Concept forum

Promoting independence: but promoting what and how?

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ABSTRACT

'Promoting independence' is a central theme of recent United Kindgdom health
and social care policy development but is rarely defined. Instead it is generally
assumed that we know what independence means. Based on a review of the
literature on independence in older age, this paper examines the terms and
meanings. While the most common conceptualisation equates independence with
the absence of reliance on others, for older people themselves independence is a
broader concept that encompasses not only self-reliance but also self-esteem, self-
determination, purpose in life, personal growth and continuity of the self.
Drawing on previous work in the field of health promotion, we therefore put
forward a model that takes older people's views into account and that re-
conceptualises independence as two intersecting dimensions representing levels of
dependence and levels of independence. While dependence equates with reliance
on others, independence can be seen as subjectively self-assessed lived experience.
Thus it becomes possible to combine high levels of dependence with high levels of
experienced or felt independence, a particularly pertinent combination for service
providers. Finally we examine the ways in which independence thus con-
ceptualised can be promoted at the individual, institutional, community and
societal levels.

KEY WORDS – independence, dependence, older people's attitudes, self-
concept, well-being.

Introduction

A central theme of the British government's modernisation agenda for
the health and social services in England and Wales is the concept of
promoting independence for all client and patient groups. This is on the

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one hand linked to a general requirement for services to be more focused on the needs of those using them, and on the other hand to the aim of reducing dependence on resource intensive services through prevention and rehabilitation (Lewis and Glennerster 1996). Social services, in particular, 'must aim wherever possible to help people get better, to improve their health and social functioning rather than just "keeping them going"' (Department of Health 1998). *The National Service Framework* (NSF) *for Older People* reiterates this requirement and is part of the government's agenda to create consistent and raised national standards (Department of Health 2001).

The promoting independence programme was established in 1999 to support the objectives of the modernisation agenda. Between 1999 and 2001 three main grant programmes resourced the initiative: 'Partnership' and 'Prevention' grants linked to the *Modernising Social Services* White Paper (Department of Health 1998), and the 'Carers' grant linked with the strategy report *Caring about Carers* (Department of Health 1999). For 2001/02, the 'Partnership' and 'Prevention' grants were combined as 'Promoting Independence' grants, while 'Carers' grants were separated from the 'Promoting Independence' programme and linked explicitly to the *Carers and Disabled Children Act 2000.* Including the Carers' Grant programme until 2001/02, £885 million was available under the programme during 1999–2002.

In the London Borough of Tower Hamlets, the grant allocations were brought together to resource a 'Promoting Independence' initiative. In the autumn of 1999, the research team at the Institute for Applied Health and Social Policy, King's College London, was commissioned by the 'Promoting Independence Team' to carry out an evaluation of the initiative, focusing on services for older people. While practical and methodological challenges mean that no evaluation is ever likely to be straightforward, in the early stages of our work it became apparent that this evaluation presented a special challenge. As Sixsmith (1986) pointed out, 'independence' is rarely defined. Instead the term is characteristically used in a taken-for-granted, unreflective way, and it is assumed that its meaning is understood. To evaluate an initiative aimed at promoting independence, however, the study required an explicit understanding of the concept.

In search of operational definitions, the published literature on independence in older age was reviewed. The initial trawl revealed extensive work on dependence, but much less on independence. It therefore had to be decided whether it was appropriate to use work on dependence to elucidate independence. It was found, however, that while there might have been a certain rigour in doing so, the terms 'dependence' and

'dependency' are extremely broad, and have 'economic, emotional, physical and domestic' dimensions (Munnichs and van den Heuvel 1976). Their inclusion was therefore likely to cover too much ground in too little detail, and it was decided to limit the review to publications dealing explicitly with independence. To locate relevant material, the *Psychinfo* database was searched for publications from 1966 to 2001. Supplementary manual searches of *Ageing & Society*, *The Gerontologist* and *Age and Ageing* for the previous three years were conducted together with the *International Bibliography of the Social Sciences*.

Despite our decision to focus on independence, as we began to analyse the relevant material it became apparent that the predominant concern of many writers was in fact the absence or avoidance of dependence, in the sense of not having to rely on others to carry out everyday activities. Other writers, however, raised questions about the validity of this conceptualisation. The following section documents and critiques the dominant ideology of dependence in the published literature. Later sections propose a model that separates independence from dependence and seeks to specify the relationship between the two. The final section considers how independence thus reconceptualised might be promoted.

Independence as the absence of dependence?

An early example of the focus on dependence in the literature on independence occurs in what appears to be the only attempt to develop a theoretical model of independence. Paillat (1976) identified three dimensions, namely income, time and activity, and proposed a five-level model typology, from 'dependence' to 'complete independence' (or almost so). Independence is conceptualised in this model in terms of the extent to which dependence is absent.

Turning to perceptions of independence, writers in the service provider literature focused predominantly on the ability to function unaided (Dixon 1991; Oliver 1993). Perhaps unsurprisingly, this focus is reflected in the measures used by clinicians to assess independence amongst older people. Several describe schedules used to measure older people's functioning in terms of their ability to carry out the activities of daily living. Similarly, others describe the use of psychometric assessments to assess levels of functioning and deterioration over time (Dant 1988; Woods 1999).

Although it has face-value resonance, this predominant view of independence, as the absence of dependence in the sense of not being reliant on others to carry out everyday activities, is open to criticism on two

grounds. First, the perceptions of older people make clear that although avoiding reliance on others for help with everyday activities is recognised as an important aspect of independence, so too are choice and the retention of a meaningful social identity and role. In the earliest of the few studies reported, Sixsmith (1986) carried out interviews with 60 older adults to discover what independence meant to them. Three main meanings of independence were identified. Two related to avoiding reliance on others, 'being able to look after oneself' and 'not being indebted to anyone', and the third was the capacity for self-direction, 'that is the freedom to choose what to do'. Similarly in research with older adults, Kaufman (1993) identified several important values, including achievement, success, productivity, work, progress, social usefulness, self-reliance and individual initiative. More recently, Mack *et al.* (1997) found that constructs of positive relations, personal growth, purpose-in-life, autonomy and environmental mastery were evident in 103 North American older people's talk about independent living.

Tanner (2001) interviewed 12 British older people who had been refused a social service on eligibility grounds, and found that, to the people concerned, assistance with daily living activities was bound up with the maintenance of a sense of self. The activities for which they had sought help involved keeping up their personal appearance, house or garden. It was not simply a matter of practicalities, but of ensuring the continuity of self. These richer ideas about independence are beginning to be recognised by other writers, *e.g.* Blakemore and Boneham (1998) stress the importance for independence in older age of roles and dignity and the right to make choices, while Bland (1999) defines the core values of independence as 'privacy, dignity, choice, autonomy and fulfilment'.

The emphasis placed on independence as the absence or avoidance of reliance on others is arguably rooted in an ideology of self-reliance that has become prevalent in the United States and in Britain, and that may have little validity for other cultures. Rose (1989) describes the emergence of this ideology and lucidly demonstrates how post-war psychology and government regulation of our lives have contributed to the internalisation of the ideal of the autonomous, self-actualising individual. As Rose is at pains to point out, this is a result of neither a conspiracy theory nor top-down social engineering. On the contrary, the wish to become self-actualising, autonomous citizens is widespread, because the concerns of psychologists and governments have converged and permeated our consciousness: the majority have become attached to the project of freedom. As a result, we seek to enhance our autonomy of our own free will, for example through the application of the various psychological therapies available. In Rose's own

words, modern western society has reached the point where we are 'obliged to be free'.

In the literature on independence in older age, as Stephenson *et al.* (1999) point out, the cultural construction of the concept is largely neglected. The culture-bound nature of the 'obligation to be free' is, however, brought vividly to life in two accounts of old age from a generation ago:

In America, one must simply not admit that, when one grows old, one will need to lean more and more upon others. In America *no adult* has any *right* to do this. At all costs, the major work must be done, the major values must be acted out. Those who cannot do these things are either 'children' or fools, useless or obsolete. It is the central values of American culture which lay down such alternatives. (Clark and Anderson 1967: 425)

Old people in this country have been influenced by the American ideal of independence and autonomy. The most important thing in the world is to be independent. So old people live alone, perhaps on the verge of starvation, in time without friends but we are independent … It is a poor ideal and pursuing it does a great deal of harm … We have reached the point where we think the only thing we can do for our children is to stay out of their hair … Old people's homes, even the best, are filled with older people who believe the only thing they can do for their children is to look cheerful when they come to visit. So in the end older people have to devote their energies to 'not being a burden'. (Mead 1971: 240–1)

Thus in the United States and Britain self-reliance is highly valued while 'dependency is a sign of weakness, of a lack of a character, or even of sickness'. In other cultures, however, reliance on others is not necessarily viewed negatively. Although perceptions are likely to vary both within and across cultures, research is beginning to emerge which highlights some of the cross-cultural differences in the concept of dependence (Redhorse 1980; Kaufman 1993; Hsu 1972; Hall 2001). For instance, Hsu (1972) notes that Chinese elders do not value self-reliance as highly as their western counterparts and would be proud to be supported by their children. On a similar point, inter-dependence has been identified as an important consideration in working with people from various minority ethnic groups (Hall 2001). How, then, can independence be conceptualised in a way that takes account of the views of older people themselves and of cultural variations in the value attached to self-reliance? In the following section we draw on previous work in the field of health promotion to address this question.

Reconceptualising independence

In the field of health promotion, a similar terminological and conceptual problem arose with the World Health Organisation (WHO 1986)

High
(Subjective assessment/experiential)

D   A

High ◄──────────────────────────────────► Low
(Reliant on others)   Dependence
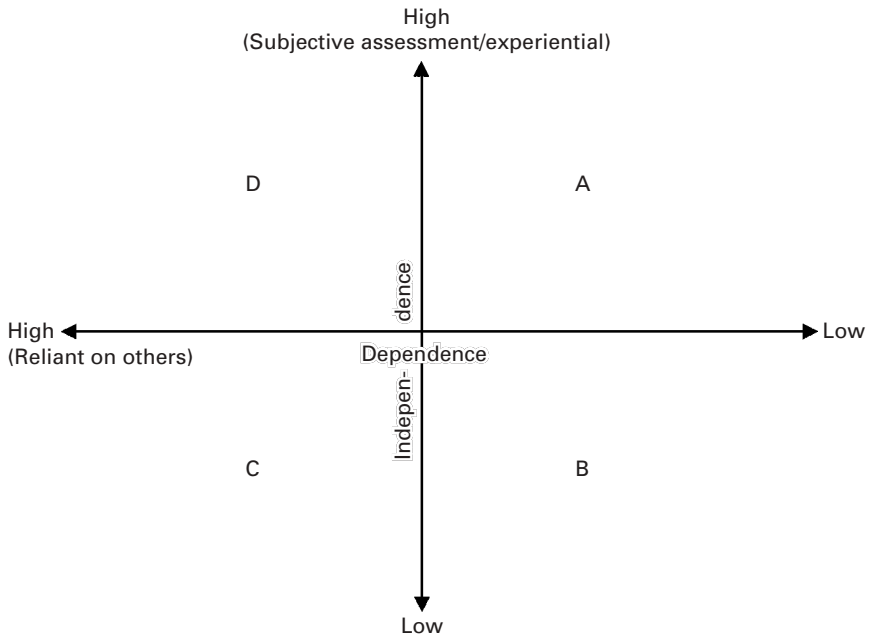
Indepen-   dence

C   B

Low

Figure 1. The two dimension model of independence.

delineation of three distinguishable goals of health promotion practice: positive health, well-being, and the prevention of illness. As with independence, attempts to define health had featured the absence or avoidance of illness, but if health promotion was to involve the promotion of positive health alongside the prevention of illness, a new definition was required. Downie *et al.* (1990) suggested that this could be achieved by conceptualising health and illness not on one continuum, but as encompassing two intersecting dimensions. One represented a continuum from low to high levels of illness, the other from low to high levels of well-being. Thus, while an individual might have serious ill health, even those with a long-term or terminal illness or a disability could and did nevertheless report high well-being.

Our proposition is that a two-dimensional model is appropriate for the conceptualisation of independence, and takes account older people's documented concerns with choice and a meaningful social role. Moreover, it accommodates cultural differences in the extent to which self-reliance is considered desirable. As Figure 1 illustrates, in this model dependence can be defined in terms of the extent of our reliance on other people, or the resources provided by others. Independence, however, is the individual's subjective assessment of whether their lived experience

matches up to the desired level of choice, social usefulness and autonomy, which in turn depends on their psychological make-up, biography, social context and cultural heritage. Fisk (1986: 4) has made a similar suggestion:

The term independence is, of course, relative and overlaps with a host of other factors that are considered important to self-respect and dignity of all, regardless of age. It describes a state of self-determination whereby the individual, with or without the assistance of others and regardless of disability, is able to dictate the path that his or her life should take. It is a state that is determined both by personality and the individual's social and physical environment.

In turn the intersecting axes of the model, representing low to high levels of reliance on others and low to high levels of experienced independence, enable us to locate an individual in one of four quadrants, labelled A, B, C and D.

It should be stressed that as an individual moves through the life course and its sequence of experiences, her or his position in the model changes. In addition, although the axes are depicted as orthogonal, we do not mean to imply that dependence, in terms of reliance on others, is unrelated to the lived experience of independence. As Tanner (2001) has remarked, for some older people in some circumstances the two may be closely related. The model does, however, enable us to think about independence separately from reliance on others, and thus consider the implications for service provision.

Taking each quadrant in turn, people located in quadrant A may be close to achieving the ideal of autonomy explicated by Rose (1989): self-reliant and experiencing a strong sense of independence. Individuals in quadrant B, however, while not reliant on others experience little sense of independence. As Clark and Anderson (1967: 391) vividly illustrate in their study of older adults in America, some older people can become virtual prisoners in their own homes in the attempt to avoid dependency: '[They] draw their curtains to avoid critical appraisals of their helplessness; they will not get enough to eat; they will stay away from the doctor and forego even vital drugs; they will shiver with the cold; they will live in filth and squalor, but pride they will relinquish only as a last resort'.

Older people in quadrant C receive assistance from others and generally have little sense of independence. Those in quadrant D, however, may possess a sense of independence despite their reliance on others, a combination that is of crucial interest for service design and delivery. By recognising that there are people in quadrant D, it is possible to take account of cultural differences in perceptions of self-reliance and interdependence. For example, those Chinese elders who are proud of being cared for by their children can be located in quadrant D, as can those for whom giving

and receiving assistance is reciprocal. In the following section we draw on the literature review to illustrate the ways in which older people's subjective, lived experience of independence can be promoted alongside or in addition to the prevention of dependence.

Promoting independence

The literature review highlighted the part that can be played in the promotion of independence by interventions and initiatives at four levels: by individuals, in institutional care settings, in communities, and in society at large. While it is not claimed that the described interventions and initiatives are an exhaustive list, they illustrate the most relevant problems and innovative solutions at the four levels in turn.

Promoting independence among individuals

At the individual level, the prevention of physical ill health is the primary aim of the promotion of self-reliance amongst older people. It is also a key concern for older people themselves, as the cited studies demonstrate (Sixsmith 1986; Kaufman 1993; Mack *et al.* 1997; Tanner 2001). For our current purposes, however, a central question is whether preventive interventions can be delivered in a way that promotes the older person's sense of independence.

As seen earlier, among the older people interviewed by Sixsmith (1986), 'the freedom to choose what to do' was an important aspect of independence. The evidence about the way in which decisions are made about older people's health indicates however that older people are less likely than other patients to be involved in joint decision-making with health professionals (Dixon 1991; Greene *et al.* 1996; Hardy *et al.* 1999). Some studies find that they are not consulted at all (Minichiello *et al.* 2000). At the risk of stating the obvious, empowering older people to make informed choices about their treatment and care, through discussion and time for reflection, is fundamental to the promotion of a sense of independence. Information about alternatives is also required but rarely provided (Tanner 2001).

While these issues are most relevant in individual consultations, Iliffe and Leniham (2001) describe an innovative approach to involving older people in needs assessment and service planning for primary care. Using a community-oriented primary care (COPC) approach, one general medical practice convened focus groups of older patients to identify the health needs and service requirements: the initiative is now established for needs assessment.

In comparison with the attention paid to physical health in older age, less attention has been paid to mental health (Woods 1999), yet mental ill health is common amongst older people. As Bradbury (1991) points out, older people are subject to the same range of psychological problems as adults of any age and, in addition, are more likely to experience depression through bereavement and chronic illness. Dementia in its various forms affects over two per cent of people aged 75–79 years, and more than eight per cent of people aged 85–90 years (Paykel *et al.* 1998).

Taking the more common psychological problems first, as with physical ill health, these different manifestations of mental ill health can lead to dependence and undermine the older person's sense of independence. Their primary prevention or treatment and care are therefore as important as in the context of physical health. Conversely, theories of learned resourcefulness suggest that cognitive behavioural approaches can promote mental well-being (Zauszniewski 1997). Learnt helplessness is the state in which individuals believe that they have no opportunity or ability to change their lives and enter a spiral of depression (Seligman, 1975). In contrast, learned resourcefulness exists when individuals take charge of their lives and keep anxiety and depression at bay (Rosenbaumn 1988). Cognitive behavioural approaches therefore may well have potential in promoting a sense of independence among individuals.

Turning to people with dementia, most writers who have addressed their independence focus on care in institutional settings (this work is considered later). Some attention has, however, been paid to therapeutic work with dementia sufferers that live in the community that has the potential to promote independence. Teri *et al.* (1999) report that training for their carers reduced depression amongst people with dementia, while cognitive behavioural therapy (CBT) also holds similar promise. For example, Husband (1999) used an adapted CBT approach to help patients with mild cognitive impairment to understand their diagnosis. Although standard outcome measures were not used, Husband reports that the patients benefited from the intervention, in that self-stigmatisation, catastrophisation and social withdrawal were all challenged. Of particular relevance for the patients' sense of independence, Husband concludes that the greatest impact was not on the most commonly accepted outcomes, such as putting one's affairs in order, but on self-esteem and personhood. Work is also appearing that directly focuses on the concerns and perspectives of those with dementia. For example, Reid *et al.* (2001) interviewed 19 people with dementia as part of a project into unmet respite care needs. They found that active listening and imaginative responses enable dementia sufferers to make informed choices about their care and treatment, and promotes a sense of independence.

Promoting independence in institutional settings

For many older people admission to long-term institutional care is a last resort, not least because it is associated both with dependence on others, and with a profound loss of choice and usefulness (Salvage *et al.* 1989; Bland 1999). For some older people, however, this may be the preferred or only viable solution to the problems associated with physical or mental frailty and it is therefore crucial that care in institutional settings is delivered in a way that promotes the older person's sense of independence. Therapeutic contact and service ethos emerge from the literature as key issues.

Therapeutic assistance or treatment for older people living in residential or nursing homes is all too often delivered in a way that undermines independence. Examples include unclear communication, not recognising residents' moods, talking over residents, taking over activities from them, rushing, not taking residents' views seriously, setting tasks that are too difficult or having inappropriate expectations (Clough 1981). Over and above appropriate physical care and treatment, social contact with other people, both staff and other residents, is a key to the provision of opportunities for meaningful activity and personal development – the qualities that older people see as important for their independence (Personal Social Service Council 1975). The evidence from institutional care settings is however that doing nothing or sleeping are the residents' predominant activities, that interactions with staff and other residents are typically minimal, and that so far as staff are concerned they are usually limited to instrumental tasks (Abbott *et al.* 2000).

In their study of 122 older people in residential settings, Abbott *et al.* (2000) found that levels of participation in running the homes were low, but that, where residents were involved, their sense of usefulness and self-esteem were enhanced. While recognising that not all residents wish to be involved, Abbott and colleagues point out that creating opportunities for participation is a first step. Drawing on previous work, they highlight several ways of achieving this, including representation on management bodies and involvement in organisational functions such as staff recruitment.

Several innovative means of overcoming the problems encountered in institutional settings have also been put forward in relation to the care of people with dementia, and these are arguably no less relevant for other older people living in institutional settings. For example, moving the chairs provided in sitting rooms from a traditional 'waiting room' arrangement against the walls into small groups has long been known to increase social interaction (Sommer and Ross 1958; Peterson *et al.* 1997). Maintaining the

arrangement of the chairs, however, invariably proves more difficult than their initial rearrangement, primarily because the practical considerations of ward routine (or 'institutional maintenance') are rated by staff as more important than therapeutic contact. In response to this problem, Lindesay *et al.* (1995) have proposed the '*domus* philosophy' by which the needs of both staff and residents are acknowledged. The idea is considered further when discussing the ethos of institutional care.

Also relevant to therapeutic contact, Kitwood and Bredin (1992) applied person-centred principles of dementia care to service provision using an ethological approach. Termed dementia care mapping (DCM), the approach aims to differentiate care practices that support personhood from those that undermine it, through observation of activity/inactivity, type of behaviour and any personal detractions, *i.e.* negative interventions/situations. In turn, care environments can be assessed in terms of a 'Dementia Care Quotient'. Using evidence from DCM assessments, Kitwood (1997) described two types of care environment, one hierarchical and based on power structures, and the other egalitarian and evincing common goals. On the basis of this evidence, DCM can assist in the development of care environments that promote independence through opportunities for therapeutic contact.

Turning to the service ethos, two tensions in the provision of institutional care are evident from the literature. The first is between the residents' need for therapeutic contact and the staff's concern with institutional maintenance. The '*domus* philosophy' is a means of resolving this tension and is based on four assumptions: that the *domus* is the resident's home for life; that the needs of the staff are as important as those of the residents; that the *domus* should aim to correct the avoidable consequences of dementia and accommodate those that are unavoidable; and that residents' individual psychological and emotional needs may take precedence over aspects of physical care (Lindesay *et al.* 1995). The authors have empirically evaluated the 'philosophy' using an uncontrolled cross-section comparison of two psychogeriatric long stay wards. While acknowledging the study's limitations, they conclude that 'a philosophy of care directed at preventing institutional maintenance is associated with improvements in the residential care for the demented elderly'.

A second tension highlighted by Bland (1999) is the need to balance the promotion of independence with the avoidance of undue risk. On the basis of her case study of a private residential home, Bland argues that the 'service' approach to residents taken at the home and mirroring that found in hotels facilitated the management of risk while at the same time maximising independence. As in many hotels for example, residents who smoked were allowed to do so at any time in their own rooms, while the

risk involved was minimised through the use of fire prevention technology. In contrast, Bland found in local authority homes a tendency to avoid rather than manage risk, for example by banning smoking in bedrooms and controlling residents' smoking materials.

Promoting independence in the community

Care in institutional settings may be the preferred or only viable option for some older people, but the importance to many of remaining in their own home or returning there as soon as possible cannot be over-emphasised. Although undertaken almost half a century ago, Peter Townsend's ground-breaking study of family life amongst older people living in Bethnal Green still provides a vivid account of the concatenation of independence and the home as a repository of memory, continuity and tradition:

Home was the old armchair by the hearth, the creaky bedstead, the polished lino with its faded pattern, the sideboard with its picture gallery, and the lavatory with its broken latch reached through the rain. It embodied a thousand memories and held promise of a thousand contentments. It was an extension of personality. (Townsend 1963: 38–9)

While the relevance of this account for today's increasingly mobile generations may be questioned, recent research has also highlighted the importance of the home for older adults in terms of the 'continuity of memories and experiences the home represents' (Csikszentmihalyi and Rochberg-Halton 1981: 133). Support that enables a person to remain in the community wherever possible is therefore central to a sense of independence and, in this respect, three main themes emerge from the literature: comfort, affection and reciprocity.

In a study of the predictors of entries to institutional care, Steverink (2001) found that both comfort, in terms of the absence of need or pain, and affection, that is, being loved as a person by oneself and others, were crucial. At the risk of re-stating the obvious, it is clear that the provision of domiciliary services, aids and adaptations and support for informal carers are key aspects of promoting independence in the community. Equally, both supporting family and friends as a key source of affection and countering the loss of affection that can result from bereavement through opportunities to meet and make new friends is of central importance.

For older people themselves, though, accepting care in the community, whether from family and friends or from services, can undermine the sense of independence just as much as accepting institutional care, as the potential for isolation in quadrant B of our model illustrates. Tanner (2001) documents how the participants in her study endeavoured to ensure that they reciprocated the care that they received in whatever ways they could,

and points to the role of networks of support for maximising opportunities to engage in reciprocal help. While the needs for domiciliary services, for carers' support and for social activities are well recognised and are the main planks of many community services, less attention has been paid to networks of support.

The social promotion of independence

Fundamental to many aspects of the promotion in our view are two issues that require to be addressed not only at the community level but also more generally in society. These are the allocation of resources to support older people, and ageism throughout society. On the former, the assistance that statutory services provide is often restricted. For instance, the social services team responsible for assessing the needs of participants in Tanner's study deemed that assistance with bathing was unnecessary in the absence of specific hygiene or medical grounds. For the participants, however, personal care was not simply a practical matter but one of maintaining a continuity of self that was closely bound up with their sense of independence (Tanner 2001). Tanner points out that standardised assessment fails to take into account the context that leads people to request a service, and highlights the need for face-to-face assessment interviews that facilitate the development of a shared understanding of context and meanings.

The *National Service Framework for Older People* highlights the link between the allocation of resources and ageism, in that it was triggered by concerns about the widespread infringement of older people's dignity and unfair discrimination in their access to care. The Framework therefore leads with plans to tackle age discrimination and to ensure that older people are treated with respect, according to individual needs (Department of Health 2001). Ageism, however, is clearly a challenge that goes far beyond the provision of services to the social attitudes that underlie discrimination in this respect. Arguably, these attitudes are evident in the focus on dependence in older age that our literature review revealed. As Fisk (1986) and Bytheway (1995) point out, the dependent older person is a pervasive stereotype, while independence is seen as exceptional and even 'darkly impressive' – the sprightly pensioner is both heroic and comic.

While research involving older people is beginning to question accepted stereotypes, Minichiello *et al.* (2000) show that negative social attitudes are internalised by older people, and impel them to dissociate from 'old age' by struggling to maintain the appearance and self-perception of independence. In this respect, Tanner (2001) welcomes the growth of social movements initiated by older people, because they are inspired not by the rejection of a negatively-perceived identity but by a shared awareness

of disadvantage. Political strength might therefore be gained through embracing and reconstructing an 'aged' identity that acknowledges both diversity and a common cause.

Conclusion

The literature review revealed discordance between the predominant view of independence, as the absence of dependence in terms of not being reliant on others, and the concerns of older people themselves, not only to avoid dependence, and with having choice and maintaining a meaningful social identity and role. Moreover, the value attributed to avoiding dependence appears to be embedded in an ideology of self-reliance that may have little validity for other cultures. It has been argued that by re-conceptualising independence in two dimensions, that encompass high and low levels of both dependence and independence, one takes into account both the concerns of older people and cultural variations in the value attached to self-reliance. The model also has therapeutic value, in that it encourages us to think about the ways in which health and social services can promote older people's subjective sense of independence.

Turning to how this can be achieved, the literature provided examples of interventions that are widely recognised as important and that, in some cases, constitute the main planks of policy and service provision. These include the prevention of physical ill-health, the provision of aids and adaptations in the community, the provision of domiciliary and intermediate care services to avoid long-term institutional care, opportunities for social contact in the community, and supporting informal carers in continuing to provide both physical care and affection. Also well-recognised, but less widely operationalised, is the need for institutional care, when unavoidable, to be founded on a person-centred ethos, whether derived from a specific philosophy, as proposed by Lindesay *et al.* (1995), or from a more generalised 'service' approach.

Other interventions identified from the literature are less well recognised but appear promising, although as O'Carroll (1999) pointed out, much more evaluation is required in this field to guide policy and practice. Promising interventions at the individual level include the use of cognitive behavioural therapy with older people including those with dementia, and joint decision-making with professionals. At the community level, creating and maximising opportunities for older people to engage in reciprocal networks of support might make a valuable contribution. Finally, at the societal level, equitable access to services based on assessment processes that take into account the older person's context and meanings is also

required. To achieve this will involve challenging the stereotypes that underpin ageist attitudes. Supporting the growth of social movements within which older people can embrace and reconstruct their own identity may be the most potent means to that end.

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