THE 15TH EDITION OF THE INTERNATIONAL CONFERENCE
EUROPEAN INTEGRATION
REALITIES AND PERSPECTIVES

# Challenges for Prevention of Falls in Older Age

**Lăcrămioara Mocanu**[1]

**Abstract:** The background papers that underlie this report refer to a considerable body of evidence indicating the effectiveness of a number of interventions for falls prevention. These include strength and balance training, environmental modification and medical care aimed at removing or reducing specific risk factors by for example review of medications and reduction of polypharmacy. Falls prevention advice is often perceived as being for other 'disabled or elderly people'. Programmes that are perceived to impact negatively on self-image are likely to be unattractive while those, which are viewed as improving skills or characteristics valued by older people, are likely to be more popular. In interviews older people say that they would participate in falls-prevention initiatives to be proactive in managing their own health needs, maintain independence and improve confidence.

**Keywords:** older age; prevention; polypharmacy

## 1. Changing Behaviour to Prevent Falls

The background papers that underlie this report refer to a considerable body of evidence indicating the effectiveness of a number of interventions for falls prevention. These include strength and balance training, environmental modification and medical care aimed at removing or reducing specific risk factors by for example review of medications and reduction of polypharmacy. The systematic reviews, evidence syntheses and meta-analyses are well referenced in the briefing papers to be found at the following WHO URL: http://www.who.int/ageing/projects/falls_ prevention_older_age/en/index.html.

**b) When offering or publicizing interventions, promote benefits that fit with a positive selfidentity**.

It seems that many older people do not acknowledge falls, for example because of fear of:

• negative stereotyping;

• beliefs that falls are an inevitable and unavoidable consequence of ageing;

• embarrassment about loss of control.

Falls prevention advice is often perceived as being for other 'disabled or elderly people'. Programmes that are perceived to impact negatively on self-image are likely to be unattractive while those, which are viewed as improving skills or characteristics valued by older people, are likely to be more popular. In interviews older people say that they would participate in falls-prevention initiatives to be proactive in managing their own health needs, maintain independence and improve confidence. (et, 2006).

[1] Associate Professor, PhD, Faculty of Communication and International Relations, Specialization Psychology, Danubius University of Galati, Romania, Address: 3 Galati Blvd., 800654 Galati, Romania, Tel.: +40372361102, Fax: +40372361290, Corresponding author: lacramioaramocanu@univ-danubius.ro.

Older people value strength and balance training activities for their potential to:

• maintain functional capabilities and thus avoid disability and dependence;

• enhance general health, mobility and appearance;

• be interesting, enjoyable and sociable. (et, Older people's views of falls-prevention interventions in six European countries. The Gerontologist, 2006 ).

Uptake of falls prevention interventions may be enhanced by emphasizing the positive benefits that are likely to accord with desirable self images for older people, in addition to those that reduce fall risks.

**e) Encourage self-management rather than dependence on professionals by giving older people an active role**.

There is strong theoretical rationale in the psychology literature generally to suggest that participation and adherence will be maximized if the older person can choose or modify the intervention. (et, Recommendations for promoting the engagement of older people in preventive health care, Manchester)

**f) Draw on validated methods for promoting and assessing the processes that maintain adherence, especially in the longer term.**

These could include encouraging realistic positive beliefs, assisting with planning and implementation of new behaviours, building self-confidence, and providing practical support. There is substantial evidence for a range of techniques for changing healthrelated behaviour but it is most effective to combine a variety of such approaches. (World Health Organization. Adherence to long-term therapies: evidence for action., 2003). Potentially important ingredients include:

• creating a supportive partnership relationship with the therapy provider;

• providing with good practical support (access and appropriate supervision);

• promoting the belief that the intervention is necessary and effective;

• building confidence in being able to carry out the intervention;

• developing skills for generating and maintaining new behaviours (e.g. goalsetting, planning, self-monitoring, and self-reward);

• tailoring interventions to individual needs.

**Three pillars of the WHO Falls Prevention Model:**

***a)*** *Pillar One - Building awareness of the importance of falls prevention*:

There is a need to build awareness of the importance of falls within all sectors of society that are impacted by falls and fall-related injuries. Awareness building is not restricted to educating individuals and groups about the significance of falls as modifiable risk factors for disabling conditions and increased mortality. It also involves education about the increasing economic and social costs associated with the failure to address falls and fall-risk factors in a systematic manner. Awareness will need to be built within the following constituencies:

*Older persons*

Any strategy to build awareness of the importance of falls and fall prevention must begin with older persons themselves. Many of them are unaware that falls are preventable. In many cultures falling is considered to be a normal, unavoidable consequence of growing older. The WHO Active Ageing

Framework calls for increasing basic-health education and health literacy through a commitment to lifelong learning about health and disease prevention.

*Family and caregivers*

Both informal and formal caregivers have a critical role to play in building awareness about the importance of falls and falls prevention. It is especially important to provide family members, peer counsellors and other informal caregivers with information and training on how to identify risk factors for falls and how to act to decrease the likelihood of falling among those at greatest risk. It is also critical to ensure that formal caregivers are fully familiar with the latest evidence related to the assessment, prevention, and treatment of falls.

*Youth and young adults*

Any active-ageing strategy that strives to be effective in reducing the prevalence of chronic diseases and disabling conditions will need to adopt a life course perspective. This is especially important in the area of falls and falls prevention because many of the individuallevel determinants, which predispose a person to be at risk for injurious falls, begin to manifest themselves early in life.

*Community*

The majority of older persons grow old in their own homes and in the communities, they have lived in for most of their lives. Accordingly, it is important to educate all sectors of these communities about the importance of a proactive, evidence-based strategy for reducing falls. Building awareness of risk factors for falls at the community level is particularly important because there is evidence that the structure of the physical environment can impact the likelihood of an older person to fall. It can also make the difference between independence and dependence for individuals who live in unsafe environments or areas with multiple physical barriers. These barriers can render older persons more susceptible to isolation, depression, reduced physical activity, and increased mobility problems.

*Health sector*

The WHO Active Ageing Framework recognizes that building awareness and changing the attitudes of health and social-service providers is paramount to ensuring that their practices enable and empower individuals to remain as autonomous and independent as doable for as long as possible. This will increase their awareness and understanding of contemporary research and practices so that they are able to counsel healthy lifestyle practices that reduce falls and fallrelated injuries among men and women of all ages.

*Media*

The media have an important role to play in promoting a positive image of ageing, therefore building awareness among them of the significance of falls and falls prevention is paramount. The media can help by widely disseminating realistic and positive images of active ageing, as well as by sharing educational information on falls and falls prevention strategies.

***b)* Pillar Two – Improving the identification and assessment of risk factors and determinants of falls**

There is a growing appreciation that a complex combination of individual-level, community-wide, and societal factors influence the probability of falls and fall-related injuries among older persons. Although the evidence bases regarding how best to identify and assess the various risk factors and determinants for falls is growing, there are many areas where information is lacking and improvements are needed. A systematic multisectoral strategy for reducing falls and fall-related

injuries will require concerted efforts to improve assessment and identify critical determinants in each of the following domains:

*Health and social services*

Convenient and affordable access to health and social services can greatly impact an older persons' likelihood of experiencing a fall or fallrelated injury. Health and social services should be structured in such a way as to routinely screen older persons for knownrisk factors for falls. Health professionals should be trained to use evidence-based protocols and procedures that help to identify those individuals who are at the greatest risk.

The WHO Active Ageing Framework notes that health and social services need to be integrated, coordinated and cost-effective.

*Behavioural*

There is a growing appreciation that a number of important behavioural factors impact older persons vulnerability to falls and their likelihood to seek treatment or care for falls and fall-related conditions. Many older adults incorrectly believe that it is too late to change their behaviour and adopt a healthy lifestyle in old age. Others experience a significant fear of falling that greatly limits their activity choices, reduces their independence and decreases their engagement in society. It is not sufficient to simply educate older adults about the importance of falls and falls prevention, it is also crucial to assess their readiness to change their lifestyles and adopt preventative and/ or rehabilitative therapies.

*Personal*

There are many personal or individual-level risk factors and determinants that can influence an individual's likelihood of experiencing a fall. In any comprehensive falls prevention programme, effective evidence-based strategies will need to be developed to screen for and identify individual-level risk factors known to be associated with an increased risk for falling. Accurate identification of individual-level risk factors and determinants can greatly increase the likelihood of selecting an appropriate prevention or treatment strategy that is targeted to meet the needs of the individual older person.

*Social*

Older persons who have suffered from fall-related injuries and others who experience a fear of falling can often become isolated and disengaged from the community. Any comprehensive falls prevention programme will need to recognize and acknowledge the critical role that social support plays in providing opportunities for older persons to fully participate in society. The WHO Active Ageing Framework recognizes that opportunities for education and lifelong learning, peace, and protection from violence and abuse are key factors in the social environment that enhance health, participation and security as people age. Loneliness, social isolation, illiteracy and a lack of education, abuse and exposure to conflict situations greatly increase older people's risks for disabilities and early death. Inadequate social support is associated not only with an increase in mortality, morbidity and psychological distress but a decrease in overall health and well-being.

*Economic*

The economic environment, in which an older person lives, can play a profound impact on their health and quality of life. The WHO Active Ageing Framework reminds us that economic factors such as income, work and social protection need to be considered when developing effective strategies in the area of active ageing. All ageing policies must acknowledge the reality of poverty and the impact that

a lot of lack of personal resources has on the opportunities available to an older person. Active-ageing policies need to intersect with broader schemes to reduce poverty at all ages. While all poor people face an increased risk of ill-health and disabilities, older people are particularly vulnerable. In many countries and cultures, older people are, by necessity or choice, continuing to work in the labour force well into old age.

***c)* Pillar Three - Identifying and implementing realistic and effective interventions**

Falls are complex events that are caused by a combination of intrinsic impairments and disabilities which are often compounded by a variety of environmental hazards. Due to the multifactorial nature of falls risk factors and determinants, numerous studies have shown that interventions can be effective in reducing falls in older people by simultaneously targeting several intrinsic and extrinsic risk factors or determinants. Successful multifaceted-intervention programmes have included such components as:

• medical assessment, home safety checks and advice; monitoring of prescription medications; environmental changes; tailored exercise and physical activity; training in transfer skills and gait; assessment of readiness to change behaviour; referral of clients to health-care professionals.

Unfortunately, multifactorial falls prevention interventions can be labour-intensive and expensive both for the individual and the community. For these reasons, decisions regarding whether to implement a comprehensive, multifaceted falls-prevention intervention, or targeted interventions addressing individual risk factors and determinants will need to be made at the local or national level.

*Health management*

There is good evidence that access to appropriate and affordable medical care can significantly impact health and quality of life as well as decrease the likelihood of developing noncommunicable diseases (Ebrahim S, Epidemiology in Old ages , 1996). Because older people are more likely to suffer from a variety of chronic conditions, their access to medical care is especially important and can make the difference between early detection and timely intervention, and delayed and/or non-existent treatment and care.

*Physical activity*

The WHO Heidelberg Guidelines for Physical Activity for Older Persons recommend that virtually all older persons should participate in physical activity on a regular basis. There are well established physiological, psychological, and social benefits associated with participation in physical activity. For healthy older adults at low risk for falls, engaging in a broad range of physical activities on a regular basis is likely to be sufficient to substantially reduce the risk of falling.

In contrast, older adults at higher risk for falls will benefit from engaging in structured exercise programmes that systematically target the risk factors amenable to change and are progressed at a rate that is determined by the individual's capabilities and previous experience with physical activity.

## Concluding Remarks

Quality of Life is an important field for aging as well as for rehabilitation. In both fields, QoLis considered a multidimensional construct composed by several domains referring to the individual and his/her context. In spite of this fact, two main problematic issues have emerged: from a bio-medical perspective QoL is mainly reduced to health, and several health measures have been taken as QoL measures. When several domains were considered, QoL was reduced to the individual's

subjective appraisal of those domains. This panorama determines the existence of a variety of self-report methods assessing QoLcombined with a minority of rating-by-other scales. With some exceptions, QoL measures can be placed in an immature state.

## References

AGE Planorm Europe (Ed.). (2010). *European Charter of the Rights and Responsibilities of Older People in Need of Long-term Care and Assistance*

Arber, S.; Davidson, K. & Ginn, J. (Eds.). (2003). *Gender and ageing*. Maidenhead. UK: Open University Press.

Brunnstrom, F.; Sorensen, S.; Alsterstad, K. & Sjostrand, J. (2004). Quality of light and quality of life – the effect of lighting adaptation among people with low vision. *Ophthalmology Physiology*.

Reyes-Ortiz, Carlos A.; Soham, Al Snih; Loera, Jose´; Ray, Laura A.; Markide, Kyriakos (2004). Risk factors for falling in older Mexican Americans. *Ethnicity & Disease*, Volume 14, Summer.

Hendrie, D., Hall, S.E., Legge, M. & Arena, G. (2003). *Injury in Western Australia: The Health System Costs of Falls in Older Adults in Western Australia.* Crawley: The University of Western Australia.

Carmel, S.; Morse, C. A. & Torres-Gil, F. M. (Eds.). (2007). *The art of aging well.* Amityville: NY Baywood Publishing.

Costa, D. L. (2004). Causes of improving health and longevity at older ages: A review of the explanations. *Genus,* 61(1), pp. 21-38

Ebrahim S, K. A. (1996). *Epidemiology in old age.* London.