Perceptions of disabled workers' transition from worker role to retiree: Narrative review; The perceptions of ageing disabled workers confronted with the transition to retirement

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Perceptions of disabled workers’ transition from worker role to retiree: Narrative Review.

Research Project:
The perceptions’ of ageing disabled workers confronted with the transition to retirement

Name: Naomi Goods
A report submitted in Partial Fulfilment of the Requirements for the 
Award of Bachelor of Science (Occupational Therapy)(Honours), 
Faculty of Computing, Health and Science, 
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September 2009

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Acknowledgements

I would like to express my gratitude to the people who assisted in the completion of this project. First, I would like to thank my supervisor Associate Professor Jeannine Millsteed who provided encouragement, guidance and support during the research and completion of this project. I am also grateful for my co-supervisor Dr. Sonya Girdler’s guidance and support with this honours thesis. For providing vital information during the initial phase of researching this topic I would like to thank Caleb Goods from Curtin University, and Pam Thornton from Edith Cowan University. This thesis would not have been possible without Darrell Andrews from Westcare Industries who provided current industry information which assisted in keeping the literature and focus of this study grounded to the issues affecting business services. Also Westcare Industries for allowing access to their workers and interviews with them to take place during work hours. Foremost, the participants who volunteered to express their thoughts and concerns for this study regarding transitioning to retirement which was integral to the project. Finally my parents and partner Zane whom supported me throughout the year.
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Perceptions of disabled workers’ transition from worker role to retiree: Narrative Review

Name: Naomi Goods
Abstract
The disabled working population is ageing creating a need for transitional programs in supported employment. Limited research in this area makes it difficult to design programs which adequately address their needs which affects the quality of service provision. A review of Scopus, CINAHL, MEDLINE, PsycInfo and ISI Web of Science databases was conducted. Outcomes of interest were studies looking specifically at perceptions of disabled workers in supported employment making the transition to retirement. Due to the dearth of information on this topic studies focusing on non-disabled populations or disabilities though injury or illness were included. Major findings suggest when workers perceive their input into retirement transitions as limited it can affect their health and well-being in retirement. Understanding the disabled workers’ perceived change form worker role to retiree will assist in establishing more effective bridging programs during this transitional stage. Occupational therapists can play an important role in enabling the disabled workforce to age in place and enjoy active and fulfilling lives during their retiree years.

Naomi Goods
Supervisor: Associate Professor Jeannine Millsteed
Co-Supervisor: Dr. Sonya Girdler
August 2009
Background

Participation in the workforce for people with disabilities has been historically challenging (Morris & Lloyd, 2004; Winn & Hay, 2009) and barriers associated with gaining access to the workforce have been researched widely (Kennedy-Jones, Cooper, & Fossey, 2005; Martorell, Gutierrez-Recacha, Pereda, & Ayuso-Mateos, 2008; Winn & Hay, 2009). Disabled workers gain employment from both business services, which provide paid employment for people with disabilities who have high support needs (Centrelink, 2008a), and the open employment market, where disabled workers compete for positions with the general population (Centrelink, 2008b). For the purpose of this review unless otherwise specified the disabled worker will refer to individuals with psychiatric, physical, intellectual or sensory disabilities (Centrelink, 2008a).

The Australian Bureau of Statistics (2003) estimated 20% of the population has a disability. Having a disability, sickness or injury is one of the most common reason for retiring secondary to reaching the eligibility age for the pension or having adequate superannuation funds (Australian Bureau of Statistics, 2008). Although the Australian government encourages people to remain in the workforce until 65 years of age (Amies, 2008) the average retirement age is 52 years (Australian Bureau of Statistics, 2008). This is markedly lower than the governments’ preferred age for retiring and may be a result of premature retirement due to disability, sickness or injury.

Making the transition from work to retirement is a major milestone in life. The transitional path to retirement can occur as a gradual withdrawal from the workforce or as an immediate departure. A gradual withdrawal is common for the general population (Australian Institute of Health and Welfare, 2007) and is favoured by potential retirees (Onyx & Baker, 2006). Having the option of phasing retirement (or partial retirement), can theoretically increase productivity, reduce sick leave and have a positive effect on well-being and health (Walters, 1988). Sometimes the option of phasing retirement is not available which can be due to a number of factors including for example, poor health (Szinovacz & Davey, 2005). Premature retirement can be contributed to by factors other than poor health such as pressure from others. Pressure from external sources such as employers or doctors is common, while pressure from a partner is more common for women (Australian Institute of Health and Welfare, 2007).
Issues surrounding transitions to retirement for the working population have been examined widely by policy makers (Amies, 2008; Australian Institute of Health and Welfare, 2007; Quine & Carter, 2006). As the population ages a large portion of disabled workers are progressing towards the transition to retirement. This ageing workforce in supported employment has the potential to reduce viability of business services. This would be directly contributed to by increased health and safety concerns, support and compliance costs and reduced productivity of workers impacting on sales and margins (Donne, 2008). With 49% of disabled people participating in the Australian workforce (Australian Bureau of Statistics, 2006), research on this population appeared to be limited. A greater understanding of the occupational desires and needs of disabled workers transitioning to retirement is needed for occupational therapists to adequately assist them during this transition.

The objective of this narrative review was to investigate the perceptions of the disabled worker making the transition to retirement. The first section reviews studies which specifically look at making the transition from work to retirement. The Model of Human Occupation (MOHO) (Keilhofner, 2008) will be used as a framework for explaining the complexity of factors which can contribute to transitioning to retirement. The final section will discuss the factors based on MOHO which can affect transitions to retirement and the need for further study.

**Theoretical Framework**

MOHO assists in explaining the bridging process that needs to occur during the transition to retirement. MOHO “seeks to explain how people choose, organise and orchestrate their occupations to maintain lifestyles within particular environmental contexts and over their lifespans” (Farhall et al., 2007, p. 40). Using MOHO’s subsystems of volition, habituation, performance capacity and environment assists to frame the issues that are important considerations during transitions to retirement. Table 1 identifies the inter-related factors under MOHO’s subsystems that can affect the transition to retirement for disabled workers.
Volition is the process which occurs when anticipating, choosing, experiencing and interpreting what is being done (Keilhofner, 2008), which is an integral part of participating in life’s activities. Habituation refers to the routines which are consistently carried out and exhibited through a person’s roles and habits (Keilhofner, 2008). Factors directly related to habituation are expected to be highly affected during the transition to retirement due to changes in roles which take place. Performance capacity refers to both objective and subjective factors which affect a person’s ability to participate in life’s activities (Keilhofner, 2008). One’s performance capacity is expected to be a major contributor to beginning the transitional process to retirement for disabled workers. MOHO’s environmental subsystem not only refers to built and natural environments which a person lives in but also the social, cultural, economic and political factors which affect a person’s occupational performance or participation (Keilhofner, 2008). MOHO creates a holistic framework to approach the transition to retirement for disabled workers. A review of the literature based on MOHO therefore encompasses all areas potentially effecting transitions to retirement for disabled workers.

Methods

Search Procedures

Five databases were electronically searched to identify and locate relevant studies for inclusion. Each database was searched from its earliest record (Scopus from 1983, CINAHL
from 1995, MEDLINE from 1983, PsycInfo from 1972 and ISI Web of Science from 1995) to June 2009, this was due to the dearth of information available on the topic. The main search terms used were ‘transition’, ‘adaption’, ‘retirement’ and ‘disability or disabled’. With the assistance of a librarian, all terms were truncated, explored and adjusted to match the specific database being searched. Reference lists of all retrieved relevant studies were manually searched, along with publication histories.

**Inclusion Criteria**

A priori criteria for inclusion of studies were applied first to abstracts, then to the full text articles if the abstracts provided insufficient information. Outcomes of interest were studies looking specifically at perceptions of disabled workers in supported employment making the transition to retirement. Studies were included if the participants were of working age and were limited to published literature in English. Conference proceedings were not searched. Studies focusing on children and life histories were excluded. Due to the dearth of literature on transitions for disabled workers to retirement studies focusing on non-disabled populations or disabilities though injury or illness were included. This enabled an expansion of the workers’ perspective and identification of differing issues across the ageing workforce. A narrative review was undertaken to summarise findings and provide an assessment of methodological issues.

**Results**

Electronic searches located 50 articles from Scopus, 10 from CINAHL, 15 from MEDLINE, 22 from PsycInfo and 31 from ISI Web of Science for a total of 128 potential articles. Using the stated inclusion criteria, titles, abstracts and reference lists were reviewed for inclusion. This resulted in 10 articles that related to the objective. The research methods and data collection tools for each study are summarised in Table 2 (See Appendix A p.27).

Overall, the methodological quality of the studies ranged from adequate to strong. Five studies were non-experimental designs based on interviews or surveys (Balandin, Llewellyn, Dew, Ballin, & Schneider, 2006; Hodges & Luken, 2006; Jonsson, Borell, & Sadlo, 2000; Lawrence & Roush, 2008; Rosenkoetter, Garris, & Engdahl, 2001). Two studies were pre-experimental designs (Ashman, Suttie, & Bramley, 1995; Hodges, Luken, & Hubbard, 2004) and two were quasi-experimental designs (Heller, Factor, Sterns, & Sutton, 1996; Mahon &
Goatcher, 1999). The final study consisted of a two part design, one was pre-experimental and the other a randomised control trial (Laughlin & Cotten, 1994).

The focus of studies involving retirement transitions were largely devoted to preretirement planning (Heller et al., 1996; Laughlin & Cotten, 1994; Lawrence & Roush, 2008; Mahon & Goatcher, 1999; Rosenkoetter et al., 2001). Of the ten studies only two focused their data collection on interviews to gather information on perspectives of retirement from people with disabilities (Balandin et al., 2006; Hodges et al., 2004). The majority used questionnaires (Ashman et al., 1995), assessments (Mahon & Goatcher, 1999) or information gathered from non-disabled people (Hodges & Luken, 2006). Studies focused on psychiatric or physical disabilities were limited as the majority of literature was based on people with intellectual disabilities (Laughlin & Cotten, 1994; Lawrence & Roush, 2008). The factors that people with other disabilities encounter during the transition from work to retirement remains largely unknown.

Overall, the issue of transitioning from supported employment to retirement for disabled workers is complex and can be affected by many factors. Many of these factors do not appear to have been fully investigated or analysed from the disabled worker’s perspective. Only in doing this can retirement bridging programs be effective in assisting disabled workers to enjoy successful retirements.

Discussion

Transitions to Retirement

For the general population the transition from working life to retirement is a major milestone in life. The level of education and type of work in which a person is involved can influence the timing of retirement (Dahl, Nilsen, & Vaage, 2000). Being unprepared for this transition has been associated with increased stress and reduced life satisfaction in retirement (Marshall, Clarke, & Ballantyne, 2001). Disabled workers have a higher vulnerability of unpreparedness for retirement due to their decreased opportunities in career prospects (Ozawa & Hong, 2003). Other issues with transitioning to retirement for disabled workers, particularly in supported employment, is their reluctance to partake in the transition as it may result in their placement being lost. This makes it difficult to return to work if the choice to retire is not perceived as satisfactory (Hodges & Luken, 2006). There is an ethical and moral obligation for workplaces
with disabled workers to prepare their employees for the transition to retirement (Wadsworth, Harper, & McLeran, 1995).

**Habituation**

**Financial Preparation**

Research into the financial preparation people with lifelong disabilities make for retirement appeared to be limited. For the disabled population financial barriers have been reported across the life span (Dalton & Ong, 2007; Hodges & Luken, 2006) and typically continue into retirement due to the void work leaves and reduced income to fill this void (Hodges & Luken, 2006). Disabled workers are reportedly concerned with the reduction in income upon retiring (Ashman et al., 1995; Mahon & Goatcher, 1999) however no studies appear to have investigated the extent this affects retirement transitions. For people with disabilities, acquired through injury or illness, income status was influenced by occupation, education and marital status rather than disability (Ozawa & Hong, 2003). People with life-long disabilities have reduced opportunities to gain higher education, increased paying occupations (Ashman, Suttie, & Bramley, 1993) and find partners and therefore typically have reduced income capacities in retirement (Ozawa & Hong, 2003). The financial barrier associated with retirement, due to loss of income, has been reported as one of the most common restrictions in social participation (Hodges & Luken, 2006; Mahon & Goatcher, 1999; Messent, Cooke, & Long, 1999). For disabled workers the restrictions on income associated with giving up work has been perceived as a negative incentive to retire (Ashman et al., 1993, 1995; Mahon & Goatcher, 1999). The full effect of reductions in income capacity for disabled workers making the transition to retirement does not appear to be known and therefore needs to be investigated further.

**Leisure and Recreation**

Transitioning to retirement can leave a void in time use, once filled by work. Involvement in leisure and recreational activities during and transitioning to retirement is important (Hawkins, 1993a) as it can reduce this void and is strongly associated with life satisfaction (Hawkins, 1993b). Volunteering has also been suggested as a way to fill time and therefore reduce social isolation (Balandin et al., 2006). Volunteering was perceived positively by most disabled workers however training has been reported to be necessary to support them making the transition to volunteering (Balandin et al., 2006). Barriers to participating in leisure and
recreational activities have included staffing problems regardless of accommodation status (Messent et al., 1999), environmental and social support (Hawkins, 1991) and limitations in supported employment services (Janicki, 1992). This included loss or changes in friends when transitioning between programs such as supported employment and leisure-based programs, and fewer opportunities to obtain assistive services during transitions to retirement such as preretirement counselling (Janicki, 1992). Overall, disabled workers appear to have a reduced capacity for leisure participation during retirement transitions.

For disabled workers, admittance to services that offer leisure activities such as day centres can be difficult. This is due to services often being made available to current system users who have changing needs due to ageing (Bigby, Balandin, Fyffe, McCubbery, & Gordon, 2004), which makes access for new clients such as those transitioning from work to retirement potentially difficult. The staff within these services require education on the capacities of the ageing population (Hodges & Luken, 2006) and this has the potential to reduce stigma associated with many disabilities (Hodges et al., 2004). Participants in these services can range in age from 24 to 90 years which can result in inappropriate mixes of age groups (Bigby et al., 2004). Stigma and stereotypical views have created a fear that if retired workers are accepted into centres they would not be accepted by the participants of the service (Hodges & Luken, 2006), thus creating a trend towards services being segregated.

Day centres which implement individualised planning, flexibility and choice into their programs have shown the greatest outcomes for people with disabilities (Bigby et al., 2004). Participation in community programs is important as it has the potential to enhance social inclusion and give access to active ageing programmes. Social inclusion or participation in social activities has been associated with happiness in retirement (Calvo, Haverstick, & Sass, 2007) and can reduce the likelihood of poor health in later life for people with disabilities.

Disabled workers have indicated control over issues affecting their lives, participating in meaningful roles and maintaining choice in leisure options were important (Buys et al., 2008; Hawkins, 1991). Ageing disabled workers voiced a preference towards continuing involvement in activities which gave them pleasure rather than discontinuing them (Buys et al., 2008). Alternative findings have suggested older individuals participated in fewer activities and people with Down syndrome were less likely than the older individuals to both initiate new activities and participate in current ones (Hawkins, 1993b). This suggests
participation in leisure activities may be influenced not only by age (Hawkins, 1993a) and gender (Onyx & Baker, 2006) but also by the individual’s disability. Research on leisure participation appears to be primarily based on people with intellectual disabilities therefore further research into leisure participation of people with other disabilities is needed.

Gender Differences
The differences men and women make when transition to retirement has been inconsistently reported. Some research indicated reasons for retiring were similar across genders (Onyx & Baker, 2006) while others suggested women were more influenced by life events, for example, death of a spouse (Szinovacz & Washo, 1992) and men were more influenced by age (Dahl et al., 2000) in the decision to retire. Once retired, men have consistently been described as identifying hobbies as a means to fill time (Hershey, Jacobs-Lawson, & Neukam, 2002; Rosenkoetter et al., 2001) whereas women frequently identify self-orientated activities (Hershey et al., 2002; Onyx & Baker, 2006). Overall, for the general population, activities which dominate people’s lives upon retirement are influenced by gender, a finding which is not unexpected given the other influences gender has across the lifespan (Turner & Helms, 1995). The issue of gender difference should be considered for all people regardless of disability status when designing pre-retirement planning programs.

Pre-Retirement Planning
While research on disabled workers transitioning to retirement appears limited, research based upon planning for retirement dominates the literature for both the disabled and general ageing population. Pre-retirement planning has shown varying results for well-being based on differing factors. For the general population satisfaction and well-being in retirement can be influenced highly by discussing retirement planning with a spouse or friend (Noone, Stephens, & Alpass, 2009). Aspirations focused on self-development also influenced well-being which highlighted the importance of having meaningful personal goals in retirement planning (Lapierre, Bouffard, & Bastin, 1997).

The brokerage model of program planning has a greater application than traditional age-integration day programs for the ageing disabled (Bigby, 2005). The brokerage model uses organisations already in place and assists in individualising planning. The use of services already in place which are not specific to disabled workers’ needs have, however shown staff within these services can have low expectations and stereotypical views of ageing people
which produces barriers to participation (Bigby et al., 2004) and can affect well-being in retirement. Research based in the United States suggested disabled workers need organisations to use imagination and expertise to provide choices and opportunities during retirement transitions (Sutton, Sterns, & Schwartz Park, 1993). Evidence has suggested including the disabled worker in the decision making process is highly important (Sutton et al., 1993) for individuals making the transition.

Planning early for the transition from working life to retirement has been reported to have a beneficial impact for all people (Hodges & Luken, 2006; Jacobs-Lawson, Hershey, & Neukam, 2004; Llewellyn, Balandin, Dew, & McConnell, 2004). Having a pre-determined age where retirement planning would be implemented (Hodges & Luken, 2006), much like planning for the transition from school into the workforce (Winn & Hay, 2009), could benefit supported employment programs to assist workers to make well-informed decisions. Not only should retirement planning begin from early working life but it should also involve practical activities such as goal setting (Hershey, Mowen, & Jacobs-Lawson, 2003) and have involvement from recent retirees (Llewellyn et al., 2004). Research has consistently indicated pre-retirement planning should focus on personal goals and exploration of needs and be more client-centred in focus.

Leisure planning for the general population in pre-retirement programs has shown to result in positive expectations for retirement (Taylor-Carter, Cook, & Weinberg, 1997). For disabled workers, however some reports have indicated an increase in disabled worker’s knowledge on retirement options, but not in their attitudes or life satisfaction in regard to retirement (Heller, Miller, Hsieh, & Sterns, 2000; Laughlin & Cotten, 1994). Others, however, have found pre-retirement planning has positive impacts on life satisfaction and leisure participation (Mahon & Goatcher, 1999). The variations in effectiveness of pre-retirement planning for people with disabilities can result in skills such as choice-making not being generalised into other areas (Heller et al., 1996). Overall, there is an indication that retirement planning needs to be highly tailored to the specific population participating in the program (Hodges & Luken, 2006; Llewellyn et al., 2004).

Evidence has suggested earlier involvement from stakeholders could result in more effective transitions for disabled workers (Hodges & Luken, 2006). In contrast to pre-retirement programs some have suggested intensive time-limited supports are more effective than group
programs to assist with transitions to retirement for disabled workers (Hodges et al., 2004). The most influential factor for a satisfying and successful retirement has been reported to be the worker being involved in the decision to retire (Sutton et al., 1993). Further research is needed on specific factors which make programs successful for disabled workers is needed to increase the effectiveness of pre-retirement planning programs.

**Volition**

**Choice**

For the general population the impact choice has when deciding to retire has been highlighted as important for well-being in retirement (Calvo et al., 2007; Quine, Wells, de Vaus, & Kending, 2007). When choice is not present during the transitional stage to retirement depressive symptoms increased (Szinovacz & Davey, 2004). The factors associated with perceptions of forced or premature retirement were health limitations, job displacement, care obligations (Szinovacz & Davey, 2005) and poor working conditions (Krause et al., 1997). These conditions included not only physical and organisational aspects of work environments, but reduced job satisfaction and poor social support at work (Krause et al., 1997).

To reduce feelings of lack of control over the decision to retire, it has been recommended workplaces assist workers to find alternate employment opportunities (Szinovacz & Davey, 2005). The overwhelming influence of choice in retirement for the general population highlights the importance of retirement planning programs to broaden their scope from financial readiness to more holistic approaches to retirement (Sharpley & Layton, 1998). For disabled workers the impact of choice on retirement transitions has been posited to assist with greater happiness in retirement, which is also influenced by good health and social inclusion (Calvo et al., 2007). Further research into the effects choice has on disabled workers transitions to retirement is needed to ensure greater well-being in retirement.

**Attitudes towards retirement**

The perceptions of the ageing workforce towards retirement have been widely researched in the general population. Many baby boomers (born between 1946 to 1965) from lower socioeconomic circumstances are unprepared for retirement believing the government should support them in this time (Quine, Bernard, & Kending, 2006). This perception is reportedly based on the belief of having inadequate time to accumulate sufficient superannuation funds
to finance their retirement (Quine et al., 2006). Feelings of preparedness are considered crucial during the years leading to retirement irrespective of whether a person has a disability (Laughlin & Cotten, 1994).

Maintaining worker roles upon retiring either through staging retirement (Jonsson & Andersson, 1999) or through new occupational roles regarded as work (Hillman & Chapparo, 2002) is reportedly common in the general population. Western society values the identity associated with a person's occupation and being involved in the workforce therefore many people are reluctant to relinquish this role entirely (Jonsson et al., 2000). Likewise people with disabilities value work (Inman, McGurk, & Chadwick, 2007; Kennedy-Jones et al., 2005) which has resulted in a negative or hesitant attitude towards retirement (Ashman et al., 1993). This was due to concerns associated with loss of income and friendships upon ceasing work (Ashman et al., 1993; Hodges & Luken, 2006; Mahon & Goatcher, 1999). Many people with disabilities reported finding it difficult to comprehend retiring, stating they felt too young to retire (Mahon & Goatcher, 1999). Retirement was, however, perceived positively by people with intellectual disabilities if they felt prepared (Laughlin & Cotten, 1994), although those who had made the transition did not report their lives as unhappy (Ashman et al., 1993). Retirement has also been described as an exciting venture leading to lifestyle changes and opportunities for trying new things (Mahon & Goatcher, 1999). Literature on disabled workers’ perceptions of retirement were primarily based upon the intellectually disabled. Information on how the disabled workforce as a whole perceives the transition to retirement appears to be limited. Studies on factors disabled workers perceive they need in order to feel prepared were not found, suggesting a need for research within this area.

**Performance Capacity**

**Ageing with a disability**

Changes in institutions and health care services has seen an increase in older age survival rates for people with disabilities (Janicki, 1992). The perception that people with disabilities age prematurely is unsupported by the literature, with the exception of Down syndrome (Bigby, 2000; Janicki, 1992). People with mild to moderate intellectual disabilities have similar life expectancies to the general population (Adlin, 1993; Bigby, 2000). Life expectancies of people with Down syndrome are continuing to rise from approximately 55 years in 1993 (Janicki, Dalton, Henderson, & Davidson, 1999) to nearly 60 years recently.
Health complications are common in this population, 40% are likely to develop Alzheimer’s disease or dementia. Other complications people with Down syndrome encounter are hearing loss, thyroid disease, sleep apnea and heart disease (Adlin, 1993). Comparatively people with severe and profound intellectual disabilities have shortened life expectancies. Whilst those with life long histories of using anti-seizure medication for epilepsy, have an increased risk of osteoporosis (Adlin, 1993).

The effects of ageing on people with cerebral palsy have not been widely studied, age related decline generally occurs with speech (Adlin, 1993) and respiratory problems (Blair, Watson, Badawi, & Stanley, 2001). Research on the age-related decline of people with psychiatric disabilities appears to be limited. Advances in medications such as atypical antipsychotics however, has seen improvements for many people with psychiatric disabilities (Ames & Ritchie, 2007). Declining health is often a contributing factor for workers to make the transition to retirement (Sutton et al., 1993; Szinovacz & Davey, 2005).

In the United States causes of death in the disabled population are becoming more aligned with that of the general population and are less associated with poor living conditions and limited access to medical care (Janicki et al., 1999). This highlights the need for health care to focus on prevention and health maintenance (Ashman & Suttie, 1996a; Janicki et al., 1999) to achieve the greatest outcomes. Common problems with health maintenance for intellectually disabled people are associated with negotiating health systems, seeking medical assistance, communicating problems and understanding treatment instructions from health professionals (Adlin, 1993; Ashman & Suttie, 1996a; Edgerton, 1994). Overall, prevention and health maintenance should be the focus for disabled workers as early intervention could prevent complications and poor health practices (Ashman & Suttie, 1996a; Janicki et al., 1999).

Promotion of healthy ageing within the disabled population should be focused around social networks and community-based supports (Bigby, 2008a). Poor social networks reduce the ability for community inclusion as people age. The opportunity of healthy ageing and social inclusion in later life has been associated with greater happiness in retirement (Calvo et al., 2007). A greater cohesion of services and advocacy by professionals would therefore better provide for the needs of people with disabilities as they age (Buys & Rushworth, 1997; Hodges et al., 2004).
Neglecting the healthcare needs for disabled workers transitioning to retirement would increase pressure on government spending (Amies, 2008). Early estimates for the general population (who do not have informal carers) requiring greater government support predict the Australian government’s spending on aged care to rise from 3% to 9% by 2050 (Amies, 2008). If good health and active ageing programs are not promoted within the ageing population, particularly for disabled workers, this is predicted to impact on government spending in the long term (Amies, 2008).

**Environment**

**Government and Institutional Support**

The difficulty with the disability workforce ageing and transitioning to retirement is the so-called ‘underlap’ in services available to them. Services available from disability services often are not appropriate because their expertise does not spread to age-related issues such as premature dementia. Likewise, the aged-care services cannot deal with disability specific issues (Bigby, 2008a; Buys & Rushworth, 1997). In Australia this ‘underlap’ in services for ageing disabled workers often results in people with intellectual disabilities using the nationally funded aged-care services rather than the state-funded Disabilities Services Commission (Bigby, 1998). For the ageing population with psychiatric disabilities similar issues with transitioning between services exists (Ames & Ritchie, 2007). It has been reported that no organisations providing assistance to people with disabilities had specialised services for the ageing disabled population (Buys & Rushworth, 1997). The gaps in services have also reportedly reduced the capacity of ageing people with disabilities to ‘age in place’ resulting in earlier institutionalisation and loss of natural supports for many people with disabilities (Bigby, 2008a).

Care facilities are reported to have a cultural trend towards a reduction in social participation and choice in care (Ashman & Suttie, 1996b). Occupational therapy services in Australia have identified effective strategies for working with older adults with intellectual disabilities such as; advocating for clients during transitions, enhancing quality of life through choice and reducing environmental constraints (Llewellyn, 1991). Greater cohesion of services and advocacy of professionals to better provide for the needs of people with disabilities (Buys & Rushworth, 1997; Hodges et al., 2004) has been highlighted. This may initially be a time-
intensive task, but in the long term result in greater independence (Hodges et al., 2004) in retirement for disabled workers. This is likely to reduce early institutionalisation for those who fall through the system of support (Buys & Rushworth, 1997) allowing disabled workers more support and choice upon retirement whilst living within the community.

**Social Support**

The social supports of disabled workers are reported to be of primary importance for maintaining successful transitions throughout the lifespan. As disabled workers age, however, their social supports often age too and social services are reportedly inadequately suited to assist them (Doka & Lavin, 2003). Having poor social networks reduces the ability of community inclusion as people with disabilities age, people with intellectual disabilities can be involved in community day programs but have limited advocacy and friendships outside this formal setting, which can reduce social inclusion (Bigby, 2008b). Unlike many negative stereotypical views many ageing people with intellectual disabilities experience considerable personal growth, via experiencing increased autonomy and independence while transitioning not only from the workforce but also from family care (Bigby, 1997).

Relinquishing care of a family member with a disability can have negative impacts on family members who have a lifetime of expertise in their care (Grant, Nolan, & Keady, 2003). This can result in a loss of a valuable resource for the disabled worker. After the death or declining health of a parent caregiver the disabled worker can have limited choice in this occurring. Siblings can often be required to take on a caring role, the long-term effects this can have on the relationships between siblings over time appears to have limited research (Dew, Balandin, & Llewellyn, 2008). Few families make concrete plans for the future care of their family member with a disability, which requires more explicit private and public responsibilities in long-term care of older adults with intellectual disabilities, in particular the sibling role (Heller & Factor, 1994). Families require support programs to be put in place to assist in the care of their ageing family member with a disability. The importance of a strong social network for disabled workers transitioning to retirement can impact greatly on satisfaction in this stage. It has also shown to impact social inclusion such as in leisure-based activities (Messent et al., 1999) and housing options (Heller & Factor, 1994). Evidence suggests that people with disabilities cannot build or maintain social supports without the assistance of caregivers or professionals (Bigby, 2008b).
Accommodation

The transition to retirement can mean an increase in autonomy and social opportunities for people with disabilities (Bigby, 1997) when coinciding with a transition from parental care. Living with ageing parents can result in restrictions in social participation for many people with disabilities often due to caring responsibilities and interdependent relationships (Bigby, 1997). As a result, moving from their care, often as a consequence of the parents’ poor health or death, can increase their opportunities for social participation. Conversely, if this transition involves moving from their supportive neighbourhood, it can result in reduced social support including friends and informal supports such as neighbours (Bigby, 1997).

Once retired, the prospect of staying in the home in which the disabled worker has grown up may no longer be a reality. The aged-care accommodation services can be inappropriate (Bigby, 1998) for retiring disabled workers. Criticisms of the appropriateness of aged-care accommodation for people with disabilities have included: tendencies toward nurturing dependence, offering unstimulating milieus, staff having reduced knowledge and understanding of the person’s disability and residents being much older than the person with a disability (Bigby, 1997). The concept of grouping people with intellectual disabilities in nursing facilities while it has positive impacts on leisure participation (Bigby, Webber, Bowers, & MaKenzie-Green, 2008) should be done with caution. Grouping has the potential to fracture community supports if the person with a disability is moved too far from the community they have been involved in over a lifetime (Bigby et al., 2008). Studies of the general population have found that transitions in living arrangements are not only influenced by a reduction in health or death of a spouse but also unbalanced exchanges in relationships (Wilmoth, 2000). An unbalanced exchange in relationships has the potential to contribute to earlier institutionalisation of ageing people (Wilmoth, 2000) with disabilities.

The ability to adapt to changes in residential environments requires increased individual, family and friend involvement (Jacobson & Wilhite, 1999). Training or education is needed for both staff and residents in supported communities in tasks such as choice making or maladaptive behaviour (Young & Ashman, 2004) for better outcomes in well-being. The effect of a person’s accommodation on factors such as participation and perceptions of freedom have shown to affect life satisfaction. Disabled workers have shown reductions in life satisfaction ratings following pre-retirement planning programs (Heller et al., 1996). This was reported to be due to the restrictions associated with their accommodation status and their
new found knowledge of the opportunities available within the community to which they have limited access (Heller et al., 1996). This indicates the importance of disabled workers having not only the knowledge and access to services within the community (Heller et al., 1996) but also the opportunity to ‘age in place’ which is provided to the general population.

**Summary**

This narrative review has synthesised the limited available research in the area of transitions to retirement for disabled workers. A large portion of information in areas such as the influences of finance, choice, leisure interests and preparation or planning requirements remains unknown. This in turn affects the quality of service provision and makes it difficult to design programs which adequately address the issues confronting disabled workers making this transition. When the worker perceives their transition to retirement as forced or their input as limited, this can have negative effects on their health and well-being in retirement (Szinovacz & Davey, 2004). Further research is required into the perceived role change from worker to retiree for disabled workers to understand the extent of the barriers and enablers (Keilhofner, 2008) during this major milestone in life. Understanding these perceptions will assist with developing client-centred strategies for goal attainment and healthy ageing. Assisting disabled workers to make the transition from worker to retiree would reduce the negative impacts this can have on health when the transition is not facilitated well (Messent et al., 1999). It may also assist in reducing early institutionalisation due to people ‘slipping through’ the system of support (Buys & Rushworth, 1997). Overall, more effective service provision during this stage of transition has the potential to reduce long-term spending in both government and private sectors. This review has highlighted the need for occupational therapy service provision to remain client-centred in focus when addressing the issues the disabled worker encounters during transitions to retirement.

The general population desires quality of life, health and well-being in later life (Buys et al., 2008), these aspirations for later life can be expected within the disabled worker’s desires. A greater understanding is needed of what the disabled worker perceives retired life to be like and the activities that may assist him/her in gaining quality of life, health and well-being. This would assist in building more effective bridging programs to assist with the transition to retirement.
Key Findings

- Disabled workers are concerned with the reduction in income upon retirement
- Disabled workers should be included in the decision to make the transition to retirement
References


### Appendix A

#### Table 2. Summary of Articles

<table>
<thead>
<tr>
<th>Study details authors/ study aim</th>
<th>Age range (years)</th>
<th>Disability</th>
<th>Method</th>
<th>Informant/s</th>
<th>Findings</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashman, Suttie and Bramley 1995. Discover the number of people employed and retired at 55 years of age and over and the attitudes of the employed towards work and retirement.</td>
<td>55+</td>
<td>Intellectual disability</td>
<td>Questionnaire</td>
<td>People with disability</td>
<td>Retirement presents unwanted and unknown challenges for the participants currently working who had concerns about loss of income and friendships. Indicates a need to expand pre-retirement programmes.</td>
<td>446 (Western Australia and Queensland)</td>
</tr>
<tr>
<td>Balandin, Llewellyn, Dew, Ballin and Schnwider 2006. To determine barriers and opportunities in undertaking voluntary work for employees in supported employment</td>
<td>45-69</td>
<td>Stroke, visual impairment, intellectual, physical and psychiatric disabilities</td>
<td>Structured Interviews</td>
<td>People with disabilities</td>
<td>Volunteering perceived positively and as a way to reduce isolation and loneliness. Need for training and support to participate.</td>
<td>14</td>
</tr>
<tr>
<td>Heller, Factor, Sterns and Sutton 1996. To examine the effectiveness of a later life planning training program for adults with intellectual disabilities, staff and family members.</td>
<td>35-87</td>
<td>Intellectual Disabilities</td>
<td>Later Life Planning Inventory, Inventory for Client and Agency Planning and Later Life Curriculum Test</td>
<td>People with disabilities</td>
<td>Participants had a decrease in life satisfaction ratings primarily due to reduced satisfaction with their residential settings. Participants also had greater involvement of families and more individualised goals in service planning.</td>
<td>42 intervention group 38 comparison group*</td>
</tr>
<tr>
<td>Study details authors/ study aim</td>
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</tr>
<tr>
<td>Hodges, Luken and Hubbard 2004. To document the three year process of an older adult with autism and depression making the transition to retirement with the assistance of a recreational therapist.</td>
<td>55</td>
<td>Autism</td>
<td>Case study and structured interview</td>
<td>Person with disability</td>
<td>Time-intensive support assisted in less professional support over time. Participant benefited from individual supports more than pre-retirement classes.</td>
<td>1</td>
</tr>
<tr>
<td>Hodges and Luken 2006. To determine the perceptions of stakeholders to enhance retirement choices for older adults with developmental disabilities.</td>
<td>45+</td>
<td>Developmental disabilities</td>
<td>Focus groups</td>
<td>Family members, vocational providers, senior service providers and one potential retiree</td>
<td>Need for a culture of retirement for adults with developmental disabilities, education of stakeholders and a reduction in structural barriers. Highlights the need for preretirement planning for adults with developmental disabilities.</td>
<td>26</td>
</tr>
<tr>
<td>Jonsson, Borell and Sadlo, 2000. To explore retirement as an occupational transition</td>
<td>65-66</td>
<td>N/A</td>
<td>Interview</td>
<td>Recent/transitoning retirees</td>
<td>New occupations did not always fill the void in time made when retiring from work. Participants found they spent more time on daily tasks they previously rushed rather than taking up new occupations. The perspective of slowly going 'downhill' was held by many retirees.</td>
<td>29</td>
</tr>
</tbody>
</table>
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</tr>
</thead>
<tbody>
<tr>
<td>Laughlin and Cotton 1994. Identify attitudes towards retirement among adults with intellectual disabilities and effect of pre-retirement planning.</td>
<td>50-72</td>
<td>Intellectual Disability</td>
<td>Questionnaire, Pre-retirement Knowledge and Preference Assessment and Life Satisfaction in the Elderly Scales</td>
<td>People with disabilities and non-disabled workers from supported employment</td>
<td>Preparedness for retirement and general life satisfaction was strongly related to attitudes towards retirement. Preretirement planning was found valuable in teaching retirement options to people with intellectual disabilities but did not change attitudes towards retirement or life satisfaction.</td>
<td>Questionnaire 75 disabled 75 non-disabled Experimental 15 Control 15</td>
</tr>
<tr>
<td>Lawrence and Roush 2008. Describe the preretirement and related services available to people with intellectual disabilities 60 years and over in Ireland.</td>
<td>60+</td>
<td>Intellectual Disabilities</td>
<td>Survey</td>
<td>Irish Intellectual Disabilities Services</td>
<td>Bridging programs for the transition from work to retirement should begin early to allow people with intellectual disabilities sufficient time to explore their options. Services should be individualised in focus.</td>
<td>122 organisations</td>
</tr>
<tr>
<td>Mahon and Goatcher 1999. Assess the effectiveness of leisure education-based later-life planning model for people with intellectual disabilities.</td>
<td>Mean age 58 (experimental group) Mean age 62 (control group)</td>
<td>Intellectual disabilities</td>
<td>Later-Life Planning Program, Leisure Satisfaction Scale, Five Dimensional Life Satisfaction Index, Leisure Constraint Scale</td>
<td>People with Disabilities</td>
<td>Participants had significantly greater increases in leisure and life satisfaction, most common constraint was money. Loss of friends, income and age were cited as common reasons not to retire.</td>
<td>10 in each group</td>
</tr>
</tbody>
</table>
## Appendix A
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</tr>
</thead>
<tbody>
<tr>
<td>Rosenkoetter, Garris and Engdahl 2001. Examine the perceptions of retirees regarding changes in time use following retirement and implications for retirement planning and interventions.</td>
<td>Mid 40s – over 90</td>
<td>N/A</td>
<td>Retirement Assessment Questionnaire (RAQ)</td>
<td>Retirees from an international corporation</td>
<td>Healthier people participated in more activities. Minimal differences were found across gender, no changes were found for physical exercise or social activities and there was an increase in sedentary activities.</td>
<td>764</td>
</tr>
</tbody>
</table>

* Study did not report dropouts, total number of participants for both groups was listed at 70 therefore cannot be determined which group participants dropped out from or the reasons for not being included in this study which may effect their findings.

References:
Appendix A

Table 2. Summary of Articles


Authors Guidelines for Literature Review
Introduction

The British Journal of Occupational Therapy (BJOT) is the official journal of the College of Occupational Therapists. Its purpose is to publish contributions of papers relevant to theory, practice, research, education and management in occupational therapy.

Vision: A monthly journal presenting high quality international research and practice related papers that informs the knowledge and evidence base of occupational therapy and is easily accessible through online searches.

Online submission of articles

From March 2008, the submission of articles is online, through Manuscript Central, available at: http://mc.manuscriptcentral.com/bjot

Categories of submission

Please note that the word counts given for the different categories apply to the main text only; the abstract, references, tables, figures and appendices are not included. Abstracts are obligatory; their maximum word counts are shown.

1. Research

Research papers are particularly welcomed and will be given publishing priority. Quantitative, qualitative and mixed method studies are all eligible for submission.

Manuscripts may be submitted as 5,000-word full papers or 2,000-word short papers.

Shorter papers are actively encouraged for studies that report small-scale projects, pilot studies or preliminary findings. We encourage authors to contact the editor if they are unsure of whether to submit a short or a full paper.

Manuscript format

The format of the manuscript will vary depending on the focus and methodology but, where appropriate, must include the following:

- Abstract, 200 words (100 words for short papers):
  A succinct summary of the purpose, procedures, findings and conclusions of the study, stating the relevance of the work to occupational therapy.

- Introduction: A brief rationale for the study and an outline of the primary aims, hypotheses or questions.

- Literature review: A critical appraisal of current relevant literature. The review should identify limitations in knowledge and provide a rationale for the study.

- Methods: Methods of data collection and analysis must be fully and sufficiently described to allow replication of the study, with coherence between methodology, data collection and analysis. Issues concerning validity, reliability, trustworthiness, credibility and ethics must be addressed.

- Results/findings: The results must be presented in a way that is accessible to readers and clearly linked to the aim(s) of the research and methods employed.

- Discussion: The implications of the study for occupational therapy must be outlined and the contribution of the study to the current state of knowledge stated. Methodological limitations must be addressed and the implications for practice and further areas of work outlined.

- Conclusions: A clear summary of the main points of the paper.

Key messages: Authors are required to submit the following:

(i) Key findings – a summary statement of two or three key findings. These should not be more than 30 words in total (that is, 10-15 words each).

(ii) What the study has added – a statement of how the study has contributed to the relevant field. This should not be more than 30 words in total.

This information will be printed in highlighted boxes within the article to assist its readability.

2. Critical Reviews

Critical reviews will address clinical, conceptual, theoretical, methodological or ethical issues relevant to occupational therapy. They will:

(a) Describe and summarise the literature within a particular area

(b) Synthesise and evaluate this literature, based on a critical appraisal of the quality of the work described

(c) Distil the most important elements for the benefit of readers and make recommendations about areas in which further evidence is required.

Manuscript format

Abstract (200 words): A succinct summary of the background, source of review data, how papers were selected and evaluated, the main findings and implications for practice.

Introduction: An explanation of the area or topic and the rationale for conducting the review. It should also make a clear case for the relevance and significance of the review for occupational therapy.
Methods: An explanation of the approach taken to searching the literature, the search parameters and key terms used, the inclusion and exclusion criteria used to identify key papers, the criteria used to judge the papers and how key information was extracted from each paper.

Findings: Presentation of the main evidence and a summary of its quality.

Discussion: This should outline the implications of the review for occupational therapy, highlight the methodological limitations of the review, identify any gaps in the literature and make recommendations for further work.

Conclusion: A clear summary of the main points of the paper.

Key messages: Authors are required to submit the following:
(i) Key findings – a summary statement of two or three key findings. These should not be more than 30 words in total (that is, 10-15 words each).
(ii) What the study has added – a statement of how the study has contributed to the relevant field. This should not be more than 30 words in total.

The maximum word count for a critical review will be 5,000 words.

3. Practice Analysis
The aim of a practice analysis is to present a brief critical analysis of an instance of occupational therapy practice. This might include the consideration of work with a client, patient, family or group; it might focus on a particular assessment, treatment method, educational approach; or it might report a novel practice venue.

Manuscript format
Abstract (100 words): A succinct summary of the context, critical reflection on the instance of practice and implications for practice.

Statement of context: An outline of the context of the practice

Critical reflection on practice: This will describe what took place and will include a critical reflection on either (i) how the practice was informed by relevant policy, occupational therapy theory and/or occupational therapy research, or (ii) how the practice contributes to our understanding of relevant policy and occupational therapy.

Summary: The piece will end with a short summary, which highlights issues for future consideration.

Key messages: Authors are required to submit a summary statement of two or three key messages. These should not be more than 30 words in total (that is, 10-15 words each).

Where relevant, authors submitting a practice analysis will be required to provide signed consent for publication from the participants using the BJOT consent form (available on Manuscript Central).

Collaborative work with clients, patients or other professionals is welcome.

The maximum word count for a practice analysis will be 2,000 words.

4. Case Reports
Case reports will discuss an interesting case (one to three clients or patients or a single family) that raises a problem or challenge and has implications for occupational therapy. They may also report novel approaches or adverse events, or illuminate the wider side of clinical practice.

Manuscript format
Abstract (100 words): A succinct summary of the case report and implications for practice.

Text: Should include:
- A brief history and context
- An explanation of what happened (the therapy process and outcome)
- Engagement in problem solving, reasoning and reflection.

Summary: A short summary highlighting the relevance to evidence-based practice.

Key messages: Authors are required to submit a summary statement of two or three key messages. These should not be more than 30 words in total (that is, 10-15 words each).

Signed consent for publication from the participants in the case report will be required, using the BJOT consent form.

Collaborative work with service users is welcome.

The maximum word count for a case report will be 2,000 words.

5. Personal Journeys
These should describe how it feels to face a specific situation related to the role of being a client, patient, therapist or student. It must involve or be of interest and relevance to occupational therapists.

Manuscript format
Abstract (100 words): A succinct summary of the personal journey and the implications for practice.

Text: Should include:
- A brief outline of the personal situation and context
- Using the idea of a journey, a description of what happened over time, focusing on, for instance, an aspect of care, therapy or education. It will address issues such as the impact on day-to-day life, relationships, families and quality of life; coping strategies; and practical information and advice.

Summary: A short summary highlighting the relevance to evidence-based practice.

Any person mentioned who is not an author must give signed consent for publication. Co-authors are accepted, but the first author must be the person giving the account.

The maximum word count for a personal journey will be 1,500 words.

6. Opinion Pieces
These provide authors with the opportunity to express an opinion concerning any aspect of occupational therapy. These submissions are designed to encourage topical
debate and an exchange of ideas. Contributors may discuss specific aspects of occupational therapy or debate the impact on the profession of the current political or financial climate. Irrespective of the topic discussed, opinions should be supported by evidence or theory.

Opinion pieces should:
- Include an abstract (100 words)
- Be structured and incorporate headings
- Include a list of references, following the guidelines for references below.
- The maximum word count for an opinion piece will be 1,500 words.

7. Editorials
These raise issues of importance to the profession. Editorials should not exceed 500 words. Editorials including more than three references must be shorter to fit the journal page.

8. Letters to the editor
These offer comment on previous articles in the journal or on any relevant topic. The editor reserves the right to shorten letters.

Letters should not exceed 500 words. They should be submitted by email to the editor.

9. Executive summaries
This category is designed to provide an effective mechanism for communicating official College of Occupational Therapists' (COT's) reports to the membership and readership in a concise and timely manner; therefore, it will not be a category of submission open to authors other than those working on COT reports.

Executive summaries will be used to provide a précis or summary of substantial COT documents, such as strategic or policy documents or commissioned research. The purpose of the summary is to communicate key aspects of the document to readers, the full version of which will be available via COT, the COT website or both.

The executive summary should contain:
- An introduction explaining the rationale for the document, including reference to how the activity reported relates to the business plan or strategic development of COT
- The main body of text containing a few paragraphs, each with subheadings
- A conclusion paragraph.

If the summary is of a document other than commissioned research, it must contain the key messages and conclude with recommendations for the COT and the profession.

If the summary is of a document other than commissioned research, it must contain the key messages and conclude with recommendations for the COT and the profession.

Executive summaries will be reviewed by an appropriate senior officer of COT, such as a Head of department.

The executive summary should not exceed 1,500 words.

Multiple-part articles
Authors are discouraged from submitting multiple-part articles.

Ethics and consent

Ethics for research
Research articles must state how ethical and/or research governance approval was obtained and state the reference number, where appropriate. Authors must confirm that anonymity and confidentiality are assured and that ethics approval has been gained where appropriate.

Consent*
Consent for publication of personal information (case reports, personal journeys): The publication of any personal information about an identifiable living patient requires the signed consent of the person (this is a requirement under the UK’s Data Protection legislation). Authors should use the BJOT consent form.

Information or illustrations that may identify a person, service or organisation must state that consent has been obtained giving permission for the material to be published. The consent form must be signed and dated by the author(s), the patient(s) and a witness, with their names printed underneath. The original consent form should be sent to the editor at the same time as the manuscript is submitted. The manuscript will not be sent for review unless the consent form is received.

Publication without the consent of the person (or family) will be permitted only if all of the following conditions are met:
(a) The person is dead and his or her family is untraceable to seek consent from
(b) The article contains a worthwhile clinical lesson or public health point which could not be made as effectively in any other way. (‘Worthwhile’ is intended to sit on a spectrum between ‘interesting’, which is the publication threshold with an individual’s consent, and ‘overriding public health importance’, which is the publication threshold over refusal of consent.)
(c) A reasonable person in the position of the person’s relatives would not be expected to object to the publication of the case. (This requires an assessment of the intrusiveness of the disclosure and the potential that it has for causing the patient’s family embarrassment or distress. Particular attention must be paid here to differences of cultural and social attitudes. It must not be assumed that what is a matter of indifference in one society will have the same status in another.)

*The sections on Consent and Conflict of Interests are adapted and reprinted by kind permission of the British Medical Journal from:
- http://resources.bmj.com/bmj/authors/editorial-policies/copy_of_patient-confidentiality
- http://resources.bmj.com/bmj/authors/checklists-forms/competing-interests
(d) The risk of identification of the patient is minimised by measures designed to prevent the identity of the patient being revealed either to others or to the patient's relatives. (These measures will include anonymisation of the case and/or the author. The publication of photographs without consent will require particular scrupulous attention to anonymisation.)

Conflict of interests*

All authors will be required to submit, via Manuscript Central, a statement disclosing conflicts of interest before publication can proceed.

A conflict of interest exists when professional judgement concerning a primary interest (such as a person's welfare or the validity of research) may be influenced by a secondary interest (such as financial gain or personal rivalry).

It may arise for the authors when they have a financial interest that may influence – probably without their knowing – their interpretation of their results or those of others.

We believe that to make the best decision on how to deal with a paper, we should know about any such conflicts of interest that authors may have. We are not aiming to eradicate conflicts of interests – they are almost inevitable and we will not reject papers simply because you have declared a conflict of interest, but we will make a declaration, within the published manuscript, on whether or not you have a conflict of interests to enable the reader to interpret the work with this in mind.

To ascertain whether or not you have a conflict of interest which must be declared, please answer the following questions (all authors must answer):

1. Have you in the past 5 years accepted the following from an organisation that may in any way gain or lose financially from the results of your study or the conclusions of your review, editorial, or letter:
   - Reimbursement for attending a symposium?
   - A fee for speaking?
   - A fee for organising education?
   - Funds for research?
   - Funds for a member of staff?
   - Fees for consulting?

2. Have you in the past 5 years been employed by an organisation that may in any way gain or lose financially from the results of your study or the conclusions of your review, editorial, or letter?

3. Do you hold any stocks or shares in an organisation that may in any way gain or lose financially from the results of your study or the conclusions of your review, editorial, or letter?

4. Have you acted as an expert witness on the subject of your study, review, editorial or letter?

5. Do you have any other competing financial interests? If so, please specify.

If you have answered 'yes' to any of the above five questions, we consider that you may have a conflict of interest, which, in the spirit of openness, should be declared when you submit your paper.

If you declare a conflict of interest, you will be required to submit a statement to publish with the article. It might, for example, read:

Conflict of interests: AB's NHS Trust paid a consultancy fee to CD's university in payment for services and CD has been reimbursed for attendance at a conference to present the results of this study.

If you did not answer 'yes' to any of the five questions above, we will publish 'Conflict of interests: None declared.'

Submission and review

All manuscripts must be typed double spaced. It is essential that all pages are numbered consecutively. An anonymised copy of the manuscript should be submitted to enable the double-blind peer review process to take place. Manuscript Central will guide you through the submission procedure.

Text

Abbreviations

Abbreviations should first be written in full, followed by the abbreviation in parentheses. Following this, the abbreviation can be used within the text. Avoid using abbreviations in the title and abstract. 'Occupational therapy' and 'occupational therapist' should always be written in full and never abbreviated to 'OT'.

Measurements

All measurements must be given in metric units. Whole numbers less than 10, which do not refer to a measurement unit, should usually be written in full. Numbers of 10 or above should be written as digits except at the beginning of a sentence.

Acknowledgements

The contributions of persons, institutions and agencies, particularly those that provided funding, must be acknowledged. It is the author's responsibility to ensure that each individual is willing to be acknowledged.

Tables and figures

Tables and figures should be used when necessary to supplement and clarify the text. Indicate clearly in the main body of the text where each table and figure should be placed.

In tables, vertical lines should not be used to separate columns. Each table must be numbered consecutively in Arabic numerals (e.g. Table 3).

Figures can be either line drawings, graphs or photographs and must include captions. All figures should be numbered consecutively in Arabic numerals (e.g. Fig. 5).

Photographs should usually be black and white and of high quality, showing as much contrast as possible.

Written permission to publish must be obtained from any person recognisable in the photographs (see guidance on consent).
Authors must obtain and submit copyright permission from the publishers to reproduce or adapt any tables or figures that originally appeared in another publication.

References
Only published items, apart from theses, may be cited as references. A manuscript that has been accepted but not yet published may be cited if the journal or the book publisher is named. Such references should state 'in press'. The references should be set out in the following style.

References in the text
- Reference citations in the text must give the surname followed by year e.g. (Melton 2007).
- Works by different authors cited within the same parentheses must be listed chronologically and separated from the previous reference by a comma e.g. (White 2000, Butler 2002).
- If there are two authors then both should be named in the text e.g. (Ballinger and Clemson 2006).
- If there are three or more authors, only the first author should be cited followed by 'et al' e.g. (Payne et al 2005).
- If an author is cited in the text but not in parentheses the surname is followed by the date in parentheses e.g. Cage (2007).
- A direct quotation must be either enclosed within quotation marks when in the body of the text or indented and on a new line. The author's surname, year of publication and page number must be listed. It may be necessary to obtain permission from the publisher for quotes exceeding 100 words from any one work.

Reference list
All references must be listed alphabetically. There are different styles depending on the type of publication. Authors should select the most recent and relevant articles.

Journals

Books

Chapter in a book

World Wide Web

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The perceptions' of ageing disabled workers confronted with the transition to retirement

Name: Naomi Goods
Abstract

This study investigated how workers with disabilities perceived they would make changes in their occupational roles when transitioning from worker to retiree. A mixed methods qualitative-dominant approach was used. Two interviews were undertaken firstly focusing on the worker role and secondly, on the worker's perceived retiree role.

The findings suggest the perceived habits of disabled workers upon retirement became highly unstructured. Goal setting was seen as unimportant and social environments were perceived as highly limited upon retirement. The study provides support that occupational therapy interventions may be helpful in assisting ageing disabled workers to prepare for and explore meaningful occupations as they make the transition from worker to retiree. Occupational therapy support during this life transition for ageing disabled workers may reduce the risk of isolation and build their knowledge of resources within their communities.

Key Words: disability, pre-retirement planning, social environments, mixed methods

Naomi Goods
Supervisor: Associate Professor Jeannine Millsteed
Co-Supervisor: Dr. Sonya Girdler
September 2009
Notes

Supported Employment also known as Disability Supported Employment Services or Business Services, provide paid employment for people with disabilities who have high support needs (Centrelink, 2008).

Introduction

The ageing workforce in supported employment has the potential to reduce viability of Business Services due to the reduction in productivity of ageing disabled workers (Donne, 2008). Strategies which enable disabled workers to make successful transitions from supported employment to retirement are needed. Being unprepared for this transition has been associated with increased stress and reduced life satisfaction in retirement (Marshall, Clarke, & Ballantyne, 2001). Disabled workers have a higher vulnerability of unpreparedness for retirement due to their decreased opportunities in career prospects (Ozawa & Hong, 2003). Workers with disabilities in supported employment value work highly and the transition to retirement is often perceived negatively (Ashman, Suttie, & Bramley, 1993). There appears to be, however, a dearth of literature on the basis of this negative perception of retirement.

Literature Review

People with disabilities in supported employment identify strongly with the status of being a worker (Ashman et al., 1993; Inman, McGurk, & Chadwick, 2007). Removing the structure and routines of this role reportedly results in negative perceptions of retirement (Ashman et al., 1993). Within the general population individuals with unbalanced work routines, tend to continue with unbalanced routines in retirement. This unbalance in routines resulted in old routines and occupations being absorbed, reducing the amount of time retirees had for new occupations (Jonsson, Borell, & Sadlo, 2000). Literature on the extent habits or routines change in retirement for disabled workers is limited and therefore the full effect this can have on transitions to retirement remains unknown.

Planning retirement transitions could benefit supported employment services to assist workers to make well-informed decisions. This could occur by having a predetermined age where
Transitions to Retirement

retirement planning would be implemented (Hodges & Luken, 2006), much like planning transitions from school to work (Winn & Hay, 2009). Inclusion of practical activities such as personal goal setting increases effectiveness of programs (Heller, Miller, Hsieh, & Sterns, 2000; Hershey, Mowen, & Jacobs-Lawson, 2003).

The general population has shown positive expectations for retirement when pre-retirement programs have included leisure planning (Taylor-Carter, Cook, & Weinberg, 1997). The ‘Well Elderly Study’ also indicated the application of information learned in occupational therapy groups to personal situations had beneficial outcomes (Clark et al., 1997). This was due to programs being highly individualised, allowing participants to apply the content to their personal circumstances. This approach to occupational therapy intervention made programs meaningful to the individual and contextually anchored to their lives (Clark et al., 2001; Clark et al., 1997). For the disabled population, the key for active ageing is suggested to be a greater emphasis on empowering people with disabilities (Buys et al., 2008). There appears to have been limited exploration of factors which disabled workers perceive they would need assistance with when transitioning to retirement.

Social supports of people with disabilities have shown to influence their participation in leisure activities (Hawkins, 1991). The ageing disabled worker often has an ageing family network (Bigby, 2008b; Grant, Nolan, & Keady, 2003), increasingly resulting in early institutionalisation due to an unbalanced exchange in relationships (Wilmoth, 2000). Unbalanced exchanges present as a high dependence on family members as a person ages (Wilmoth, 2000). Premature institutionalisation can result in fractured social environments for people with disabilities, particularly when ‘clustering’ similar disabilities occurs (Bigby, Webber, Bowers, & MaKenzie-Green, 2008). Ageing people with disabilities are reported to be disadvantaged by gaps in Australian government services. This is due to the state-funded disability services and nationally-funded aged care services being incompatible for the ageing disabled workforce (Bigby, 2008a). The effect of poor social environments as disabled workers age and make the transition from work to retirement do not appear to have been fully investigated.

Adapting to changes in physical environments requires increased individual, family and friend involvement in relocations (Jacobson & Wilhite, 1999). With limited social environments or supports this adaptation could be impaired. Disabled workers’ physical environments or
accommodation affect not only their participation and perceptions of freedom, but also life satisfaction. This was evident in reductions in life satisfaction ratings following pre-retirement planning programs (Heller, Factor, Sterns, & Sutton, 1996). Reduced life satisfaction was attributed to restricted accommodation status and new found knowledge of opportunities available within the community to, which they had limited access (Heller et al., 1996). Disabled workers’ physical environments upon retirement should allow not only knowledge and access to services within the community, but also the opportunity to ‘age in place’.

The purpose of this study was to investigate how workers with disabilities perceived changes in their occupational roles when they made the transition from worker to retiree. It was proposed disabled workers would not have considered their life transition to retiree and this would limit their planning and perceptions of retirement transitions.

**Methods**

Due to the explorative nature of this topic a mixed-methods, qualitative-dominant approach was used to investigate the perceived transition in roles from worker to retiree (Johnson, Onwuegbuzie, & Turner, 2007). Using mixed-methods enables greater depth and breadth of understanding and corroboration (Johnson et al., 2007), this increases credibility via triangulation of data (Depoy & Gitlin, 2005). Interviews were structured on the occupational circumstance assessment interview and rating scale (OCAIRS) (see interview materials for validity and reliability), which is based on the Model of Human Occupation (Forsyth et al., 2005). The Model of Human Occupation provides a useful framework for explaining individual’s choices in organising their occupations within their environmental contexts over their lifespans (Farhall et al., 2007).

**Participants**

Ten participants were selected using purposive sampling (Teddlie & Yu, 2007) of workers about to retire at a supported employment agency. Consent was obtained and ethical approval was gained from the University’s Human Research Ethics Committee. The inclusion criteria were:

- English speaking.
- Working at least eight hours per week at the supported employment agency.
• Had sufficient comprehension and verbal communication to complete an interview.
• Had capacity to give informed consent.
• Had no history of aggression or antisocial behaviour.
• Were considering retiring in the next five years.

Age was not a criterion for participation due to the inclusion of participants with degenerative conditions. To ensure confidentiality all participants were assigned a pseudonym. Participants received a gift certificate for participating in this study.

**Interview Materials**

Data were collected in various formats. The OCAIRS (Forsyth et al., 2005) was administered with the exclusion of the domain ‘Interpretation of Past Experiences’ as this was deemed non-comparable. OCAIRS was used as it is a valid measure of occupational adaption and has evidence of concurrent and construct validity and reliability (Lai, Haglund, & Keilhofner, 1999). The Pie Chart Assessment (PCA) was a simple visual analogue measure, based on a 24 hour day. Participants were asked to record their time use for a ‘typical day’ as a worker and then for their perceived retiree role. This assisted participants to list their typical activities which were then transferred to the PCA. Visual scales measuring time use provide a simple and valid way to collect complementary data (Aadahl & Jorgensen, 2003; Wewers & Lowe, 1990).

**Interviews**

Two interviews with each participant were conducted at their workplace, with the time between interviews varying from a minimum of five days and a maximum of three weeks. Interviews were digitally recorded then transcribed for analysis to increase the credibility of findings (Depoy & Gitlin, 2005). The first interview collected information on the disabled workers’ current status by exploring the worker role using both the OCAIRS and PCA.

The second interview focused on collecting information on the participant’s perceptions of transitioning to retirement. This interview used both the OCAIRS and PCA. This was followed by a semi-structured interview based on the PCA’s to gather information on participant’s perceptions of role change. Throughout the research process a journal was kept
to provide both an audit trail for dependability and to increase confirmability by practicing reflexivity (Depoy & Gitlin, 2005).

**Data Analysis**

Separating the two interviews gave comparable data on how participants perceived they would transition between the worker and retiree role. This method was also used for triangulation of the two stages allowing for cross-checking of data and interpretations. Framework analysis (Ritchie & Spencer, 1994) of interview transcripts based on OCAIRS were coded using the Model of Human Occupation (Keilhofner, 2008) as the guiding theoretical perspective to map themes and findings. The rating scale from OCAIRS was used to gather information on participant’s perceptions of their strengths and challenges during transitions to retirement (Keilhofner, 2008).

The PCA’s variables identified by participants were operationalised and categorised using the International Classification of Functioning, Disability and Health (World Health Organisation, 2001). These were then charted into percentage of time use for each variable, for both worker and retiree PCA’s. The PCA’s were comparable to the OCAIRS data in the specific domains of ‘Roles’, ‘Habits’, ‘Interests’ and ‘Social Environments’, which allowed for further triangulation of data (See Figure 2 for all OCAIRS domains).

**Findings**

Six of the participants were men and the majority of ranged in age from 51-68 years (n=9). Seven lived alone. Seven worked an average of 20 hours or more per week and six had been working at the supported employment agency in excess of 16 years. Participants’ primary disabilities (see Figure 1) included acquired brain injuries, degenerative, and psychiatric disabilities. Some participants had multiple primary disabilities for example psychiatric and degenerative disabilities. Along with these primary disabilities, participants had age-related conditions such as arthritis and reduced walking and standing tolerance.
Of the ten participants, one believed retirement would be a realistic option, with five participants viewing retirement as a very negative option. These negative perceptions were based on retirement being boring, not having much to offer or the expectation of loneliness. The OCAIRS rating scale data revealed seven participants had a negative shift in perceived values in retirement. Four participants who identified work as highly valued had great difficulty identifying anything of value in retirement or identified values to which they had little conviction. This result in reduced values in retirement contributes to negative perceptions placed on retiring among these disabled workers.

**Habits**

The strongest theme across all data collected was the perception of a reduction in habits in retirement. The OCAIRS rating scale data revealed eight participants had a negative shift in habits on the rating scale when comparing work to retirement. This shift may be explained by all participants’ routines currently being structured around work. When work was removed from the structure six participants were unable to describe what their day would involve or how they would spend their time. When Stewart was asked what a typical day in retirement would be like he replied:

I’ve not even thought of it.

Stewart was unable to imagine what retirement would be like, as his weekday routine was highly structured around work. Without the structure of work and with limited interests and roles outside his worker role, retirement for Stewart was seen as being too unstructured, leaving his days too empty and ‘slack’. 
Seven participants were unable to specify how they would use the time currently occupied by work when retired. Some expanded the time they currently spend on activities such as meal preparation, rather than starting new activities to fill the space work left. Four participants had plans to look into new activities in retirement, but not until they were retired. For six participants, retirement was viewed as either an opportunity to increase sleep and/or to reduce the structure of their routine, giving them more time to relax. Overall, three participants could name leisure activities they hoped to participate in when retired. Wally described these themes in time use in retirement as:

If I did retire, I wouldn’t sit at home, I mean, maybe the first couple of days or whatever but you know, I’d get myself to go out so, until it becomes habit.

Wally like many other participants, looked forward to being able to relax when he no longer had to go to work. He perceived, however, this would only occur in the beginning stages of retirement. Many participants had vague plans for taking on other activities or roles when retired, but very limited knowledge of resources to assist them to do so outside their workplace.

**Goals**

Setting goals or making plans for the future appeared to be highly restricted among all participants. The OCAIRS rating scale data indicated half the participants had negative shifts in short-term goal setting when comparing worker to retiree roles. Six participants had no short-term goals or goals which were loosely defined. For retirement, eight participants had no short-term goals. For those who identified goals, most revolved around holidays and identified barriers to achieving these such as not enough money, holiday companies being booked out and needing to travel with carers.

Seven participants were unable to identify any specific long-term goals, both now or in their perceived future retiree role. Only two participants set any long-term goals for both work and retirement. Wally describes his philosophy behind the lack of long-term goal setting as:

I could be dead by tomorrow.
This reasoning was behind more than one participant’s response when asked about their long-term goals. Participants were concentrating on living in the moment rather than planning for the future. Figure 2 demonstrates differences on comparison of the OCAIRS rating scale. It shows Lauren who is planning her retirement and Harry who does not like to think about retirement. This difference in planning their retirements is not only shown in long-term and short-term goal setting, but also perceptions of changes in habits and social environments.

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**Legend**
- Work: Facilitates
- Retirement: Inhibits

**Social Environment**

The OCAIRS rating scale data revealed five participants had a negative shift in social environments when comparing their current worker role to their future retiree role. Nine participants relied on the workplace for friendship or social interaction and support, when this was not available to them, six participants described their social environments as unsupportive or were unable to identify alternate supports. These participants perceived they would spend their time alone. Four participants saw retirement as an opportunity to increase the time they spent interacting with their family or within their church.
On average, participants perceived they would spend 87.1% of their retirement time in sedentary activities such as watching television or reading. Within this, three participants perceived 100% of their time would be spent on sedentary socially-isolated activities. Figure 3 demonstrates this shift in activities. While Shelly was able to name new activities such as exercise and reading, her sleep increased by 19% and she did not specify any time use for social activities. Of the participants who did describe the desire to increase their interests outside their current routine, four stated they would need help from someone to do so in retirement.

![Figure 3 Shelly’s Perceived Occupational Change](image)

**Physical Environment**

The OCAIRS rating scale data revealed no change in physical environments for six participants when comparing work and retirement. This may have been due to six participants having plans for relocating in the future when they perceived their current housing would be inappropriate. These plans ranged from moving to ground floor apartments to relocating to nursing homes or lifestyle villages. Shelly described her plan as:

We are thinking of shifting now, so we are looking into it now so we would like to move into a smaller place ... I’d like to go [to] one of those retirement villages down the country somewhere the ones they advertise on TV, with all the old people swimming and all that.

Shelly perceived the option of being able to live in a retirement complex as appealing due to the perception of these facilities being well located to resources and activities of interests.
Unlike Shelly, Harry perceived his housing was inappropriate as it would constrict his participation in the future, but was unable to describe a solution to this.

**Discussion**

The perception of an unstructured empty routine in retirement was common across participants. Despite perceptions of retirement as unstructured and ‘boring’, participants had vague plans for increasing their interests or hobbies to structure routines when retired. This was contributed to by participants having no identified interests or hobbies they attended on a regular basis outside their current worker role. This perceived increase in time spent on old routines in retirement was similar to findings in the general population (Jonsson et al., 2000). Participants in this study had difficulty identifying preferences for time use in retirement and had limited knowledge of resources within their area. Increasing their retirement habits was seen as something to look into upon retirement. They often could not identify resources outside the workforce they would ask for assistance if required. This limitation in interests and knowledge of resources not only has the potential to affect the structure of their routines, but also their ability for social interaction and support. Disabled workers require assistance during and following transitions from the workforce to allow them to structure their routines in ways which work formally did.

In this research the perception that goal setting was unimportant was strong among participants. This lack of goal setting or planning for the future may affect participant’s ability to increase the structure of their habits or routines in retirement. Those planning to take on new interests or hobbies once retired, who have not previously set goals, are at risk of not succeeding once retired. This is due to achievement of goals for people with disabilities, particularly intellectual, requiring assistance of support workers or family members (Heller et al., 2000). With seven of the ten participants living alone, and many having difficulty identifying people they could ask for assistance, achieving goals without intervention is possible but unlikely. The lack of goal setting for the future may represent a perception of health decline or low life expectancies as demonstrated by many participants believing they would not be alive in five or ten years’ time. Disabled workers transitioning to retirement need intensive goal setting to allow planning for retirement (Heller et al., 2000). This should take the form of individualised goals in order to make this successful and meaningful to disabled workers.
Supported employment agencies offer substantial assistance for many of their supported employees (Suzuki, Kikuchi, & Watanabe, 2008). This has resulted in a dependence on the social support and routines they provide. When disabled workers are making the transition to retirement or identified as potentially making this transition in the future, supported employment agencies could begin linking disabled workers to external agencies to ensure they are within the ‘system’. In this research disabled workers’ interests were largely sedentary and socially isolating, which highlighted the importance of making this link with appropriate resources before leaving work. This would assist in gaining important support during retirement, which has the potential to provide increased structure to routines. Without this intervention, evidence suggests people with disabilities do not build friendships and social supports (Bigby, 2008b). This is evident by participants describing life without work as lonely or spending time alone, unable to identify supports outside the workforce.

Contributing to this isolation was a reluctance to rely on family members despite these often being their only identified social supports outside the workforce. This was reportedly due to the perception of being a burden to their family, as family members were seen as having enough to worry about without looking after them. This suggests a knowledge of unbalanced exchanges in relationships (Wilmoth, 2000) evident from the reluctance to ask families for assistance as it would increase their burden. This could contribute to perceptions of restricted social environments upon retirement as they could no longer balance their support needs between their family unit and workplace. Disabled workers therefore, need knowledge of alternate resources upon retirement to assist social inclusion in meaningful activities. Without assistance or knowledge of resources within their area, retiring disabled workers are vulnerable to social isolation. Providing a link between employment services and retirement orientated services during transitions is therefore, integral.

In this research participants described the desire to relocate when they perceived it was appropriate, such as when they were over 55 or had health declines. This plan could be impaired due to participants not setting goals or making specific plans for the future, which could reduce their successfulness at achieving this. This factor could contribute to the early institutionalisation of people with disabilities (Bigby, 2008a). These perceptions of unrestricted physical environments could contribute to participant’s restricted social environments and interests, resulting in a limited focus on housing. Less than half the
participants described details outside the home when discussing their physical environments. This highlights a lack of social and active interests for disabled workers which has the potential to affect their interaction within the community and their health. This seemed to be due to participants largely restricting themselves to the house in sedentary activities in retirement. This trend of wanting to relax or sleep in, when retired could indicate an underlying physical or emotional stress apparent in ageing disabled workers. This was however, beyond the scope of this study and would need further research. It is important for disabled workers to maintain accessible environments not only within the home, but also within the community to increase their opportunities for social inclusion in retirement.

Disabled workers need the opportunity to increase their knowledge of resources during and following transitions to retirement. The opportunity to connect with activities through occupational therapy interventions, which are personally meaningful and contextually anchored, has shown positive outcomes in health and well-being for the general population (Clark et al., 2001). This indicates it is not just the opportunity to participate in activities which can increase health and well-being in older age, but that activities are meaningful for the individual (Clark et al., 2001). Activities which are contextually relevant to disabled workers are important as many participants raised concerns about the financial impact of increasing participation within the community and activities in general. Overall, the implications for disabled workers who do not make plans for the future; have limited knowledge of resources; and lead sedentary, socially isolated lives has major negative impacts on health and well-being. Opportunities for active ageing are therefore important for disabled workers transitioning to retirement not only to reduce social isolation, but also for the implications on health and well-being.

Future research may consider larger sample sizes to allow for internal comparison of like disabilities to measure the effect a worker’s disability has on issues surrounding transitions to retirement. Time constraints of this project restricted the sample size, which subsequently prevented generalisability of conclusions. Due to the explorative nature and limited research in transitions to retirement for disabled workers this was considered an appropriate number for addressing the research aim and defining factors affecting transitions for disabled workers (Depoy & Gitlin, 2005). The focus of future research into retirement transitions could involve the wider disabled population from multiple employment agencies to allow generalisable findings.
Summary

Exploration of disabled workers’ perceptions on role change in retirement was undertaken to better understand the issues surrounding their transitions to retirement. Disabled workers were interviewed to gain their perceptions on role change from worker to retiree. The habits of disabled workers were perceived to change dramatically upon retirement, leaving their routines highly unstructured. Disabled workers could benefit from assistance to increase their ability to structure their routines in retirement. Goal setting was not seen as important and was not undertaken by most participants. This lack of goal setting not only affects habits and involvement in interests or social activities in retirement but also physical environments. The social environments for many participants were perceived as being limited when retired. Disabled workers require assistance to increase their knowledge of resources to be able to link up with community programs when transitioning to retirement. This would reduce the likelihood of social isolation and assist with their social inclusion in meaningful activities. Occupational therapy support during this life transition for ageing disabled workers may reduce the risk of isolation and build their knowledge of resources within their communities.

Key Messages

- Disabled workers perceived their routines as likely to be unstructured upon retirement
- Goal setting for retirement was not undertaken
- Knowledge of resources were perceived as limited upon retirement
- Occupational therapists are well qualified to assist in the process of disabled workers transitioning to retirement
References


Authors Guidelines for Project Report
Introduction

The British Journal of Occupational Therapy (BJOT) is the official journal of the College of Occupational Therapists. Its purpose is to publish contributions of papers relevant to theory, practice, research, education and management in occupational therapy.

Vision: A monthly journal presenting high quality international research and practice related papers that informs the knowledge and evidence base of occupational therapy and is easily accessible through online searches.

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Please note that the word counts given for the different categories apply to the main text only; the abstract, references, tables, figures and appendices are not included. Abstracts are obligatory; their maximum word counts are shown.

1. Research

Research papers are particularly welcomed and will be given publishing priority. Quantitative, qualitative and mixed method studies are all eligible for submission.

Manuscripts may be submitted as 5,000-word full papers or 2,000-word short papers.

Shorter papers are actively encouraged for studies that report small-scale projects, pilot studies or preliminary findings. We encourage authors to contact the editor if they are unsure of whether to submit a short or a full paper.

Manuscript format

The format of the manuscript will vary depending on the focus and methodology but, where appropriate, must include the following:

Abstract, 200 words (100 words for short papers): A succinct summary of the purpose, procedures, findings and conclusions of the study, stating the relevance of the work to occupational therapy.

Introduction: A brief rationale for the study and an outline of the primary aims, hypotheses or questions.

Literature review: A critical appraisal of current relevant literature. The review should identify limitations in knowledge and provide a rationale for the study.

Methods: Methods of data collection and analysis must be fully and sufficiently described to allow replication of the study, with coherence between methodology, data collection and analysis. Issues concerning validity, reliability, trustworthiness, credibility and ethics must be addressed.

Results/findings: The results must be presented in a way that is accessible to readers and clearly linked to the aim(s) of the research and methods employed.

Discussion: The implications of the study for occupational therapy must be outlined and the contribution of the study to the current state of knowledge stated. Methodological limitations must be addressed and the implications for practice and further areas of work outlined.

Conclusions: A clear summary of the main points of the paper.

Key messages: Authors are required to submit the following:
(i) Key findings – a summary statement of two or three key findings. These should not be more than 30 words in total (that is, 10-15 words each).
(ii) What the study has added – a statement of how the study has contributed to the relevant field. This should not be more than 30 words in total.

This information will be printed in highlighted boxes within the article to assist its readability.

2. Critical Reviews

Critical reviews will address clinical, conceptual, theoretical, methodological or ethical issues relevant to occupational therapy. They will:
(a) Describe and summarise the literature within a particular area
(b) Synthesise and evaluate this literature, based on a critical appraisal of the quality of the work described
(c) Distil the most important elements for the benefit of readers and make recommendations about areas in which further evidence is required.

Manuscript format

Abstract (200 words): A succinct summary of the background, source of review data, how papers were selected and evaluated, the main findings and implications for practice.

Introduction: An explanation of the area or topic and the rationale for conducting the review. It should also make a clear case for the relevance and significance of the review for occupational therapy.
Methods: An explanation of the approach taken to searching the literature, the search parameters and key terms used, the inclusion and exclusion criteria used to identify key papers, the criteria used to judge the papers and how key information was extracted from each paper.

Findings: Presentation of the main evidence and a summary of its quality.

Discussion: This should outline the implications of the review for occupational therapy, highlight the methodological limitations of the review, identify any gaps in the literature and make recommendations for further work.

Conclusion: A clear summary of the main points of the paper.

Key messages: Authors are required to submit the following:
(i) Key findings – a summary statement of two or three key findings. These should not be more than 30 words in total (that is, 10-15 words each).
(ii) What the study has added – a statement of how the study has contributed to the relevant field. This should not be more than 30 words in total.

The maximum word count for a critical review will be 5,000 words.

3. Practice Analysis
The aim of a practice analysis is to present a brief critical analysis of an instance of occupational therapy practice. This might include the consideration of work with a client, patient, family or group; it might focus on a particular assessment, treatment method, educational approach; or it might report a novel practice venue.

Manuscript format
Abstract (100 words): A succinct summary of the context, critical reflection on the instance of practice and implications for practice.

Statement of context: An outline of the context of the practice

Critical reflection on practice: This will describe what took place and will include a critical reflection on either (i) how the practice was informed by relevant policy, occupational therapy theory and/or occupational therapy research, or (ii) how the practice contributes to our understanding of relevant policy and occupational therapy.

Summary: The piece will end with a short summary, which highlights issues for future consideration.

Key messages: Authors are required to submit a summary statement of two or three key messages. These should not be more than 30 words in total (that is, 10-15 words each).

Where relevant, authors submitting a practice analysis will be required to provide signed consent for publication from the participants using the BJOT consent form (available on Manuscript Central).

Collaborative work with clients, patients or other professionals is welcome.

The maximum word count for a practice analysis will be 2,000 words.

4. Case Reports
Case reports will discuss an interesting case (one to three clients or patients or a single family) that raises a problem or challenge and has implications for occupational therapy. They may also report novel approaches or adverse events, or illuminate the wider side of clinical practice.

Manuscript format
Abstract (100 words): A succinct summary of the case report and implications for practice.

Text: Should include:
- A brief history and context
- An explanation of what happened (the therapy process and outcome)
- Engagement in problem solving, reasoning and reflection.

Summary: A short summary highlighting the relevance to evidence-based practice.

Key messages: Authors are required to submit a summary statement of two or three key messages. These should not be more than 30 words in total (that is, 10-15 words each).

Signed consent for publication from the participants in the case report will be required, using the BJOT consent form.

Collaborative work with service users is welcome.

The maximum word count for a case report will be 2,000 words.

5. Personal Journeys
These should describe how it feels to face a specific situation related to the role of being a client, patient, therapist or student. It must involve or be of interest and relevance to occupational therapists.

Manuscript format
Abstract (100 words): A succinct summary of the personal journey and the implications for practice.

Text: Should include:
- A brief outline of the personal situation and context
- Using the idea of a journey, a description of what happened over time, focusing on, for instance, an aspect of care, therapy or education. It will address issues such as the impact on day-to-day life, relationships, families and quality of life; coping strategies; and practical information and advice.

Summary: A short summary highlighting the relevance to evidence-based practice.

Any person mentioned who is not an author must give signed consent for publication. Co-authors are accepted, but the first author must be the person giving the account.

The maximum word count for a personal journey will be 1,500 words.

6. Opinion Pieces
These provide authors with the opportunity to express an opinion concerning any aspect of occupational therapy. These submissions are designed to encourage topical
debate and an exchange of ideas. Contributors may discuss specific aspects of occupational therapy or debate the impact on the profession of the current political or financial climate. Irrespective of the topic discussed, opinions should be supported by evidence or theory.

Opinion pieces should:

- Include an abstract (100 words)
- Be structured and incorporate headings
- Include a list of references, following the guidelines for references below.

The maximum word count for an opinion piece will be 1,500 words.

7. Editorials
These raise issues of importance to the profession. Editorials should not exceed 500 words. Editorials including more than three references must be shorter to fit the journal page.

8. Letters to the editor
These offer comment on previous articles in the journal or on any relevant topic. The editor reserves the right to shorten letters.

Letters should not exceed 500 words. They should be submitted by email to the editor.

9. Executive summaries
This category is designed to provide an effective mechanism for communicating official College of Occupational Therapists' (COT's) reports to the membership and readership in a concise and timely manner; therefore, it will not be a category of submission open to authors other than those working on COT reports.

Executive summaries will be used to provide a précis or summary of substantial COT documents, such as strategic or policy documents or commissioned research. The purpose of the summary is to communicate key aspects of the document to readers, the full version of which will be available via COT, the COT website or both.

The executive summary should contain:

- An introduction explaining the rationale for the document, including reference to how the activity reported relates to the business plan or strategic development of COT
- The main body of text containing a few paragraphs, each with subheadings
- A conclusion paragraph.

If the summary is of commissioned research, it must contain a brief outline of the methodology. In this case, the body of the text should present the key findings and the conclusion should include recommendations for the COT and the profession.

If the summary is of a document other than commissioned research, it must contain the key messages and conclude with recommendations for the COT and the profession.

Executive summaries will be reviewed by an appropriate senior officer of COT, such as a Head of department.

The executive summary should not exceed 1,500 words.

Multiple-part articles
Authors are discouraged from submitting multiple-part articles.

Ethics and consent

Ethics for research
Research articles must state how ethical and/or research governance approval was obtained and state the reference number, where appropriate. Authors must confirm that anonymity and confidentiality are assured and that ethics approval has been gained where appropriate.

Consent*

Consent for publication of personal information (case reports, personal journeys): The publication of any personal information about an identifiable living patient requires the signed consent of the person (this is a requirement under the UK's Data Protection legislation). Authors should use the B/OT consent form.

Information or illustrations that may identify a person, service or organisation must state that consent has been obtained giving permission for the material to be published. The consent form must be signed and dated by the author(s), the patient(s) and a witness, with their names printed underneath. The original consent form should be sent to the editor at the same time as the manuscript is submitted. The manuscript will not be sent for review unless the consent form is received.

Publication without the consent of the person (or family) will be permitted only if all of the following conditions are met:
(a) The person is dead and his or her family is untraceable to seek consent from
(b) The article contains a worthwhile clinical lesson or public health point which could not be made as effectively in any other way. ('Worthwhile' is intended to sit on a spectrum between 'interesting', which is the publication threshold over refusal of consent.)
(c) A reasonable person in the position of the person's relatives would not be expected to object to the publication of the case. (This requires an assessment of the intrusiveness of the disclosure and the potential that it has for causing the patient's family embarrassment or distress. Particular attention must be paid here to differences of cultural and social attitudes. It must not be assumed that what is a matter of indifference in one society will have the same status in another.)

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(d) The risk of identification of the patient is minimised by measures designed to prevent the identity of the patient being revealed either to others or to the patient’s relatives. (These measures will include anonymisation of the case and/or the author. The publication of photographs without consent will require particular scrupulous attention to anonymisation.)

Conflict of interests*

All authors will be required to submit, via Manuscript Central, a statement disclosing conflicts of interest before publication can proceed.

A conflict of interest exists when professional judgement concerning a primary interest (such as a person’s welfare or the validity of research) may be influenced by a secondary interest (such as financial gain or personal rivalry).

It may arise for the authors when they have a financial interest that may influence – probably without their knowing – their interpretation of their results or those of others.

We believe that to make the best decision on how to deal with a paper, we should know about any such conflicts of interest that authors may have. We are not aiming to eradicate conflicts of interests – they are almost inevitable and we will not reject papers simply because you have declared a conflict of interest, but we will make a declaration, within the published manuscript, on whether or not you have a conflict of interests to enable the reader to interpret the work with this in mind.

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1. Have you in the past 5 years accepted the following from an organisation that may in any way gain or lose financially from the results of your study or the conclusions of your review, editorial, or letter:
   - Reimbursement for attending a symposium?
   - A fee for speaking?
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   - Funds for research?
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2. Have you in the past 5 years been employed by an organisation that may in any way gain or lose financially from the results of your study or the conclusions of your review, editorial, or letter?

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5. Do you have any other competing financial interests?

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If you have answered ‘yes’ to any of the above five questions, we consider that you may have a conflict of interest, which, in the spirit of openness, should be declared when you submit your paper.

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If you did not answer ‘yes’ to any of the five questions above, we will publish ‘Conflict of interests: None declared.’

Submission and review

All manuscripts must be typed double spaced. It is essential that all pages are numbered consecutively. An anonymised copy of the manuscript should be submitted to enable the double-blind peer review process to take place. Manuscript Central will guide you through the submission procedure.

Text

Abbreviations

Abbreviations should first be written in full, followed by the abbreviation in parentheses. Following this, the abbreviation can be used within the text. Avoid using abbreviations in the title and abstract. ‘Occupational therapy’ and ‘occupational therapist’ should always be written in full and never abbreviated to ‘OT’.

Measurements

All measurements must be given in metric units. Whole numbers less than 10, which do not refer to a measurement unit, should usually be written in full. Numbers of 10 or above should be written as digits except at the beginning of a sentence.

Acknowledgements

The contributions of persons, institutions and agencies, particularly those that provided funding, must be acknowledged. It is the author’s responsibility to ensure that each individual is willing to be acknowledged.

Tables and figures

Tables and figures should be used when necessary to supplement and clarify the text. Indicate clearly in the main body of the text where each table and figure should be placed.

In tables, vertical lines should not be used to separate columns. Each table must be numbered consecutively in Arabic numerals (e.g. Table 3).

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Only published items, apart from theses, may be cited as references. A manuscript that has been accepted but not yet published may be cited if the journal or the book publisher is named. Such references should state ‘in press’. The references should be set out in the following style.

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Receipt of the manuscript will be acknowledged. Two reviewers will be selected by the editor to evaluate a manuscript’s quality and suitability for publication. Should these reviewers disagree, a third reviewer will arbitrate on its suitability for publication.

Some revision of manuscripts is almost always required following comments from reviewers. Requesting revisions to a manuscript does not automatically mean that it will be accepted for publication. Revised manuscripts are sent to the same reviewers for comment, if required.

Prior to publication, the author will receive a proof of the manuscript for verification and minor corrections. Once the manuscript is published, the corresponding author will receive a pdf of the final version.

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