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Barriers to Community Integration for Older People in Malaysia: A Qualitative Study from Occupational Therapist Perspectives

Yau Y. Hui, BSc [Student][1]; Nathan Vytialingam, PhD[1]; Sangeeta K. Singh, PhD[2*]

[1]*Perdana University, School of Occupational Therapy (PUScOT), Wisma Chase Perdana, Kuala Lumpur 50490, Federal Territory of Kuala Lumpur, Malaysia*
[2]*Perdana University-Royal College of Surgeons in Ireland School of Medicine, Serdang 43400, Selangor, Malaysia*

[*]***Corresponding author***
Sangeeta K. Singh, PhD
Senior Lecturer, Perdana University-Royal College of Surgeons in Ireland School of Medicine, Serdang 43400, Selangor, Malaysia; Tel. +603 89418646, ext 182; Fax. +603 89417661; E-mail: sangeetakaur.sran@gmail.com

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ABSTRACT

Introduction
Existing research has addressed the importance of community integration (CI) and its benefits of dwelling in a community but has yet to address the methods and efficiency of improving these activities among older people. Thus, it is vital to understand how healthcare workers can integrate the benefits of CI among older people, especially with the use of occupational therapists (OTs). The latter are actively working to improve ageing individuals mobility within the community.

Objective
This study aims to identify Malaysian OTs' perspectives on CI's and its implication on older people.

Method
Occupational therapist from different states of Malaysia participated in a semi-structured interview, through a virtual medium (Zoom Cloud Meetings). The interview guide encapsulated the theory of critical incident technique (CIT).

Results
Thematic content analysis, over fourteen participants from 13 states of Malaysia, provided insights into CI's barriers for older people in Malaysia. The findings revealed that multifaceted factors from an individual, organisational and socio-environmental perspective limit older people's active CI engagement.

Conclusion
South-East Asia hierarchal and collectivist culture play a significant role in influencing all factors of CI. OTs must understand and incorporate appropriate cultural norms during CI practice development for the older population in Malaysia.

Keywords
Occupational therapist; Critical incident technique; Older people; Community integration; Qualitative study; Societal norms; Cultural norms.

INTRODUCTION

Our world's population is ageing at an accelerated pace. South-Eastern Asia has one of the fastest paces of the growing ageing population. The population aged 65-years and above doubled from 6% in 1990 to 11% in 2019.[1] Similarly, in Malaysia, the population aged 60 and over has doubled from one million in 1970 to 2.2 million in 2017. By 2040 the Malaysian population is projected to increase by 40 million, of which 7 million will be aged individuals[2]—labelling us as the "ageing nation".[3] Apart from the population growth, aged are also living longer. Therefore, it is essential to ensure that the older Malaysian well-being is are of the utmost priority. It is undeniable that older individuals are less healthy than the young ones; this is concerning since there are only 40 geriatrics and 2000 occupational health specialist in the country. Thus, emphasising the need for prevention focused on promoting a better quality of life- such as work, retirement, income, housing, family, community and leisure activities. In addition to this, as de-

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scribed in the World Health Organization (WHO), World Report on Ageing and Health, 2015 social change, filial piety and ageing has also weakened in the 21st century. The rise of smaller families and the younger generation's migration have left a detrimental impact on older people. Burdens such as sharing physical, emotional and financial responsibilities of an aged parent, have left older people facing social exclusion, isolation, poverty and abuse.

Background of Study

In these transitioning times, individuals are diverting from reliance on family or institutional care for older persons because they want to work or care for themselves. Thus, specific consideration is needed to meet older persons' needs to ensure that environments are accessible, including homes and public spaces, such as building workplaces and transportation, to improve their socialisation factor. One such consideration is community integration (CI). CI refers to how people can live independently, participate and socialise in their community.[4] Shaikh and Kersten[5] introduced the latest CI model through a conceptual analysis of 33 articles, including the five prominent CI frameworks.[6-10] They summarise CI as an intervention that enhances an individual's ability to be independent to experience a sense of belonging within the community. When such intervention is applied, an older person will enjoy mobility within the place they live in, continue to be socially connected and psychologically adjusted into the community. Occupational therapists (OTs) are already fostering this intervention in their approach to enhance a meaningful occupational activity such as leisure or productive activities among the older population.[5]

The evidence on CI currently elaborates primarily on younger demographics or people with specific health conditions such as acquired brain injury, people with intellectual disabilities, people with spinal cord injuries, and mental illness rather than older people.[11-17] These health conditions are also evident among the ageing population. Who faces various anatomical and physiological changes with an added complication of a slow recovery rate. These physical changes can often lead to disabilities and impairments within the elderly population. For instance, deteriorating health conditions mentioned above could lead to chronic pain that results in life on a wheelchair. Such restrictions can limit mobility and strength, along with cognitive impairments. The older population may face CI challenges due to various medical conditions or experience different transitions throughout their life course. Lifecourse changes in later stages can impact negatively on older person's physical and mental health. Changes such as the death of a spouse or friend, retirement, migration of children, psychological problems, change in social and economic status, social discrimination such as ageism and some realising that their days are coming to an end.[13,18-21] These forms of numerous factors can impact social, financial, psychological and physical change. The fact that one has to go through a process of adjustment in later life stages highlights how CI can help the ageing population.

Stav et al[22] in their systematic review of occupational engagement and health outcomes of the community-dwelling older adults, concluded that the core of occupational therapy practises lies in using engagement in occupation in the community to promote well-being and prevention of illness. As the definition of healthy ageing transitions from a medical model to "the process of developing and maintaining the functional ability".[23] OTs play a primary role in facilitating and identifying factors regarding older people's ability or inability to participate in the community. We notice that various CI attributes highlighted by authors Shaikh, Kersten[5] fell in the similar territory of the person-environment-occupational-performance (PEOP) model. Based on the PEOP model, OTs are often required to view clients holistically. OTs must take into account internal (such as psychological, cognitive, physiological factors) as well as external conditions (natural and built environments, social support, social culture and values) that may hinder or facilitate older person participation in purposeful activities.[24] This form of integration is possible since OTs training prepares them with the knowledge base of various conditions and impairments with specific attributes to address modifiable behaviours of the older persons habits or routines which may impact their physical health and wellness.[25] Such interventions are beneficial for the growing number of the elderly population, and it helps with lowering public healthcare burden.[22] Thus, there is a need to ensure continuous capacity building activities among healthcare workers, who should have adequate knowledge to cope and equip with information on who to refer their patients to manage their patients efficiently.

Within the Malaysian healthcare context, there is a lack of information on the support OTs provide and their ability to enhance elderly integration back into the community. There is evidence within the Malaysian context, indicating the meaningful community engagement improves an older person's quality of life.[26] Therefore, this study aims to capture Malaysian OTs' perspectives on integrating CI's and its implication on older people.

METHODOLOGY

A qualitative approach was applied to integrate critical incident technique (CIT) that captures rich, in-depth perceptions and experience of OTs in Malaysia. This approach helped formalises the interpretation of OTs experience of facilitating older people integration into the community. Purposive sampling was applied to recruit 14 OTs from 13 states in Malaysia. The state of Selangor had two OT representatives as it is the state with the highest population.[28] The participants were distinguished based on their location (state) and their practice area (private practice, government hospital setting, or private hospital setting). Study team applied stringent selection criteria on the recruitment of participants. For instance, selected qualified participants had a minimum of one-year working experience with older people. Online interviews were conducted from August to September 2019. The interviews lasted for 20-30-minutes and were recorded through the Zoom application. Researchers applied thematic content analysis to reflect critical incidents finings which addresses study objectives.[27] The study findings are based on all nine CIT credibility checks developed by Butterfield, Maglio[29] as listed: audiotaping interviews, interview fidelity, independent extraction of a critical incident, exhaustiveness of themes, participation rates, placing incidents into categories by

an independent judge, cross-checking by participants, expert opinions, and theoretical agreement. This research has been approved by the Perdana University Internal Review Board (IRB) committee (PU IRBHR0224).

RESULTS

The average age of participants was 32.1, whereby the average years of work experience between these individuals is 8.5-years. Thematic findings were divided into three main categories of factors. These themes are described in Table 1.

Table 1. *Summary of OTs Perceptions of Barriers to Community Integration of Older People in Malaysia*

Factor	Barriers
Individual related factors	• Lack of volition of older people • Complex medical condition of older people • Lack of awareness of older people • Self-consciousness
Organisational factors	• Lack of resources • Administrative restrictions
Socioenvironmental factors	• Lack of awareness among family members • Lack of cooperation of family members • Overprotective family

Individual Related Factors

Lack of volition of older people: OTs define lack of volition as a lack of willingness, motivation, interest, or refusal to participate in the tailored intervention actively. Mainly OTs identify individual factors that limit an older person to engage in CI actively. Some OTs reported that the time allocated for intervention is spent on persuading the older person to participate in the intervention, mainly due to a lack of motivation. Furthermore, OTs have also reported that some older clients leave sessions or activities before completion. This form of limitation is described as a huge limitation that inhibits OT to complete the therapy process; these stunts progress. An example of this is quoted below (P12008).

"…*when we have activities, in a group, there are those who are interested and those who are not. So those who are not interested would usually go home earlier*" (P12008).

Complex medical condition of older people: Due to various medical conditions, it becomes increasingly difficult to motivate the clients as their health deteriorates. Participant P12013 quoted the following as a barrier.

"… *when they are in pain, especially chronic pain, they are reluctant to come out and join the community. So, I feel that this is an obstacle for an OT or the caregiver. How do we encourage such individuals to actively take part while they are experiencing physical pain…*" (P12013)?

OTs report that increased doctors, clinic, and surgery appointments correlate to the older person's ability to participate in therapy due to lack of time or mobility issues.

Lack of awareness of older people: Awareness here is defined as understanding the importance and benefits of being engaged in meaningful activity or community interactions. As for the social factor, family or caregivers seem to play a vital role as well. For instance, OTs reported that older people assume that it is their children's familial obligation to care for them; therefore, they do not need to be independent or integrated into the community. This is expressed in the following quote from P05511 participant.

"… *the older people here feel like their sons and daughters should take care of them… a common response is: "Oh. I raised my kids so that they can care for me now. So why do I need to do these things myself?*" (P05011).

OTs also states that the older population hold firm cultural beliefs, in contrast to the modern understanding that it is beneficial to be actively involved within the community. A quote to express such a notion from participant P07006 is noted below:

"… *she (the older person) used to be a housewife who cared for many of her children; therefore, she stayed home most of the time… I think she grew up with the concept that women stay at home. Therefore, she 'doesn't feel the need to go out*" (P0700).

Self-consciousness: In this case, OTs define self-consciousness as older people being conscious or afraid of how the public or loved ones view them. They either do not wish to see others deemed "more capable" than them or do not want to let others know that they are less capable. This was captured in a quote by participant P13006.

"… *due to the fact he feels that ' 'he's not the same as other (abled) individuals, he thinks less of himself. He feels inadequate when he compares to others who seemed to look "normal". He feels embarrassed whenever he sees other people staring when he fumbles during a walk or walks with a walking stick. He would rather sit still and be silent instead"…*" (P13006)

This mindset prevents older people from going out into the community and discourages invitation of people to come within their spaces. One OT reported that older people within a nursing home discouraged her from bringing people of a similar age group to visit them. Reasons being that they felt inferior, seeing peers in a better condition than them.

Organisational Factors

Lack of resources: FA large portion of the OTs credited the inability to perform successful CI due to the lack of resources and facilities, such as time, specific equipment, human resources and funding. When faced with a lack of resources, OT interventions are often streamlined, compromising therapy's effectiveness. For example, the OT cannot demonstrate real environment opportunities that improve the mobility aspect by which the patient could apply in their day to day-based activities. It is essential to show how a patient can use the therapy in the comfort of 'patient's home; especially for those who are actively engaged in preparing meals for themselves or to help family members with such preparation. A

participant P05003 expressed such concern in the following quote:

"… *it would be useful to demonstrate the benefits of therapy when it is integrated into the day to day activity that the patient has to do. For instance, a patient claimed that she usually carries out her meal preparation in the sedentary position. Thus, making it difficult to demonstrate safe use of the walker or walking aid to show that she could improve her mobility by moving around the kitchen rather than sitting down to help out or prepare the meals*…" (P05003).

Administrative restrictions: OTs have also reported that they are not empowered to carry out interventions and programs despite believing that it is beneficial for older people. Such empowerment would be helpful, especially in the current situation since most therapeutic, evidence-based approaches require consent from a health professional or a family member's approval.

"… *sometimes therapeutic planning or interventions are delayed or stretched over time because a plan must be proposed to the doctor, followed by and approved. Besides, the family member's approval is needed before this is conveyed to the patient or acted on. At times such delays impact our ability to interact with the patient while they are in the hospital. Limiting our ability to convey or apply any form of the therapy, because the patient is already discharged from the hospital. At times doctor work on their timelines that is rarely communicated with us because we don't have a say* …" (P05017)

OTs' empowerment or streamlining operational guidelines that permit OTs to carry out relevant interventions is critical, especially for community-based activities. For instance, OTs should be allowed to plan and supervise older person visitation to community spaces such as beaches, malls, or even the use of public transportation.

Socioenvironmental Factors

Lack of awareness among family members: Findings also indicate that the family members do not understand the need for the therapy or differentiate the necessary therapy type, which would be beneficial. The following is an example shared by participant P05016, who stated that an older ' 'person's caregiver could be the barrier in ensuring implementation of CI (independence and occupational performance) which could directly benefit the older person.

"… *it depends on whether the sons and daughters also support the therapy and recommendations because sometimes they feel, "oh, ' 'it's (the concept of being independent) not necessary, I can bring Mom out whenever she wants. She'll be in a wheelchair anyway so that I can push her*"(P05016).

Lack of cooperation of family members: Low engagement correlates to lack of family 'members' active participation in the older person's life. An example of this is noted when a family member actively engages in the therapy sessions, older person compliance improves. This result, into meaningful CI engagement. Quote on this example is noted below:

"…*my ' 'client's daughter is not supportive. Whenever I'm conducting my sessions, I'll try to include the daughter. ' 'I'll request her active engagement in the therapy by showing her what and how to apply the learnings from a session on her own when they are at home but instead, she will dismiss the learnings or interactions to concentrate on her handphone*…" (P07001).

These forms of disassociation or lack of active engagement also contribute to the fact that there is no dedicated caregiver among family members. Instead, the family members will select different caregivers based on the type of follow-up or medical need. At times other family members will opt to take the older person to their preferred health professionals.

Overprotective family: OTs reported that at times family members or a caregiver believe there is no need for the older person to engage in any activities. The belief is based on the fact that it is unsafe for the older person to participate in activities such as cooking or driving, thus discouraging involvement in activities or community involvement.

"…*the caregiver is concerned over the safety of the older person, thus carries out all day to day task themselves – for instance, the caregiver will not permit the older person to participate in the preparation of meals actively. At times the caregiver also states that its time consuming to wait around while the older person completes a specific task – it's much faster if I do it myself. So, they prefer promptness in completing the task, which the patient cannot replicate*…" (P06003).

DISCUSSION

The participants of the study identified barriers in CI attributing to individual-related, organisational and socio-environmental factors. Barriers which are linked to the environmental factors and individual autonomy were more prominent than others.[31-34] Such factors were predominantly driven by cultural influences which are critical contributing factor hindering effective CI interventions in Malaysia.

OTs reported that the older people believe that it is their children's familial obligation to care for them; therefore, they do not need to be independent (one of the factors of CI). Such beliefs are generally documented across Asia as cultural norms that reduce the emphasis on independence and places a high interdependence value[33,35,36] These cultural norms are integrated into Asian values of filial piety caring for parents or elders as a sign of respect.[37] In addition to this, older people who had family responsibilities, such as caring for young ones felt the lack of need or desire to participate in community activities.[33] Similarly, it is also specific cultural beliefs that older people are accustomed to, which transitions into a norm. An example of a norm in Asian societies is that women should stay at home in contrast to being out in the community, which causes them to be more isolated.

In the study, OTs reported that older people do not desire to view others who are more mobile than they are, causing them to be self-conscious. This mindset links to a social construct in Asia known as "face". The "face" is the governing force that

influences social interaction based on how one perceives the other person opinion. The "face" is imperative as it determines' 'one's status and position, which is vital in an honour culture society seen across Asia.[38] One of the factors that threaten "losing face"(defined as loss of respect or social status), would be a lack of mobility.[39] Therefore, aspects of CI such as social connection, and sense of belonging and adjustment in the community is reduced to maintain a sense of self-respect rather than "lose face" by drawing attention or care.

The participants' lack of resources in this study is similar to obstacles faced by other OTs,[31,32,40] particularly time and funding. The current findings are based on the number of OTs in the population, as the ratio of OTs per population in Malaysia is 1:20,000 in contrast to the ideal 1:5,000,[41] highlighting the dire lack of OT professionals in the Malaysian context. Therefore, this study's results highlight the significant consequences of how lack of resources can compromise service quality.[40] This study illustrates OTs' inability to provide holistic or community-based interventions, as they are often required to prioritise curative care due to limited resources.[31,32] Without OTs being able to safely simulate scenarios and environments where older people can practice functional skills, CI attributes such as independence, occupational performance and adjustment are challenging to achieve.

A lack of professional autonomy limits the number of interventions that the OTs could provide to the older population. Such limitations, in obtaining approval from medical experts and family members to proceed with specific interventions, often delay the therapy's benefits. These forms of barriers are also echoed by Kronenberg and Pollard,[36] who emphasised that in the Asian context, the medical field's hierarchical concepts regarding medical doctors, who are the authoritative figure who makes the definitive decision inpatient care. OTs in Malaysia and other sub-disciplines in health care, all face similar inpatient care barriers.[42,43] This hierarchical approach is an evident and notable social tendency approach in other studies reported within South East Asia.[44,45] Alternatively, the lack of CI intervention can also be due to the lack of understanding of the OT role proposed by Turcotte and Carrier[31]; 'OT's often integrates and customises interventions gardening or arts crafts to benefit therapy outcomes. Other health professionals or hospital authority who collaborate to maintain older people's quality of life may not understand such interventions' therapeutic benefits, thus tend to decline or disregard such efforts.[31,32]

Family members' knowledge, attitude and perception are crucial as they often heavily influence or take autonomy of decisions regarding the older's medical care. This transfer of authority is a common phenomenon in the current literature.[46,47] This amplifies when family members provide financial support for the older person's medical needs, or when older people no longer have the cognitive capacity to decide for themselves. In such circumstances, the family members then often step in to decide what they believe is right for older people. The strong autonomy of family members can contrast CI's attribute of place to live. For instance, barriers to integrating CI could hinder older persons' homeownership and decision-making on activities they could carry out within the home. The lack of awareness reported in older people is closely related to cultural beliefs of a collectivist mindset or interdependent society of – "*if I can care for the older person, they do not need to do anything*". This mindset directly contradicts CI attributes, and therefore family members see OT services as "unnecessary".

Overprotective behaviour is concerning as OTs identified the older clients as having the potential and capacity to be integrated into the community, but unable to do so due to family members' restrictions. Such restrictions are due to caregivers' resentment towards their caregiving role and the patient's attitude of dependency.[48] These study findings reflect cultural norms documented across Asian countries; societal norms that place the burden on children to care for their parents have resulted in resentment towards caregiving. Thus, older persons' caregiving is seen as the "caring trap" in cultural and social expectations.[49] Undoubtedly, the results of this 'study's highlight the issue of overprotective behaviour in an Asian context and how it directly conflicts with CI attributes such as independence and place to live.

This study finding reflects the fact that multi-facets barriers hinder older person active engagement in CI. Some of the obstacles are a) cultural and ethics, such as the elderly's mindset that reflects cultural norms; b) the social construct of "face"; c) hierarchical social system among health professionals; and finally, d) collectivist culture that leads to family autonomy on the elderly's healthcare and overprotective behaviour of family members. There is a need to increase the general public's awareness regarding the benefits of dignity through independence, which is the first step of promoting CI among the older population. In contrast to the concept of "losing face" that portrays the inability of older individuals or their incapability and valuing dependency upon the family as a sign of filial piety. Instead, the government should enforce a policy that protects a rights-based approach to healthy ageing where the legal, social and structural barriers are protected.

Limitations of the Study

The study explored the barriers to CI from OTs perspective. Unfortunately, there is a limited body of knowledge related to CI factors concerning older people. From an extensive review of the literature, there is little evidence reflecting OTs perspective, especially in an Asian context. The closest comparable research focuses on social participation which reports only one component of CI; consequently, this was used to compare and contrast this study's findings.

Practitioner Implications and Recommendations

Cultural norms have contributed to substantial barriers; these beliefs are also forming the older population mindsets. Furthermore, such beliefs and norms are also seen as barriers of the social construct of "face", that is heavily embedded in the hierarchical social system. Therefore, future research should focus on ascertaining solutions for barriers reflected in this study. Some suggestions include implementing a tertiary education system that trains

prospective healthcare providers to understand the implications of interprofessional behaviour and roles, fortifies structural barriers that impact healthcare access.[50,51] Also, to integrate education on possible psychological interventions for the elderly in overcoming social and infrastructural obstacles.[52,53]

Furthermore, more attention should be in evaluating CI holistically, considering the client's needs and priorities, especially with the new CI model.[5] Lastly, the study notes that no interventions or factors addressed two different CI components, reflecting the sense of belonging and adjustment. More attention and intervention should identify various methods to increase these two factors among the elderly, which should be essential for CI.

CONCLUSION

Healthcare professionals, especially OT, should be empowered to tailor or customise interventions to implement CI for older people in Malaysia. This is imminent since cultural norms are predeterminant factor. As a result of this observation, there are various suggestions for practice and research that incorporate the OTs' experiences in Malaysia succinctly to aid current and future OT practice.

DISCLAIMER

This study finding is the author's statement; hence, views expressed in this manuscript are not an institution or funder's official position.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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