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**Abstract**

**Objectives:** The aim of the current, large-scale evaluation study was to explore the effects of the Israeli Lifestyle Program (ILP) on Israeli older adults’ quality of life and depressive symptoms. **Method:** The study employed a non-randomized controlled pre-post intervention research design. Participants were 99 older adults, aged 60 years and above, who lived independently in the community. The intervention group (*n* = 79) participated in 15 weekly group meetings and two individual sessions. The control group (*n* = 20) received an information booklet based on the ILP content. Participants completed a Quality of Life Questionnaire (WHOQoL-BREF; WHO, 1998) and a Personal Health Questionnaire (PHQ-9; Kroenke et al., 2001). **Results:** No meaningful demographic differences were found between the groups. QoL in terms of physical health (WHOQoL-BREF) increased beyond group (η2 = .06). Psychological health (WHOQoL-BREF) increased in the intervention group (η2 = .15) and did not change in the control group. Social relationships (WHOQoL-BREF) increased in the intervention group (η2 = .13) and did not change in the control group. Likewise, QoL in terms of the environment (WHOQoL-BREF) increased in the intervention group (η2 = .11) and did not change in the control group. Depression showed no change in the intervention group (η2 = .01) and increased in the control group (η2 = .07). **Discussion:** The ILP was found to increase participants’ QoL and to reduce depression, and therefore can be deemed as a promising health-enhancing intervention for community-dwelling older adults.

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**The Effects of the Israeli Lifestyle Program on the Quality of Life and Depressive Symptoms of Israeli Older Adults**

As the global population continues to age rapidly, the parallel growth of age-related diseases has created challenges for the health system and policymakers, as well as for older adults and their caregivers (Chang et al., 2019). Health promotion interventions are therefore critical for preventing age-related functional decline and maintaining quality of life (QoL) among the aging population (Berger et al., 2018; Peel et al., 2005). Otero-Rodríguez and colleagues (2010) found that lower self-perceived health-related QoL in older adults was associated with significantly higher mortality. Over the years, various definitions of QoL have been documented. Some researchers have argued that objective descriptors, for example physical, material and social components of well-being, should be included in the definition. However, other researchers have defined QoL in a more subjective manner, such that it reflects one’s level of satisfaction with life, or a perception of one’s position in life (Karimi & Braizer, 2016).

According to the World Health Organization (WHO), QoL is defined as “an individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (WHOQOL Group, 1995). This broad definition implies that QoL cannot be defined by a single measure, rather it includes various aspects, such as physical, psychological, social and environmental components (Skevington et al., 2004). The physical health domain regards activities of daily living and dependence on medical aids, as well as physical abilities and symptoms, such as mobility, sleep, pain and fatigue. The psychological domain measures perceptions of one’s body and self, as well as one’s feelings and spirituality. It additionally includes cognitive components, such as learning and memory. The social relationships domain consists of personal relationships, social support and sexual activity. The environmental domain includes factors such as financial resources, perceptions of one’s level of freedom, personal safety, healthcare, the home environment and the surrounding outdoor environment, as well as one’s participation and opportunities to engage in recreation activities (WHO, 1996).

The World Health Organization recognizes mental health as an important component of general health. Over 20% of adults aged 60 years and older experience mental health conditions such as depression and anxiety; however, these conditions are often undetected by health care professionals, as well as by the older adults themselves (WHO, 2017). Depression was found to be significantly associated with poorer QoL in older adults (Sivertsen et al., 2015). It is associated with increased morbidity and mortality, and is a significant public health issue, especially among the older adult population (Yaka et al., 2014). For example, during the COVID-19 outbreak in Israel, 19% of 65-year-olds reported suffering from depression, as opposed to 16% of those in the general population (Shnoor & Cohen, 2020). This discrepancy demonstrates the importance of developing and researching interventions that aim to reduce depression and elevate QoL specifically in the older population.

Older adults’ participation in daily life activities is correlated with higher ratings of QoL and well-being, as well as lower rates of depression (Johansson & Bjorklund, 2016; Park & Park, 2020; Smallfield & Molitor, 2018). Occupational therapists (OTs) strive to enhance older adults’ participation by promoting their occupational engagement in meaningful activities, such as social or leisure activities. Beyond the health benefits, occupation-based interventions were also found to be cost effective and to contribute to reducing healthcare-related financial burdens (Hay et al., 2002; Zingmark et al., 2016).

Lifestyle Redesign (LR) is an occupational-based intervention that aims to promote health, maximize independence and enhance functioning in the older adult population. This program was developed in the United States and has been studied for many years (Clark et al., 2012). In a randomized controlled trial with 361 culturally-diverse participants, aged 60 years and above, researchers found that the participants in the LR group showed improvement in health perception, functioning and QoL as compared to participants in the control groups (a social activity group and a nontreatment group) (Clark et al., 1997). A later study, with a larger study sample consisting of 470 participants aged 60-95 years old, again demonstrated enhanced outcomes in the LR group compared to a nontreatment control group (Clark et al., 2012). Moreover, previous studies have shown that the LR program could be adapted to participants from different cultures (Johansson & Bjorklund, 2016; Schepens Niemiec et al., 2019) and who suffer from various health conditions (Ng et al., 2013; Simon & Collins, 2017).

Life expectancy in Israel is among the highest in the world, with an average of 83 years. As in the rest of the world, the population of older adults in Israel is growing, such that older adults constitute 12% of the overall population. In regard to perceived health, 76% of older adults in Israel report their overall health status as being either good or very good (Shnoor & Cohen, 2020). Strategies for health enhancement have thus become of greater priority, in terms of both research and policy efforts (Shnoor, 2015). In Israel specifically, a pilot study was previously conducted in order to assess the feasibility and potential effectiveness of the Israeli Lifestyle Redesign (ILR) intervention program (Maeir et al., 2020). Based on the promising results of the pilot study (*N* = 18), which demonstrated potential for improving QoL and reducing depressive symptoms among independent, community-dwelling older adults, the aim of the current study was to explore the effects of the Israeli Lifestyle Program (ILP) on older adults’ well-being within a large‐scale evaluation study (*N* = 99). The study hypothesis was that participants in the intervention group would demonstrate increased QoL and a reduced number of depressive symptoms following the intervention as compared with participants in the control group.

**Method**

**Participants**

Participants in the present study were older adults – there were 79 participants in the intervention group and 20 participants in the control group. Inclusion criteria were as follows: independent (according to self-report) older adults who were 60 years old and above and who were living independently in the community. Individuals were excluded if they scored below 19 on the Montreal Cognitive Assessment (MoCA). Participants were mostly women (84%) and ranged in age from 61 to 83 years old (*M* = 69.01, *SD* = 5.74). Older adults in the intervention group were divided into six small groups, consisting of 9 to 18 participants; the mean number of participants per group was 13. Half of the groups took place in rural areas (*n* = 39, 49%) and the other half occurred in urban areas *(n* = 40, 51%). No demographic differences were found between the rural and urban participants except in regard to economic status, which was higher among the rural participants (*n* = 28, 74% were above average) than the urban participants (*n* = 12, 39% were above average) (*Z* = 2.93, *p* = .003). The control group received an educational booklet based on the content of the ILP.

**Measures**

***Demographic Characteristics***

Participants completed a socio-demographic questionnaire, which assessed their gender, age, marital status, education level, economic status, and country of birth.

***Physical and Cognitive Screening Variables***

The Timed Up and Go (TUG) test (Podsiadlo & Richardson, 1991) was used to measure lower extremity functions, mobility and fall risk. Participants were requested to stand up from a standard chair, without using upper extremity support, and to walk 3 meters at their typical pace, turn around, and then walk back to the chair and sit down. A walking aid could be used, if needed. Lower scores indicated better performance. A cut-off score of 13.5 seconds was used to identify people who were at a higher risk of falling (Herman et al., 2011).

Montreal Cognitive assessment (MoCA) (Nasreddine et al., 2005) – a cognitive status screening tool – was used to measure participants’ visuo-spatial abilities, executive function, attention, language, short-term memory and orientation. The measure took approximately 10 minutes to conduct and the maximum score was 30. The cut-off score for identifying people with mild cognitive impairment (MCI) was originally defined by the current study’s authors as ≥ 26. However, since the test was highly sensitive (83% – 90%), a score of 19 and above was set as the cut-off for MCI (Nasreddine et al., 2005).

***Quality of Life***

The World Health Organization Quality of Life-BREF (WHOQoL-BREF; WHO, 1998) is a self- report questionnaire, which consists of 26 items representing four domains of QoL: physical health, psychological health, social relationships and environment (Skevington & McCrate, 2012). Each item was scored on a 5-point scale. The scores were then transformed to a scale of 0 to 100, such that higher scores indicated higher levels of QoL. The test was found to have good to excellent reliability and validity scores (Skevington et al., 2004). Acceptable to good internal consistencies were found in the current study, over time: physical health- α = .77, psychological health- α = .64, social relationships- α = .73, and environment- α = .73.

***Depressive Symptoms***

The Personal Health Questionnaire (PHQ-9) (Kroenke et al., 2001) is a 9-item self-report questionnaire, which is used for screening, diagnosing, monitoring, and measuring the severity of depressive symptoms based on the criteria of the DSM-IV. Each symptom is rated on a 0 to 3 scale, such that the total score ranges from 0 to 27; higher scores indicate greater frequency of depressive symptoms. The PHQ-9 is used to identify persons at risk for depression across a variety of settings and ages (Smarr & Keefer, 2011). The PHQ-9 has a sound internal consistency and is used in both clinical and nonclinical settings (Reynolds, 2010). Acceptable internal consistency was found in the current study, across the different timepoints: α = .65.

**Procedure**

The research design was a non-randomized controlled pre-post intervention study. Study procedures wereapproved by the ethics committee of Ono Academic College in Israel. In an effort to recruit participants, the research team first visited a number of centers that organize various activities for the elderly (e.g., computer courses, exercise classes, lectures) to assess interest in the study. The organizers at the centers who expressed interest were invited to a meeting with the head researcher during which the details of the study were presented. Afterwards, an informational flyer was prepared and distributed to the older adults who attended activities at the centers. In total, organizers from six centers expressed interest and each center organized a group of people who agreed to participate (the size of the group varied by center). Only six participants across all of the groups refused to participate in the study. In total, 79 out of the 85 older adults (93%) consented to take part in the study.

 Participants in the intervention group participated in 15 weekly group sessions; each session was an hour and a half. Additionally, they attended two individual sessions, which took place in the middle and at the end of the program. These sessions were focused on setting and achieving personal goals. All sessions were facilitated by an OT, and were conducted according to a set protocol. The group meetings were held in a large room, and participants all sat in a circle. Each participant received a binder to organize the handouts and program information and were provided with class notes after each session. Further information about the adaptation of the program to the Israeli context, and its validity, are detailed in a previously published paper (Maeir et el., 2020).

 The group sessions included nine modules, similar to the original LR program. The modules focused on the following domains: (1) occupation, health, and aging; (2) the building blocks of longevity, which included various types of activities (physical, mental, spiritual, social, and productive activity); (3) stress and inflammation management; (4) time and occupation; (5) home and community safety; (6) relationships and occupation; (7) thriving; (8) hormones, aging, and sexuality; and (9) ending the group. The ILP used the same four delivery methods that are integral to all Lifestyle-Redesign-based programs: didactic presentation, peer exchange, direct experience, and personal exploration (Jackson et al., 1998).

In the second stage, participants were recruited for the control group. Flyers were distributed in the same centers from which the intervention group participants were recruited. The control group received an information pamphlet based on the content of the ILP, as well as a list (with contact information) of resources in the community that focused on encouraging healthy lifestyles, as well as places to participate in health-promoting activities. The specific topics covered in the pamphlets included safety at home and in the community, physical activity, nutrition, social participation, and productive occupations. Each unit provided explanations about the benefits of specific lifestyle components and a “how-to” portion focused on implementing each component (e.g., paying attention to rapid shifts in positioning to avoid falls, utilizing walking as a means of transportation, taking walks with friends, following specific dietary guidelines). The list of community resources included a volunteer center, a safety consultant, and local recreational events. All material in the booklets were prepared by a group of OTs who were trained in the ILP; all were members of the research team. The control group received no further intervention until the second assessment, which occurred after 15 weeks (Maeir et el., 2020).

After obtaining their informed consent and before the start of the intervention, all participants completed the socio-demographic questionnaire, the MoCA, the TUG test, the WHOQoL-BREF and the PHQ-9. The two last assessments were also administered post intervention (after 15 weeks) to participants in both the intervention and control groups. The questionnaires were completed in a single one-hour session, either in the community center or in their home.

**Data Analysis Plan**

Data were analyzed with SPSS version 26. Background characteristics of the participants were described with frequencies, percentages, means and standard deviations, according to their distribution, and compared by group with Z-tests for differences between two independent proportions and t-tests, respectively. Next, the dependent variables were evaluated. Internal consistencies for the study variables were evaluated with Cronbach’s α, using the two timepoints (prior to the intervention and after the intervention). Scores for the PHQ-9 were positively skewed and were thus log-transformed. Means, standard deviations and Pearson correlations for the main study variables, both at the pre- and post-intervention timepoints, were calculated. T-tests and Pearson correlations were calculated to assess associations between the demographic variables and pre-test study variables. Pre-test group differences were examined with a series of t-tests. Time and group differences were examined using two-way analyses of variance, and significant interactions were interpreted with estimated marginal means.

**Results**

**Descriptive Results**

Most participants were married or in a relationship (about 65%), and most others were divorced or widowed, with no significant group differences (see Table 1). Education level of most participants (about 72%) was beyond high school, and over a half (about 56%) reported above average economic status, with no significant group differences. About 60% of the participants in the intervention group and 85% of those in the control group were Israeli-born, with a significant difference (*p* = .030). Most perceived their health to be good or very good (close to 70%) with no group difference. All scored at least 19 on the MoCA, with no group difference. Mean for the initial TUG test was 9.61 seconds (*SD* = 2.92) with no group difference, and most participants in both groups were classified in the normative range.

**Table 1**

*Participants’ Background Characteristics, By Group (N = 99)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | Intervention | Control | *t*(df) or *Z* | *p* |
| Gender (*n*, % women) |  | 63 (80) | 20 (100) | -- |  |
| Age (*M*, *SD*) | Range: 61-83 | 68.96 (5.64) | 69.20 (6.26) | *t*(96) = 0.16 | .869 |
| Marital status (*n*, %) | Single | 3 (4) | 3 (15) | *Z* = 0.56(Married/in a relationship vs. other groups) | .576 |
| Married/in a relationship | 52 (67) | 12 (60) |
| Divorced | 10 (13) | 3 (15) |
| Widowed | 13 (17) | 2 (10) |
| Education level (*n*, %) | High school or below | 20 (29) | 5 (25) | *Z* = 0.35 | .727 |
| Above high school | 49 (71) | 15 (75) |
| Economic status (*n*, %) | Below average/average | 29 (42) | 10 (50) | *Z* = 0.63 | .527 |
| Above average | 40 (58) | 10 (50) |
| Country of birth (*n*, %) | Israel | 46 (59) | 17 (85) | *Z* = 2.17 | .030 |
| Other | 32 (41) | 3 (15) |
| Perception of health (*n*, %) | Not good | 8 (12) | 1 (5) | *Z* = 0.71(Not good /moderate vs. good/very good) | .480 |
| Moderate | 15 (22) | 4 (20) |
| Good | 36 (52) | 8 (40) |
| Very good | 10 (15) | 7 (35) |
| MoCA (*M*, *SD*) | Range: 19-30 | 25.30 (2.70) | 25.45 (3.17) | *t*(97) = 0.21 | .835 |
| TUG (*M*, *SD*) | Range: 5-21 | 9.48 (2.23) | 9.21 (2.76) | *t*(97) = -0.45 | .651 |
| TUG *(n*, % within normative range) |  | 77 (98) | 17 (85) | -- |  |

Participants demonstrated fairly normative functioning, both cognitively and physically. Pre-test scores on the QoL measure were moderate to high on average, and ranged from 69 to 76 (out of 100). Accordingly, the mean number of depressive symptoms reported was low. Significant correlations were found between the study variables at pre-test. As shown in Table 2, positive correlations were found between most of the QoL components. Further, QoL scores (specifically in regard to physical health, psychological health, and environment) were negatively correlated with number of depressive symptoms.

**Table 2**

*Means, Standard Deviations and Intercorrelations for the Main Study Variables, Pre-Test (N = 99)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | *M* (*SD*) | 2 | 3 | 4 | 5 |
| 1.Physical health (0 – 100) | 74.25 (16.54) | 0.26\*\* | -.09 | .50\*\*\* | -.46\*\*\* |
| 2.Psychological health (0 – 100) | 71.24 (11.40) |  | .24\* | .38\*\*\* | -.43\*\*\* |
| 3.Social relationships (0 – 100) | 69.05 (21.52) |  |  | .26\*\* | -.17 |
| 4.Environment (0 – 100) | 76.15 (12.40) |  |  |  | -.30\*\* |
| 5.Depressive symptoms (0 – 27) | 3.82 (3.42) |  |  |  |  |

\**p* < .05. \*\**p* < .01. \*\*\**p* < .001.

Associations between the majority of demographic characteristics (age, gender, marital status, and education level) and the main study variables at pre-test were not significant. However, there were a number of significant differences by participants’ economic status, such that those who reported an above average economic status (as compared to those with an average or below average economic status) reported higher levels of physical health QoL [*M* = 79.49, *SD* = 13.42 vs. *M* = 68.83, *SD* = 16.59; *t*(87) = 3.35, *p* <.001], and environmental QoL [*M* = 81.35, *SD* = 10.62 vs. *M* = 71.25, *SD* = 11.53; *t*(87) = 4.29, *p* <.001]. As such, economic status should have been entered as a covariate in the analyses; however, due to missing data on this variable (*n* = 10), we opted to examine its effects separately.

Pre-test group differences in the main study variables were examined with a series of t-tests. Except for the social relationships component of QoL, which were initially higher in the control group (see Table 3), there were no significant pre-test group differences. Differences in the main study variables by time and group were examined with two-way analyses of variance. As shown in Table 3, there were significant differences across all dimensions of QoL. Physical health increased beyond group; controlling for economic status had no effect on this finding. Participants’ psychological health increased in the intervention group from pre-test to post-test [*F*(1,94) = 16.77, *p* < .001, η2 = .15], yet remained unchanged among participants in the control group [*F*(1,94) = 0.02, *p* = .887, η2 = .00]. Likewise, participants’ quality of social relationships increased in the intervention group [*F*(1,94) = 13.69, *p* < .001, η2 = .13], but not in the control group [*F*(1,94) = 0.14, *p* = .712, η2 = .00]. However, when controlling for the initial difference between the two groups, the post-intervention difference in social relationships became non-significant [*F*(1,94) = 0.08, *p* = .783, η2 = .00], and thus the significant interaction should be interpreted with caution. Further, participants’ QoL in the environmental domain increased in the intervention group [(*F*(1,94) = 10.39, *p* = .002, η2 = .11], and did not change in the control group [*F*(1,94) = 0.53, *p* = .470, η2 = .01]. Controlling for economic status had no effect on the result.

Interesting results were found for depressive symptoms. Whereas participants in the intervention group showed no changes in the number of depressive symptoms from pre- to post-test [*F*(1,94) = 0.65, *p* = .424, η2 = .01], the number of reported depressive symptoms *increased* among participants in the control group [*F*(1,94) = 7.03, *p* = .009, η2 = .07] (see Table 3).

**Table 3**

*Means, Standard Deviations and Two-Way Analyses of Variance Results for Main Study Variables, By Group and Time (N = 99)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Intervention | Control | Pre-test group differences | Mean difference of pre-test and post-test scores |
|  | Pre-test*M* (*SD*) | Post-test*M* (*SD*) | Pre-test*M* (*SD*) | Post-test*M* (*SD*) | *t*(96) | *F*time(1, 94)(η2) | *F*group(1, 94)(η2) | *F*time X group(1, 94)(η2) |
| Physical health (0 – 100) | 74.97 (17.06) | 77.97 (14.70) | 70.45 (14.90) | 75.10 (15.40) | -1.12 | **5.58\*****(.06)** | 1.01(.01) | 0.23(.00) |
| Psychological health (0 –100) | 71.03 (11.48) | 75.61 (12.27) | 72.05 (11.39) | 71.74 (14.23) | 0.34 | 2.94†(.03) | 0.25(.00) | **3.87\*****(.04)** |
| Social relationships (0 – 100) | 65.57 (21.87) | 72.22 (18.79) | 82.63 (13.48) | 81.32 (12.74) | **3.18\*\*** | 1.80(.02) |  **8.40\*\*****(.09)** | **4.01\*****(.04)** |
| Environment (0 – 100) | 75.62 (10.84) | 79.63 (11.41) | 78.47 (17.94) | 76.59 (14.39) | 0.57 | 0.55(.01) | 0.01(.00) | **4.19\*****(.05)** |
| Depressive symptoms (0 –27) | 3.95 (3.58) | 3.23 (2.58) | 3.35 (2.76) | 4.80 (3.37) | -0.20 | **4.07\*****(.04)** | 1.02(.01) | **7.46\*\*****(.07)** |

*Note*. Significant differences are noted in bold.

†*p* < .1. \**p* < .05. \*\**p* < .01.

**Discussion**

The current study examined the influence of the ILP on QoL and depressive symptoms across a broad sample of Israeli, independent older adults. The overall aim of the study was to demonstrate the intervention’s effectiveness as a health-enhancing program for older adults. The World Health Organization previously defined health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1946). According to this interpretation of health, mental health is an integral component of the broad definition of health. In the current study, most components of QoL were found to increase significantly among the intervention group participants when comparing their scores before and after the intervention. However, QoL appeared to remain unchanged among participants in the control group, thus proving the program’s contribution to participants’ overall QoL and health.

 The ILR was adapted from an American version to suit the Israeli population and culture. During the modification process, protocols were developed in order to present the program contents to the participants within a group setting. Social isolation is recognized as one of the major public health concerns affecting the aging population, and previous research has shown that it is associated with lower QoL among the older adult population (Hawton et al., 2011). Goll and colleagues (2015) found that a lack of supportive communities and a lack of acceptable social opportunities were among the main barriers to social participation among older adults. In light of these findings, it is not surprising that previous studies have found positive effects of group interventions on QoL (Bar-Netzer & Bocos, 2018; Calandri et al., 2017; Markle‐Reid et al., 2018). Yalom (1995) described several therapeutic factors that occur during group therapy, and affect the intervention outcome. One of the factors he noted was group cohesiveness, which arises when members develop a sense of belonging to the group. Choi and Park (2006) demonstrated the perceived therapeutic effect of this factor in their study on adults with social phobia. As compared to other group therapeutic factors, the patients who improved the most rated group cohesiveness as most beneficial to their treatment.

 It is therefore reasonable to assume that the group dynamics that occurred during the sessions created an environment that encouraged social participation, which served to build a sense of belonging among participants, and consequently increased their QoL. The social aspects that were covered in the program (during module 3) may have also contributed to the increase in participants’ QoL, particularly the psychological and social relationships domains. This may be because the psychological domain of QoL includes measurements of cognitive functioning such as learning and memory, which have been found to be complexly associated with social networks and social isolation (DiNapoli et al., 2014; Litwin & Stoeckel, 2016). As one of the participants stated during the final session: “In general, the program helped me to become an even more optimistic person than I was before. And another great gift I received is that now I have a new friend, who I have a wonderful relationship with.”

 The physical aspect of aging was discussed during intervention modules that focused on mobility enhancement and the prevention of chronic inflammation, both of which have been previously found to be associated with QoL in the older adult population (La Grow et al., 2013; Nowakowski, 2014; Rantakokko et al., 2016). These associations may explain the increase in the physical domain of QoL among participants the intervention group. For example, one participant noted: “I am more aware of the importance of exercise, so now I go on walks every day.” Interestingly, even in the control group there was a small increase in self-reported physical health; as such, it is possible that the information provided in the booklet on this topic also served to encourage participants to become more physically active.

 Environmental aspects were covered in the intervention program with a home and community safety module. In their systematic review, Vaappio et al. (2009) found that, in only six out of the twelve studies reviewed, there was a positive association between fall prevention interventions and quality of life. However, in a larger systematic review that included 30 studies, Schoene and colleagues (2019) found that in most studies fear of falling was associated with poorer QoL. Similarly, other studies have found associations between actual falling and poorer QoL among the older population (Stenhagen et al., 2014; Thiem et al., 2014). The increase in safety behavior in the house and community may have increased participants’ confidence, which subsequently may have reduced their fear of falling and even prevented actual falls and, in turn, increased their QoL. As one participant noted: “The topics discussed raised my awareness of possible dangers, for example the knowledge about falls has contributed a lot to me.”

 In regard to depressive symptoms, there was no change among the participants in intervention group from pre-test to post-test, yet there was an increase among those in the control group from pre- to post-test. The particular transition period occurring in the lives of many of the participants may help to explain this finding. Many of the older adults were in the process of retirement during the study period and expressed difficulties due to the loss of interaction with coworkers and work friends. Retirement is a significant occupational transition, and it has been extensively studied over the past couple of decades in the field of occupational science. Importantly, retirement has been described as having a significant impact on occupational rhythm and balance (Jonsson et al., 2000; Wiseman & Whiteford, 2009). In further support of our findings, Kail and Carr (2019) examined the associations among retirement, depression and social support and found that, for retirees with average levels of social support, the retirement process was associated with a small but significant increase in depressive symptoms. The change in one’s social relationships as a result of retirement was also discussed by Segel-Karpas and colleagues (2018), who found that retirees were more likely to experience depressive symptoms if they felt lonely before retirement; they explained this finding by the sudden lack of distraction that was previously provided by work. This explanation may clarify the unexpected finding that participants in the control group showed an increase in depressive symptoms, as they did not have the opportunity to benefit from the social aspects of the group environment as did those in the intervention group. Whereas those in the control group faced a dramatic loss of a previously central life role without the compensation of a group program, the intervention group participants attended group sessions that may have served to provide an alternative routine, as well as an encouraging social environment. As one of the intervention group participants described, “There were topics I was not aware of before the program and today I have more knowledge. For example, in regard to preparing for retirement both financially and occupationally.”

**Limitations and Future Study Recommendations**

 The current study utilized a non-randomized controlled trial study design; however, the control group was significantly smaller than the intervention group. Future studies should include more participants in each group, and account for the gender balance of participants. Although health enhancement is a desirable outcome of healthy aging policies, the ILP was found to influence significant aspects of the older adults’ health and QoL. Future studies should continue to explore the program in Israel while, at the same time, widening the understanding of its impact by evaluating its cross-cultural applications.

**Conclusion**

 The ILP influenced participants’ QoL, as well as their experience of depressive symptoms. The success of the intervention points to its value as an innovative and feasible intervention. Israeli occupational therapists in the geriatric field can use this promising intervention to implement health enhancement programs among community-dwelling older adults.

 Health promotion programs have an even greater significance today, following the WHO recommendations “for a Decade of Healthy Ageing (2020 - 2030)” (Rudnicka et al., 2020). As one participant described: “The program succeeded in ‘touching’ each and every one of the participants, who all learned new things. Additionally, each participant was given individual attention and, most importantly, I acquired tools that I can use to improve myself in the multiple and significant domains that we covered.”

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