablement focus on the basic need for all cases (Table 1). These results are in line with Doh et al. [16], showing that functionality is the most essential feature of reablement and that functional independence is the main goal of reablement. Further, our results show a higher proportion of the cases having no home care and with minor functional dependency, got interventions with a focus on social participation, compared to cases with major functional dependency, and the number of contacts was different (Table 1). Thus, these results indicate that the severity of functional limitation has an impact on the focus of the intervention whereas age and gender have not.

The results show that there were no significant differences regarding the number of contacts ($p=0.432$) or the duration of the intervention ($p=0.974$) in relation to the focus of the intervention. One can assume that longer intervention should promote opportunities for an increased focus on social participation and that more contacts, in this case, are about more complex matters that, for example, require more supervision of staff. Further, to get intervention over a longer period, and with more contacts does not mean that the focus

is on 'the right things', that is, what the person wants. Therefore, an interdisciplinary team is important, and that everyone has a clear role and makes clear assessments.

When it comes to functioning in relation to assessment, goalsetting and/or intervention, our results show that walking indoors and self-care were most common, while leisure was the least common (Table 2). This is notable because functional mobility is the most difficult and prioritized occupation among older people who experience a functional decline. Further, that occupational performance problem in outdoor mobility is more common than indoor mobility [27]. The fact that people with functional decline prioritize outdoor mobility, imply that occupational therapists should be aware of this in their assessment, goalsetting and/or intervention, as confirmed by our results. This is in line with previous research on mobility, as several researchers argue that to move around independently in society is important for participation [28,29]. While indoor mobility is highly relevant for the ability to manage self-care and other occupations at home, it is relevant to reflect on how the ability to walk indoors can be transferred to outdoor mobility. If the intervention should be expanded to include additional contacts, the intervention could also target facets of outdoor mobility that could enhance aspects of social participation that are relevant for the client. In addition, the ability to move around in the community enables participation in, for example, leisure and social activities [30,31].

In the present study, we assume that leisure, social contacts, and communication are related to social participation. Our results reveal that leisure was the focus for assessment, goalsetting and/or intervention in only one case of 1392 cases ($<0.001\%$). Sixty-nine cases focus on social contacts, while 31 cases focus on communication (Table 2). Regarding communication, information, and communication technology (ICT) is very important, because it is increasingly part of social participation. Thus, it is difficult to participate in society if you do not use technology and the internet. This implies that even if previous research highlight the importance of more focus on social participation in the context of reablement [3–5] occupational therapists must pay attention to the person's own goals and wishes. It seems like occupational therapists' interventions may require more than one or two contacts. Given that we know the importance of social participation, it is reasonable that occupational therapists should always include how the client's current situation affects her social participation,

and if there is anything that should be addressed through the intervention. An alternative perspective could be that when basic occupational needs have been addressed, a new discussion together with the client could focus on whether other prioritized occupations should be addressed. Thus, initial goal achievement could be the first step of goal achievement, followed by a revised goalsetting focussing on, for instance, leisure and social participation towards supporting the person in living a fulfilling life, also stated as the goal of reablement [23]. The importance of social participation and the ability to build and maintain social relationships is emphasized by the WHO [1]. We believe that occupational therapy interventions have an important role in contributing to social participation by use of the person-activity-environment perspective [32]. Thus, this means that occupational therapy interventions focus on the individual's goals. Accordingly, to prevent individual problems with social participation and social relationships, as stated in the definition of reablement [33], and to consider that the intervention is person-centred. Further, there is a need for a person-centred intervention, but it is also important to know that social participation can have different meanings for men and women.

Limitations

The strength of this study is that the results are based on a comprehensive data collection about interventions performed by an occupational therapist in different Swedish municipalities in the context of reablement, reported by themselves. This is an important contribution since the data consist of specific data on age, functioning and gender-related to social participation. In the present study, data were based on our assumption that aspects such as outdoor mobility, leisure, social contacts, and communication are related to social participation. Therefore, the results in our paper should be interpreted with this in mind. Though, it is important to consider that social participation is a complex concept and an agreement on a common definition is missing [6]. Further, according to Levasseur et al. [6], social participation reflects age, gender but also the persons' sociocultural identity. This means that social and cultural norms must be considered and therefore, could be seen as a limitation in our study. Unfortunately, social and cultural norms are seldom referred to in most definitions of social participation [6]. Since different concepts are used and there were no definitions of different

interventions in the surveys, questions may have been interpreted differently between occupational therapists as well as how they described their actions. For example, if the interventions focussed indoors or outdoors. However, the surveys used were based on a previous study [33] in which similar surveys were developed in collaboration with practicing occupational therapists in the context of reablement.

A limitation is that our data does not include information on whether informal care was given. In the whole sample, it is likely that informal care also was present parallel so municipality home care and for those who were not allocated any home care. The importance of providing support to informal caregivers has been stated, among others [20].

Further studies

Further studies should focus on enabling health and social participation outside the home, taking social and cultural norms into account. Therefore, an interdisciplinary team is important, and that everyone has a clear role and makes clear assessments.

Conclusion

This study found that occupational therapist interventions focussed to some extent on social participation but need to be addressed more clearly in the context of reablement. The results indicate that the severity of functional limitation has an impact on the focus of the intervention whereas age and gender have not.

Authors' contributions

MZ and MH designed, directed the study and collected the data. MZ together with CP were responsible for data analysis. CP wrote the first draft of the manuscript with input from MZ and MH. All authors have been involved in writing up the manuscript and have agreed to the final version.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

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References

- [1] World Health Organization. World report on ageing and health. Geneva (Switzerland): World Health Organization; 2015.
- [2] World Health Organization. Active ageing: a policy framework. Geneva (Switzerland): World Health Organization; 2002. WHO/NMP/NPH/02.8; 2015.
- [3] Seeman T. Health promoting effects of friends and family on health outcomes in older adults. *Am J Health Promot.* 2000;14:362–370.
- [4] Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. *PLoS Med.* 2010;7:e1000316.
- [5] House JS, Landis KR, Umberson D. Social relationships and health. *Science.* 1988;241:540–545.
- [6] Levasseur M, Richard L, Gauvin L, et al. Inventory and analysis of definitions of social participation found in the aging literature: proposed taxonomy of social activities. *Soc Sci Med.* 2010;71:2141–2149.
- [7] Nordbakke S, Schwanen T. Transport, unmet activity needs and wellbeing in later life: exploring the links. *Transportation.* 2015;42:1129–1151.
- [8] Stenner P, McFarquhar T, Bowling A. Older people and ‘active ageing’: subjective aspects of ageing actively. *J Health Psychol.* 2011;16:467–477.
- [9] Bryant LL, Corbett KK, Kutner JS. In their own words: a model of healthy aging. *Soc Sci Med.* 2001; 53:927–941.
- [10] Vik K, Eide AH. Evaluation of participation in occupations of older adults receiving home-based services. *Br J Occup Ther.* 2014;77:139–146.
- [11] Cook AM, Polgar JM. Cook and Hussey’s assistive technology: principles and practice. Baltimore (MD): Mosby; 2008.
- [12] Bigonnesse C, Mahmood A, Chaudhury H, et al. The role of neighborhood physical environment on mobility and social participation among people using mobility assistive technology. *Disabil Soc.* 2018;33:866–893.
- [13] Nilsson I, Blanchard M, Wicks A. Occupational engagement among community dwelling older people: a time-geographic perspective†. *Health Promot Int.* 2015;30:484–494.
- [14] Wilde A, Glendinning C. ‘If they’re helping me then how can I be independent?’ The perceptions and experience of users of home-care re-ablement services. *Health Soc Care Community.* 2012;20:583–590.
- [15] Metzelthin SF, Rostgaard T, Parsons M, et al. Development of an internationally accepted definition of reablement: a Delphi study. *Ageing Soc.* 2020;:1–16.
- [16] Doh D, Smith R, Gevers P. Reviewing the reablement approach to caring for older people. *Ageing Soc.* 2020;40:1371–1383.
- [17] Witsø AE, Eide AH, Vik K. Professional carers’ perspectives on participation for older adults living in place. *Disabil Rehabil.* 2011;33:557–568.
- [18] Lee HY, Jang S-N, Lee S, et al. The relationship between social participation and self-rated health by sex and age: a cross-sectional survey. *Int J Nurs Stud.* 2008;45:1042–1054.
- [19] Magne TA, Vik K. Promoting participation in daily activities through reablement: a qualitative study. *Rehabil Res Pract.* 2020;27:1–7.
- [20] Tuntland H, Kjekken I, Langeland E, et al. Predictors of outcomes following reablement in community-dwelling older adults. *Clin Interv Aging.* 2017;12: 55–63.
- [21] Zingmark M, Evertsson B, Haak M. Characteristics of occupational therapy and physiotherapy within the context of reablement in Swedish municipalities: a national survey. *Health Soc Care Community.* 2020;28:1010–1019.
- [22] Katz J, Holland C, Peace S, et al. A better life-what older people with high support needs value. York (UK): Joseph Rowntree Foundation; 2011.
- [23] Rostgaard T, Aspinall F, Glasby J, et al. New horizons: reablement - supporting older people towards independence. *Age Ageing.* 2016; 45:572–576.
- [24] Fratiglioni L, Paillard-Borg S, Winblad B. An active and socially integrated lifestyle in late life might protect against dementia. *Lancet Neurol.* 2004;3: 343–353.
- [25] Glass TA, De Leon CM, Marottoli RA, et al. Population based study of social and productive activities as predictors of survival among elderly Americans. *BMJ.* 1999;319:478–483.
- [26] Zingmark M, Nilsson I, Norström F, et al. Cost effectiveness of an intervention focused on reducing bathing disability. *Eur J Ageing.* 2017;14:233–241.
- [27] Langeland E, Tuntland H, Folkestad B, et al. A multicenter investigation of reablement in Norway: a clinical controlled trial. *BMC Geriatr.* 2019;19:29.
- [28] Radomski MV, Latham CAT. Occupational therapy for physical dysfunction. Philadelphia (PA): Lippincott Williams & Wilkins; 2008.
- [29] Rosenkvist J. Mobility in public environments and use of public transport: exploring the situation for people with acquired cognitive functional limitations [dissertation]. Lund (Sweden): Department of Technology and Society, Lund Institute of Technology; 2008.
- [30] Polgar S, Thomas SA. Introduction to research in the health sciences E-Book. Amsterdam (The Netherlands): Elsevier Health Sciences; 2011.
- [31] Unsworth C. Community mobility promotes participation for people of all ages and abilities. *Aust Occup Ther J.* 2012;59:1.
- [32] Townsend E, Polatajko H. Enabling occupation II: advancing an occupational therapy vision for health, well-being, and justice through occupation. Ottawa (Canada): CAOT Publications ACE; 2007.
- [33] Zingmark M, Evertsson B, Haak M. The content of reablement: exploring occupational and physiotherapy interventions. *Br J Occup Ther.* 2019;82: 122–126.