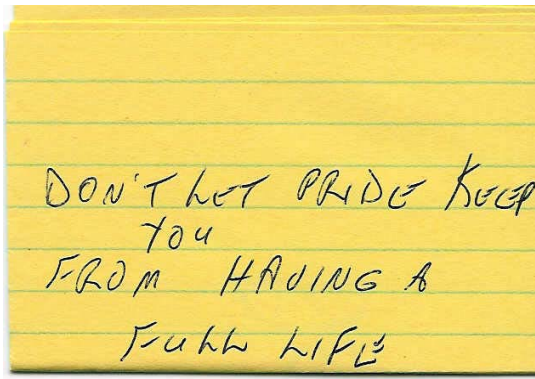


Final Report
“Laying the Groundwork for
Improved Knowledge and Use
of Assistive Devices among Canadian Veterans and Seniors”



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Appendix A

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1.0 Executive Summary

The Laying the Groundwork project was one of three funded under a special Veterans Affairs – Health Canada grant and was designed to inform two additional projects concerning mobility aids.

The central objective of this study was to identify seniors' and veterans' experiences and values concerning assistive devices. This study emphasized three specific devices: canes, bathroom grab bars and hip protector underpants.

The study was conducted through six focus groups across Canada to provide a national perspective and identify any significant regional differences. The sample provided rich but not generalizable information about seniors' views and beliefs.

The findings show that the most significant and complex influence in the use of an assistive device is the senior's own perception of need. Perception of need and the use or rejection of a device was strongly influenced by the social stigma seniors associated with devices. Most indicated devices symbolized loss of independence, disability and inevitable decline. **The look and appearance of some of the devices contributed to this negative perception.** Within this context, four major ways were identified by which seniors come to realize the need for a device: 1) experiencing a crisis or trigger event, 2) incremental coping, 3) caregiver/family recommendation/intervention or, 4) health professional intervention/referral.

Older people strongly preferred to get information about assistive devices through personal contact and especially physician or other health professional advice and intervention. Other valuable sources of information were identified, such as television, radio and written material. Participants also indicated the importance of message consistency and the reliability of the

sources of information. **Trust, expertise, and an established and preferably ongoing relationship were major requirements to gain information**

Assessment was the first step required to determine eligibility for equipment purchase. Regions of the country had varied guidelines and complicated criteria, all involving assessment, income-testing and physician prescription that all seniors found confusing. Medical coverage **was often insufficient to cover certain items.** Veterans wanting a device also required assessment but the process, while bureaucratic and lengthy, appeared to some participants to be more understood and fair.

To obtain an assistive device, the most common source was a retail store that specialized in these items.

While some seniors did not openly state that they felt social pressure to avoid using the device in public, they believed pride and stubbornness contributed to prolonged resistance to public use. However, physician's advice about needing a device carried considerable weight and doctors (in collaboration with other health professionals) have an important but poorly developed role in early intervention.

Participants agreed **the best way to help clients to use devices was to understand the person's lifestyle and identify the activities most important for that person. Seniors need support in how to use a device but, more importantly, how to incorporate this equipment into their daily life.**

Overall, participants indicated the importance of being sensitive to emotional and social factors in supporting use of assistive devices.

2.0 Introduction and Background

This project was a collaborative effort lead by Drs. Elaine Gallagher and Victoria Scott, School of Nursing, University of Victoria, British Columbia. Dr. Pattie Thomas served as project coordinator and Lee Hughes assisted in analyzing the data and writing the final report.

A Steering Committee was formed to guide the project with individuals representing seniors, veterans, British Columbia Institute of Technology (BCIT), the University of Ottawa, the University of Victoria, private industry, occupational therapists, family caregivers and Health Canada Division of Aging and Seniors.

The project was one of three funded under a special Veterans Affairs – Health Canada grant. “Laying the Groundwork” was designed to inform two additional projects concerning mobility aids.

Dr. James Watzke of BCIT will produce and test a public service announcement (PSA) concerning mobility aids. Dr. Nancy Edwards of the University of Ottawa will develop and test a community model to promote safe purchase and use of assistive devices by community dwelling seniors.

The findings of this phase of the study will help to shape the content and format of the next two projects. A logic model showing the relationship between the three projects is shown in Figure 1.

2.1 Significance of the Problem

As highlighted in the document “Enhancing Safety and Security for Canadian Seniors” (F/P/T Reference Document, 2000), falls represent a major health risk to the senior population. Falls are the most frequent cause of injury-related hospitalizations and in 1995/96, accounted for 78% of injury-related deaths for Canadians 65 years and older (Langlois et al., 1996). In 1995/96, there were over sixty thousand fall-related injury

admissions to hospital for seniors 65 years and older. Another recent study estimated the annual cost of fall-related injuries for Canadians 65 years and older to be \$2.8 billion in 1994 (Asche, Gallagher, & Coyte, unpublished manuscript).

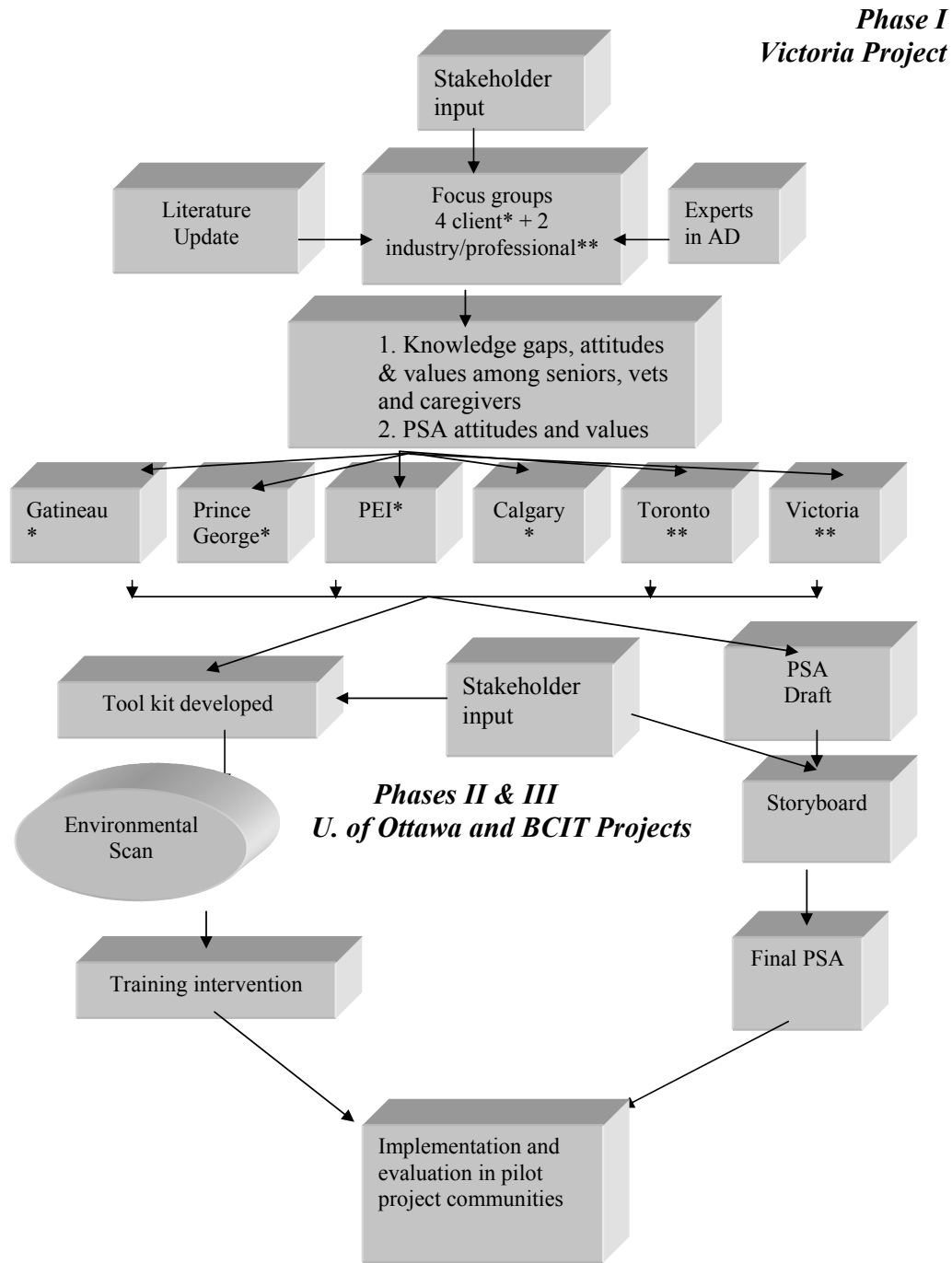
For this project, an assistive device was defined as an object that could prevent a person from falling down or one that would protect a person from injury if he or she fell down. In order to focus discussion among participants across the country, three devices were selected by the Steering Committee for discussion: canes, grab bars and hip protectors.

2.2 Brief Review of the Literature

One poorly-researched aspect of falls prevention is the decision process by which seniors come to use or decline use of various assistive devices. In a study we undertook in 1994, an average of 11 suggestions per senior were made to reduce their fall risks, many suggestions pertaining to improved safety features in the home. Fewer than 40% of the suggestions were acted upon 6 months later and “having a health problem checked by a doctor” was five times as likely to be carried out as “installing a grab bar in the bathroom” (Gallagher & Scott, 1997).

There is some evidence to suggest that veterans may have different assistive device use patterns than non-veteran seniors. Weaver et al (1999) examined home medical equipment (HME) use among 1,040 older American veterans with severe disabilities or terminal illnesses who were considered appropriate for home health services. Of the participants, 78 % were aged 65 and older. It was found that 83 percent of the veterans received at least one item during the 12-month study period, with the average HME recipient receiving 7.4 items. The most common items included commodes/bath benches (9%), canes/walkers (7%), safety equipment (7%), liquid oxygen (6%), and wheelchairs (6%).

Figure 1 – Logic Model of Three HC-VAC AD Projects



Receipt of HME was significantly related to baseline functional status, age, income, cognitive impairment, and risk of being re-hospitalized.

There is little literature concerning seniors' attitudes and values about assistive devices. Aminzadeh and Edwards (1997) conducted focus group interviews with a convenience sample of 30 community-dwelling older adults aged 61-86 (mean age 72.2) documenting personal experiences with (and the meaning of) falls, aging, and assistive device use for older adults. Participants acknowledged the many safety and functional gains of cane use, but also cited a range of attitudinal, normative, perceptual, and access barriers to cane use. Participants had favourable evaluations of bathroom safety devices, such as grab bars. Their comments suggested that, compared with canes, bathroom aids might be less frequently associated with aging and disability and more easily accepted and used by older adults.

Edwards and Jones (1998) studied ownership and use of assistive devices among community dwelling seniors in three areas of South Wales, UK. A random sample of 1,405 people was interviewed about ownership and use of assistive devices and other appliances. Seventy-four percent of respondents owned one or more aids. The most commonly owned assistive devices were non-slip bath mats (50%), a walking stick (cane) (24%), and a bath rail (21%). Many severely disabled people had no aids. For example, 75 percent had no stair rail, 68% had no lavatory rail, and 46% had no non-slip bath mat. Walking frames and wheelchairs were used more by those over age 75, as were all bathroom and lavatory appliances. This study confirms that ownership and use of aids varies with age, gender, living arrangements, and disability. Very disabled people need, but do not always own, certain basic and relatively inexpensive appliances.

It is not well known how seniors wish to receive information about assistive devices. A recent Australian study queried where, from whom and how older persons in one city wish to receive such information (Commonwealth Department of Health and Aged Care, 2000). The present project

was designed to shed light on this issue in a Canadian context.

2.3 Project Goals and Objectives

This project undertook to explore Canadian seniors' experiences and values concerning assistive device use and how best to provide information concerning these devices. There were two outcome objectives of the work:

1. To coordinate the efforts of the three separate projects concerning assistive device use funded by this Health Canada initiative.
2. To produce guidelines for social marketers, researchers and clinicians about the best way to provide information to seniors, veterans and their caregivers concerning assistive devices. This included examining:
 - How to improve product designs.
 - How to address barriers to acceptability.
 - How seniors, veterans and caregivers wish to obtain information concerning assistive devices.

3.0 Methodology

This was a qualitative study using a participatory action research approach to engage key stakeholders in planning and carrying out the data collection. Focus groups were used to collect data, and three of the authors analyzed and interpreted the findings.

3.1 Steering Committee

A project Steering Committee was formed to oversee the project. The group consisted of 9 Canadians representing seniors, veterans, family caregivers, researchers and private industry. The group included representation from across Canada's diverse geography including Quebec. An ex-officio representative of Health Canada Division of Aging and Seniors was included as well. The

Steering Committee reviewed all program materials to ensure clarity and age-appropriateness.

3.2 Focus Groups

The project hosted a series of six focus groups across the country in rural and urban communities and in both Francophone and Anglophone settings. Four of the focus groups were with seniors, veterans and caregivers, all of whom volunteered after being recommended by a local focus group coordinator. Their names were purposefully selected from an initial list of between 15-18 names. The sessions held in three communities were co-facilitated by Drs. Gallagher and Thomas. A session in a Francophone setting was conducted in French by Carol Clements, a bilingual researcher living in that community.

Two additional focus groups were conducted with assistive device industry representatives, professionals, sales personnel and funders. These groups were led by Dr. Scott, with Dr. Thomas assisting with one of the groups. All six groups were tape-recorded, and the results transcribed. The Francophone group results were translated into English.

The Steering Committee was asked to decide which devices would be the focus of this study. They recommended including canes, bathroom grab bars and hip protectors. They also reviewed a sample of the questions and format to be used in the focus groups. The final set of questions for each group is included as Appendix A.

Based on the advice of the National Steering Committee, a decision model was adopted to guide the questions in order to specifically draw out the experiences and concerns of participants at each stage of the process as suggested by Prochaska and DiClemente (1983). Their model is known as the transtheoretical model (TTM) of behavior. The model was designed to assess the readiness of an individual to change and then tailor an intervention program unique to that individual.

Focus groups are a powerful methodology to elicit a better understanding of attitudes, opinions, values and shared meanings among specific constituencies. Used in business and academic settings, the data gathered by focus groups provides valuable nuances that are missed by surveys and questionnaires. But focus groups are not meant to be representative populations. One can neither generalize about the characteristics of a population nor can one predict the behaviour of a population based upon focus group data. The data in this report is presented to enrich an understanding of seniors' and veterans' attitudes, opinions, values and shared meanings about assistive devices.

3.3 Participants in the Seniors/Veterans/ Caregivers (SVC) Focus Group

The members of the focus groups include a mix of genders, disability levels, types of assistive device use, income levels and ethnic backgrounds. A mix of seniors, veterans and caregivers were sought for inclusion in each group. The settings chosen for the focus group sessions were accessible and central, using resources such as seniors' centres, hotels and legion halls. Transportation costs were covered as needed and light refreshments were provided for all participants.

In total, 34 people participated in four focus groups distributed as follows: Charlottetown – 11 (32%), Prince George – 10 (29%), Gatineau – 9 (27%) and Calgary – 4 (12%). In terms of “mother tongue”, 62% were English, 32% Francophone and 2 “other.” Of the 34 participants, 27 (80%) were 65 and over. The age range was from 36-86 with a median age of 72. The marital status of the participants is shown in Table 1. The valid percent column excludes all missing data.

Table 1

Marital Status					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Divorced/Separated	6	17.6	18.2	18.2
	Married/Common Law	19	55.9	57.6	75.8
	Never Married/Single	1	2.9	3.0	78.8
	Widowed	7	20.6	21.2	100.0
	Total	33	97.1	100.0	
Missing	"Did not answer"	1	2.9		
Total		34	100.0		

Among the participants, 9 (27%) stated they were veterans. Women accounted for 62% (n=21). In total, 12 people (45%) said they were providing caregiving to seniors. Of those participating, 14 said they lived alone. Of those not living alone, 12 lived with a spouse, four lived with children, and three lived with "others."

The highest level of education reported by the participants was as follows: 15% had completed grade school; 38% had completed post-secondary training or other; 9% had a university degree and one person did not respond. When asked how well their income satisfies their present needs, 4 people (12%) said "completely inadequate", 3 (9%) said mostly inadequate", 10 (29%) said mostly adequate, and 15 (44%) said completely adequate.

3.4. Participants in the Professional/Vendors (PV) Group

A total of 13 people participated in the two professional/vendor focus groups. These consisted of 4 funders, 2 supplier or manufacturers of assistive devices, 2 occupational therapists, 2 physiotherapists and 3 retailers. The range of years employed in their current type of work was 1 - 27 years. Nine people were female and four were men. One listed education as "high school" and the remainder had college or university degrees. There were no seniors in the professional groups, though most of the members were over 40. The age categories of the professionals are shown in Table 2. The valid percent column excludes all missing data.

Table 2

Your Age category					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	19-29	2	15.4	16.7	16.7
	30-39	1	7.7	8.3	25.0
	40-49	3	23.1	25.0	50.0
	50-59	6	46.2	50.0	100.0
	Total	12	92.3	100.0	
Missing	Did not answer	1	7.7		
Total		13	100.0		

3.5 Knowledge and Use of Assistive Devices

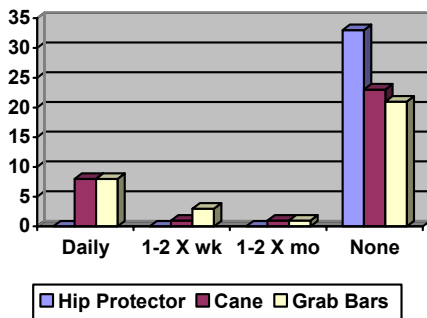
In a pre-screening questionnaire, SVC focus group participants were asked whether they had heard of any of three assistive devices and whether they had used such devices. The responses are summarized in Table 3. As this is not a representative sample of seniors, veterans and caregivers, and the number of respondents is small, these numbers are not intended to be generalizable to the population. They are included for the purposes of describing the participants.

Table 3
Knowledge and Use of Selective Assistive Devices
(n=34)

Question	Frequency of Yes Responses (1 missing)	Percent of Yes Responses (1 missing)
1. Have you heard of a cane?	34	100%
2. Have you used a cane?	13	40%
3. Have you heard of grab bars?	33	97%
4. Have you used grab bars?	17	53%
5. Have you heard of hip protectors?	3	9%
6. Have you used hip protectors?	0	97%

As shown in Table 3, while all of the participants had heard of canes and most of the participants had heard grab bars, only 3 people (9%) had heard of hip protectors. Forty percent had actually used a cane, 53% had used grab bars and no one had used a hip protector. Figure 2 shows the patterns of use of these devices. Of those who used canes and grab bars, the most frequent response category was “daily.” A smaller number used these devices periodically.

Figure 2
Utilization Patterns of Assistive Devices (n=34)



4.0 Study Findings

The findings presented below describe the data collected and analyzed from the four SVC focus groups and the two PV focus groups as described in Chapter 3, Methods. The findings are presented and organized under the following groupings that reflect the dominant themes and sub-themes that emerged from the study:

- 4.1 Specific Devices: Attitudes and Opinions
- 4.2 Realization of Need
- 4.3 Gaining Information
- 4.4 Obtaining a Device
- 4.5 Barriers and Enablers which Influence Using Assistive Devices

Taken together, these themes describe key perspectives, opinions and knowledge of the participants' response to the research questions discussed in the focus groups. Because of the small non-representative sample, these findings are suggestive and informative but cannot be generalized to the population. The findings will add to the growing body of information about the use of assistive devices by older persons, caregivers, professionals and the commercial providers who assist in their selection and recommendation for use and purchase. Further analysis of the findings, including references to the literature and implications of this study, are discussed in the concluding Chapter 5, Implications and Recommendations.

4.1 Specific Devices: Attitudes and Opinions

This section describes participants' general comments and attitudes about various assistive devices. In particular, it outlines some general beliefs about how various devices were seen to be useful to older persons. Although the comments are speculative, the data illustrates general knowledge about other devices and, in some instances, offered quite creative perspectives.

Participants' attitudes about various devices are organized into four themes:

- 4.1.1 Stability Devices.
- 4.1.2 Elevating Devices.
- 4.1.3 Security Devices.
- 4.1.4 Home Surface Alterations.
- 4.1.5 Emotional Reactions to Assistive Devices

4.1.1 Stability Devices

This group of devices were seen to aid stability, both inside and outside the home. These devices were considered useful because they were perceived to prevent slipping or enhanced the feel and texture of a surface underfoot, making it easier to negotiate the terrain. This implied, that some participants felt the use of these devices would help someone feel more sensitive to or 'connect' with the ground or uneven surfaces that they found difficult to see or sense. As one participant commented about a walker with wheels, "I can see someone who travels the streets with a...a wheeled device which I would feel must be very helpful, in that, it is something on which you can lean and it is something which pushing ahead of you would feel the bumps or...the curb."

The examples most often mentioned included: walkers and walkers with wheels, bath mats, textured 'stick-on' surfaces in bathtubs, and shoes and canes fitted with spikes to grip the ground and prevent slippage on icy surfaces. Commenting on a textured surface applied to a bathroom floor, it was noted, "...you put them on both sides of the tub and it's good to have them on the floor in the bathroom as well...yeah, it gives a nice roughness to it [the surface]." One individual commented on a creative system designed by a senior to assist him to walk steadily in his home. He found a wheelchair cumbersome but suggested putting "a rail on the ceiling, a kind of bungee cord system, so you have a harness...and then it pulls up to the rail and the person would kind of bounce about" enabling them to feel the

floor but remain steady on their feet. Evidently, this was installed and enabled this person to move with safety and stability anywhere in his home and prevent falls!

4.1.2 *Elevating Devices*

Participants mentioned a range of devices they believed were helpful to elevate someone who can't stand up safely from a low-seated position. The most common, shared experiences related to the frustration and fear of falling when getting out of a low bath, getting up from a recliner chair, low soft couch or raising oneself from a toilet seat. The circumstances described by many participants indicated that these three activities were essential parts of everyday life and it was common sense to have simple devices to raise the person's centre of gravity, allowing them to safely stand from a sitting position. All of the devices mentioned were those found inside the home. Key examples included: tub and shower chairs, bath benches, boards across a bathtub, lifts to assist getting in and out of a chair or tub, stabilizing poles fitted next to a bed, armchair or couch to grasp and assist standing and firm pillows to elevate any seating position.

The importance of getting an inexpensive, easy to install elevating device was seen as a simple and private way to counter common problems associated with leg and knee weakness, and prevent falls. One participant summarized this well stating, "I also have a board that goes across my tub so I can sit with a shower extension and just sit in the tub and swing [my legs] out and in and don't have to stand up and be afraid of falling there."

4.1.3 *Security Devices*

The majority of comments concerning devices to enhance personal security related to falling at home and not being able to get up and call for help. Several participants expressed a real fear that they would be injured and unable to get help. One noted, **"I just wanted to point out I haven't got the strength in my arms and legs anymore. If I fall, I can't get up off the floor...that's why**

I have this Lifeline...so I can call for help."

The most common examples of security devices included: call bells, electronic alarm devices that a person wears and nightlights.

4.1.4 *Home Surface and Implement Alterations*

Additional discussion about specific devices focused on utensil/tool design and surface alterations. Tool design alterations were mentioned because they prevented unnecessary bending or awkward reaching that could impact on balance and cause a fall. Key examples included long handled 'grabbers' and long handled sponges for bathing.

Helpful items to correct or alter problems that could lead to a fall included: carpet tape, threshold ramps and stair lifts. Loose carpets were mentioned as a significant risk factor in falls, but problematic because no one wants to get rid of their carpets. Carpets have sentimental value and contribute to the 'hominess' of a dwelling. As one participant noted, "there are often carpets on top of carpets and you don't want to get rid of them." Some people expressed distaste for using carpet tape.

Finally there was passing mention of other devices that may be useful or needed by certain individuals faced with specific challenges or circumstances. These included: knee braces, automated temperature controls for tub and shower (for seniors unable to discriminate temperature), orthopaedic shoes, and wheelchairs.

4.1.5 *Emotional Reactions to Devices*

While this study was interested in a wide range of assistive devices and did not limit focus group discussion to particular assistive devices, the emphasis was placed on canes, bathroom grab bars and hip protector underpants. Although unsolicited, every focus group discussed walkers at some length.

Discussions about different devices included varying emotional overtones. For example, bathroom grab bar discussions focused on the utility, installation and price of the items rather than how the person might feel about them or what they thought others would think or feel. The following exchange was typical of these discussions:

- Female: It's for getting off the toilet and for getting in and out of the tub because it's close to both of them.
- Male: Is that the bar that clamps on the side of your tub?
- Female: No, no, it's a wall bar. It's on the wall.
- Male: I have one on the side of the tub that comes up.

Discussions about hip protector underpants were both functional and emotional. Hip protector underpants evoked emotional responses with people not only commenting, but also making grimacing faces when holding the models. Because only one in three people had heard of hip protectors, much of the discussion among SVC group members consisted of questions directed at the researchers. Typical questions concerned whether one would be able to see bulges through clothing, thus making the hips look larger. There were also questions about the ease with which one could put on and take off the underpants as well as questions about the efficacy of protection.

Canes and walkers were discussed in terms of how they looked to others, specifically how the assistive devices marked a person as old or disabled. In a discussion about whether canes made one feel stronger or weaker, one veteran said, **"If I were to go to the Legion with a cane they'd start asking me, 'What are doing with a cane? What's wrong with you?' I'd have to start talking about those things and I don't want to. So I just act as if there wasn't anything wrong with me."** One woman stated that she would only use a cane if she moved to a different place. Some of the seniors discussed the styles and fashion of canes and walkers, including the history of canes as an accessory for gentlemen.

4.2 Realization of Need

Overall, this category reflects the processes identified in the data to describe how participants thought older people first recognized that an assistive device might be needed. Four 'decision paths' were identified that best reflected these processes:

- 4.2.1 Experiencing a Crisis or Trigger Event
- 4.2.2 Observing Gradual Decline and Coping Incrementally
- 4.2.3 Caregiver/family Recommendation/intervention
- 4.2.4 Health Professional Intervention/referral

4.2.1 *Experiencing a Crisis or Trigger Event*

The first and most commonly cited process leading to recognition of need was the occurrence of a significant trigger event or crisis by an individual. This was mentioned most by those participants who had personal experience or knew someone having personal experience with a severe fall, a fracture from a fall, or significant mobility problems resulting in a medical crisis (persistent dizziness, unsteady gait, constant tripping). **The trigger event or crisis so challenged the usual functioning/quality of life for that person that a change in their coping and behaviour was actually forced on them.**

One man described how he came to use a cane, referring to a sudden, persistent dizziness and ringing in his ears from an inner ear infection, so severe that he had great difficulty walking. He stated, "And that's when I got my first cane. Anyhow, that's what started it."

4.2.2 *Observing Gradual Decline and Coping Incrementally*

The second process leading to realization of need for a device was a decreasing ability over

time to do necessary routine activities, such as getting in and out of a bath, or gradual but noticeable changes in gait such as persistent tripping with near falls, unsteadiness and poor balance leading to constant fear of falling. Participants cited various ways they used to compensate and cope, but few senior participants indicated that they thought early on about needing an assistive device. Individuals indicated they coped by curtailing an activity or they somehow muddled along until their coping became ineffective. In this case, **increasing problems with balance and functioning, rather than realization of “a need” for an assistive device, lead to looking for some type of help.**

One woman said, “I had very poor balance. I would wobble around. In the house I had a lower level [a basement] but I realized I didn’t have to use that. I sort of eliminated all the things I didn’t have to do.” Faced with an increasing physical challenge or decline in physical functioning, the older person indicated they started to think in terms of the future and, “What will I do if?”

This approach suggests that **awareness or realization of need grew gradually out of fear of a worsening condition and thus prompted their seeking help.** Some participants anticipated needing a device as they aged because they believed that aging led to decreasing ability over time. One veteran said he did not use a cane or walker in spite of having balance problems but reflected about possible use of a device in future: “I don’t use a cane or a walker or anything. Not yet anyways, but probably the day might come.”

Some seniors in this study thought that having an assistive device would give them peace of mind, should their condition decline in the future. One senior who had previously had a severe fall, chose to use a Medical Alert wrist watch alarm to provide her with a sense of security should she fall in the future. She expressed great relief in knowing that, “I can just call for help...it gives you a great peace of mind.”

4.2.3 *Caregiver/Family Recommendation/Intervention*

The third process leading to realization of need for an assistive device was the unsolicited recommendation or intervention of a family member or caregiver who suggested the use of a device or who simply brought one to their loved one.

One family participant noted, “We bought it [a cane] for mother because she loved walking and we were afraid she would fall.” Family interventions were usually described as proactive and anticipatory approaches. Families believed they recognized significant problems were developing with gait and unsteadiness leading to increased risk of falls. As one supplier suggested: **“By suggesting the use of an assistive device, family members believe they are helping their loved one retain independence.”**

In contrast with this, this recognition of need was not necessarily shared by the individual nor was the individual always receptive to family suggestions. Some older individuals indicated that family intervention signalled “loss of autonomy.” As one stated, **“Some people don’t want to admit that they need something.”**

4.2.4 *Health Professional Intervention/Referral*

The fourth process leading to realization of a need for an assistive device was direct medical referral or other health professional intervention. Hearing the words from a doctor regarding need for a cane or handrails, for example, simply carried more weight with some older persons regardless of whether their family had said the same thing. As one professional said, **“First of all, children try to do it [recommend a device]. Often times they can’t. An outside professional is needed, who will probably give exactly the same advice as the children will give.”** Having a medical label for a problem (e.g.,

hypertension or osteoarthritis), seemed to enable some of the older individuals to accept the need to use an assistive device.

In summary, the findings indicate that perception of need is both a complex and personal experience. **As one older participant said, “You’ve got to have that feeling in you that you really need it.”**

These four patterns reflect commonly expressed ways by which individuals realize a need for an assistive device. They were by no means the only reasons nor were they mutually exclusive reasons. The data does suggest that people are most likely to decide to obtain an assistive device if one or more of the following conditions exist: a trigger event such as a serious and debilitating incident concerning mobility; noticeable decline in mobility such as problems with gait, balance, gradual weakness or pain in legs over time; family recognition of changes in function that could lead to increased risk of injury and falling; and, health professional intervention and diagnosis.

4.3 Gaining Information

Overall, this category reflects how and in what format participants thought older people best accessed information about assistive devices.

Themes that were identified include:

- 4.3.1 The Importance of Personal Contact in Obtaining Information
- 4.3.2 Receiving Professional Advice
- 4.3.3 Other Sources of Information Concerning Assistive Devices
- 4.3.4 Consistency of Messages
- 4.3.5 Reliability of Sources

4.3.1 *The Importance of Personal Contact in Obtaining Information*

The most frequently mentioned method of gaining information was one-to-one interaction with one or more persons. Many examples were provided including: calling an information line or 1-800 number and talking to someone; a visit to a physiotherapy clinic in the community or in

hospital and talking to staff; visiting a nursing home and talking with front-line caregivers who used the devices in their daily work; and chatting with the pharmacist at a local drug store.

The common component in all the examples was the value placed on personal contact, i.e., simply talking with someone who was perceived to be knowledgeable. As one participant commented on her nursing home visit, “The staff there, the people who do the actual care-giving know better than RNs in some cases [about assistive devices], because they are actually doing it.”

Several mentioned their dislike of phone information lines where you get a recorded message. One participant stated, “No, I hate recordings. I want to talk to a person.” Additionally, a few participants commented that calling a toll free number could present cognitive challenges for some of the seniors. A recorded message required preparation with paper and pencil and an ability to mentally track information given in very fast sequence, a requirement that could be difficult and frustrating for some seniors to follow.

Some people indicated that a central source to access information, even if this service referred the caller to another source, would be useful...as long as they talked to a “real person.” The common key element was personal contact.

4.3.2 *Receiving Professional Advice*

Once older persons decide they could benefit from an assistive device, they often turn to professionals to validate this need and determine which device will be appropriate for them. Participants discussed a number of ways to receive professional advice about assistive devices. As noted earlier, professionals may have been the ones to trigger the inquiry at the outset, so these processes do not necessarily follow in this order nor are they experienced by all seniors.

Many of the seniors participating in this inquiry would have preferred to receive advice from their family physician. Several people commented that they had a well-established relationship and the doctor knew their whole medical history. As one person stated, “[You] go to your family doctor who you are comfortable with. He or she will look up that information for you.” Another noted that this **considerable trust placed in the family physician was particularly true of this generation of seniors**: “This generation does listen to their doctors generally.”

Although receiving advice from a physician was the preferred route identified by most older participants, some caveats and drawbacks were noted. Some seniors were quite reluctant to visit the doctor, believing issues such as getting an appointment could be difficult. They seemed to believe their concerns would be perceived as trivial. **“Even if you feel you need this, you are reluctant to disturb a doctor [with such a trivial concern].”** There was evidence that some doctors do trivialize these matters. One senior related her experience saying, “I wanted somebody to help me. And the first thing he [doctor] said, well, you know you’re just getting older. I said, that’s the reason why you should help me live longer...He didn’t appreciate that.”

Some participants expressed the view that doctors tend to tell seniors what they need, focusing on disability and limitations, rather than explaining how a device could increase their safety and promote their independence. A caregiver noted, **“I often find that doctors want to impose things on seniors and that makes them believe that they’re not capable anymore.** I’m sorry but I think that these people [seniors] like to feel autonomous and they want to remain like that as long as they can.”

Another concern was that in telling your doctor you are unsteady on your feet or have fallen down, he may decide you are deteriorating and need to be put on more medication or even go into a nursing home. A physiotherapist participant supported this perspective stating, **“A lot of**

clients don’t want to bring up problems to the physician because often what they get back is, well, you should think about moving into a retirement home or a nursing home.”

Physiotherapists and occupational therapists were seen as being a valuable source of advice, with many participants emphasizing that therapists explained how a device works, how it promotes independence and safety, and importantly how to use it correctly. These types of instructions and teaching features were not noted when participants discussed receiving advice from physicians.

Additionally, several participants noted that therapists, especially occupational therapists, often made home visits to assess a problem and then did follow up visits to see how the senior was managing. As one caregiver noted, **“That’s where the occupational therapist plays an important role. They show people how things work, and depending on the situation, how to manage. I think it’s important to reassure people on how to use their device.”**

The participants who mentioned PT’s or OT’s were most often people who were either using or had used an assistive device or they had a family member who was using or had used an assistive device. One industry participant strongly concurred with this, saying “We sort of follow a protocol where if that client hasn’t already been to see a therapist, we encourage that they do...contact a therapist so that we can work together.”

Participants described other sources to receive professional advice including visiting a local clinic or health unit, although several noted how confusing the health system could be for seniors who did not know how to negotiate the system and find the appropriate resources. Another option noted was talking things over with a home care worker or social worker who did know “the system” and could direct them to appropriate help.

Overall, **the key attributes that participants attached to receiving sound professional advice from whatever source they identified, was trust, expertise, and an established and preferably ongoing relationship** (even if the source was a public entity). They appreciated receiving advice that incorporated teaching and instruction that emphasized how using a device would assist independence, quality of life and promote safety.

4.3.3 *Other Sources of Information Concerning Assistive Devices*

In addition to direct personal communication, focus group participants appreciated receiving **printed material on health topics**. Participants noted that **written material, created by a reliable source, posted in respected places, sent out in brochures and flyers (e.g., Sears catalogue, drugstore flyers) was an effective way to gain information**. In one city, for example, participants discussed a local seniors' weekly publication as being a trusted source of information on a number of matters, including health. Written communication allowed seniors to hold something in their hands. They could take their time reading it. They didn't have to remember a number, and they had a central information source with some specifics on the topic.

Focus group members also talked about where they would most likely obtain written information. **Several participants believed that printed material available in a doctor's office is a convenient and trusted way for seniors to obtain printed information on health-related topics**. Miscellaneous sources of information noted by participants included seniors' centres, the Arthritis Society, rehabilitation hospitals, Canada Pension Plan (e.g., a flyer on assistive devices with pension statements), and, "anywhere that is a centre" visited by seniors. Several participants agreed that many seniors regularly pick up flyers from their favourite local and national stores or services. Another mentioned the CARP magazine (Canadian Association of Retired Persons) as an

excellent regular resource to distribute print material. As noted, "I think a hundred thousand now in Canada that get that [CARP] magazine."

Radio was considered by several participants to be a valuable method of obtaining information about assistive devices. Many seniors were thought to be regular listeners of national programs such as CBC radio. In this way, the information could be provided by a known, reliable source, without commercial advertising.

The participants' views concerning **television** as a medium were mixed and complex. On one hand, some indicated that testimonial television spots could be helpful if done in an ethical, personal and tasteful way. Even **humour could be used, with several participants noting that seniors respond well to humour**. In addition, many indicated that TV would be useful if done as a series about assistive devices, e.g., a series featured on a regular program that could be aired over time and then repeated once the program had everyone's attention.

Short, fast paced TV information spots, using 1-800 numbers, were not believed to be useful according to some of the focus group members. The major concern was that **"seniors want to take their time to review information and to assess the action they need to take."** The fast pace of the television commercials did not allow for review of the material and consideration of its usefulness.

For these participants, the least favoured mode of communication was the Internet, although several indicated that web information on assistive devices could target younger family members who are skilled in "surfing the net." Some indicated that even if someone else, such as a family member, downloaded and printed the information from the Internet, seniors would be leery to accept the information as legitimate, although a

couple of people indicated that they had considered such information in the past.

4.3.4 Consistency of Messages

The consistency of messages about assistive devices was also noted as important by focus group participants. Several people suggested that a continually running ad in the paper (or posted on buses or bus stops) - similar to the "Pregnant and Need Help?" banner- could be very helpful. One participant suggested a 1-800 DON'T FALL number could be posted in prominent locations visited by seniors. This method would give a reliable, consistent central information source.

Message consistency would lead to familiarity and trust in gathering information about assistive devices.

Some differences between veterans and non-veterans were observed in terms of information seeking. It was noted that **veterans have access to counselling services and other sources of information not available to non-vets.** Additionally, veterans have an ID number that they provide when calling the Department of Veterans Affairs. This ID number enables the veteran's program area to access a personal file on that veteran and provide more personalized information based on specific personal (confidential) file information. This system appeared to streamline sources of information for veterans in a way not available to non-veterans, allowing the information to be perceived as more consistent.

4.3.5 Reliability of Sources

Reliability of the source of information was discussed at length in the various groups. Having a reliable and known individual, possibly someone with a high public profile, could be very helpful. Alternatively, one participant suggested that information provided by someone she could relate to [a peer] would catch her eye, "People would say, oh, well she looks okay using that. I'll get one too. If you needed it." Others concurred that **having someone talk about their personal experience with a device was helpful and a**

method to which they could relate. One participant stated, "What I like are the messages in which someone is giving a testimony." There was an explicit view that these had to be real stories, not just actors acting.

Other distinctions were offered about what made a source reliable. Several reliable sources were mentioned including government. One person thought that a message delivered by well-known public figure would get seniors' attention. Another mentioned that information provided by a professional association, or even a group of associations such as physiotherapists and occupational therapists would be considered reliable. As one senior participant noted, **"I would respond better to a health care professional or an association...it comes with some evidence behind it, as well, you know, not just anecdotes."** So while personal stories appealed to some of the seniors, others wanted the "hard facts" from professionals.

In every group, people indicated that reliable, credible information is not the same as an info-mercial where a company is merely trying to sell a product. As one participant stated, **"My first reaction, if it's from a company, is that they want to sell me their equipment."** Another noted, "You know when a company advertises a product, people will say, 'Oh, I'll try that product.' But myself, I'm very mistrustful. And then after they've bought it they realize that it's not the best one on the market."

4.4 Obtaining a Device

A wide range of factors were described by focus group participants concerning the actual purchase of assistive devices. These were coded according to the following themes:

- 4.4.1 Obtaining Financial Assistance to Purchase a Device
- 4.4.2 Deciding Where to Shop for an Assistive Device

4.4.3 Getting Information at the Point-of-Sale

4.4.4 Getting the Device Installed

4.4.1 *Obtaining Financial Assistance to Purchase a Device*

Regardless of region, all participants commented that for low-income seniors, seniors on fixed incomes and even seniors with supplemental private insurance, **assessment was the first step required to determine eligibility for equipment purchase.** Regions of the country had varied guidelines and complicated criteria that had to be met, all involving income-testing and physician prescription, followed by an arduous and lengthy process of waiting, filling out forms and more forms, and final approval and referral. The assessment and eligibility component of obtaining a device was not only confusing to many seniors but it came as a shocking surprise to some that their **medical coverage - even those with extended medical coverage - was often insufficient to cover certain items.**

Many participants were critical of the limits to medical plan coverage and mistrustful of private insurance companies. According to some participants, insurance companies rarely provided for what a client needed but rather, to save money, insurers provided the “low end” item for which that client was eligible. As an example, a senior might be assessed as eligible for a bed with lift features but that meant a manual crank model, not electric, which would be totally inappropriate for a frail senior who had balance and mobility challenges. As one noted, **“they’ve [seniors] had that luxury of having a medical plan because they’ve been paying for that medical plan all their life, but they are not necessarily going to get what they think.”**

As one occupational therapist noted, “We get lots who have almost no money, who are on government income supplements, whose family are subsidizing even their living arrangements and every other extra expense. We also have those who are going without because they don’t have the money.”

Veterans wanting to obtain a device also required assessment but the process, while considered bureaucratic and lengthy, appeared to some participants to be more understood and fair. It was suggested that because the government purchased this equipment en masse for all veterans, they were able to keep the costs down through competitive tendering. Another cost-saving measure introduced was the recycling of equipment. “A veteran client would get this equipment and it would belong to the government, but be used by the veteran. Then recycling came along [was added to the program] and they started using [those items again] adding more value.”

A couple of the professionals noted that **veterans often do not know what benefits are available to them nor are they aware that they could contact a counsellor to assist them in obtaining devices.** One professional told a story of a veteran who had been paying out of pocket for medicine for several years because he assumed that only expenses connected directly with his war service would be covered. Veteran participants indicated some confusion over what expenses were covered and how to find out what is and isn’t covered, indicating that the system seemed complicated to them or to other veterans that they knew.

4.4.2 *Deciding Where to Shop for an Assistive Device*

When participants were asked to discuss how seniors might go about actually obtaining an assistive device, the most common response was they would visit a retail store that specialized in assistive devices, such as canes, grab bars, scooters, walkers, bath and stair lifts. Many participants were aware of a medical/surgical retail store in or near their area. However, **several people believed they would only visit the store to “have a look” because of the reputation for high cost of the devices through commercial outlets.**

A few participants mentioned that it was a family member, most notably children, who would walk into a retailer and purchase equipment they believed their loved one needed. One participant estimated, **“80% are purchased by children, by the family members, not the user herself.”**

Another person expressed the view that retail outlets are not suitable for individuals with significant mobility problems or “shut-ins.” She claimed, “that’s the challenge because often it’s the single, female shut-ins who are the ones who are not getting exposure or access to a lot of this stuff.”

Most of the participants at one of the study sites were familiar with a medical supply outlet in their area that was run by two individuals who themselves had physical disabilities. Their personal experience and knowledge seemed to add considerable credibility to the perception that they were trustworthy and reliable merchants.

The availability of specialized retail stores was a major difference between the focus groups.

In one rural community, many of the participants indicated that they were only aware of suppliers of equipment in a metropolitan city 400 miles away. They indicated that many purchases, especially of larger items, had to be made via mail-order or phone order. This was in direct contrast with the city described in the preceding paragraph. In a Francophone community, several suppliers were identified and two outlets were valued because they were easy to access.

In addition to specialty stores, participants identified that assistive devices could also be purchased in hardware stores, pharmacies and department stores. In particular one could obtain simple items such as canes and grab bars in these outlets.

Other modes of obtaining a device were variations of donation/lending programs for non-veterans. The Red Cross was mentioned several times as an excellent source to obtain a device if a person had very little money. Donations through service organizations or local “loan cupboards” or other

organizations were a very helpful resource for low-income seniors needing a device.

Another variation, noted by an occupational therapist working in a hospital rehabilitation program, was **“dealers would loan us equipment and then the patients got to trial the equipment and see whether they like it or not...until you actually try it you are not going to know whether it potentially works for you or not...for the dealers it was write off in terms of some [equipment] got left there indefinitely...if the patient likes that equipment that was the dealer [who] got to sell that equipment if the patient decided to buy [it].”** A positive feature noted in one region was, once the client is approved, the “therapist will call a dealer...to bring the equipment...assistive devices to the client, to the environment for a trial period. It just makes more sense to do it there because they’re going to have to make sure that it works there first.”

4.4.3 Getting Information at the Point-of-Sale

Many people expressed the view that even the purchase of smaller items required someone knowledgeable in the store to size/fit/explain the device.

Many noted that the best way to obtain a prescription and get measured for a device was to go through a health centre or health unit. Health units were believed to have professional staff that helped with this type of thing. More significantly, health units helped seniors with the assessment and eligibility requirements that had to be established to determine co-payment for the equipment.

4.4.4 Getting the Device Installed

Not only did seniors have trouble at times figuring out what to buy and where to buy it, they also had to determine how to install it if that was required. Installation of grab bars was described as a somewhat complex process, beyond a simple purchase.

Installation was noted to be costly and it required a tradesperson to come into the home. One provider noted, “Personally, I would never recommend a grab bar unless it’s professionally installed.” There was a concern that improper installation might create a situation that was more hazardous than having nothing there. Another participant concurred stating, “I don’t care if it’s their son-in-law or the superintendent, I said, ‘If you want me to order it from you...that’s the bottom line. The company has to install it.’”

While specialized retail outlets were the most familiar and perhaps convenient way to view and/or directly purchase a device, other options were available in some communities through the health units or community organizations. However, except for those instances involving direct donation to an individual, **obtaining a device was seen as the last step in what many participants believed to be a lengthy, complex, sometimes contentious process of assessment, determining eligibility, and obtaining funding for various products.** Client income and type and extent of medical insurance, with few exceptions, were the major drivers influencing the outcome of this process.

4.5 Barriers and Enablers Which Influence Using Assistive Devices

Participants’ discussed many different elements and dimensions that influence a senior’s use of an assistive device. **Overall, when a person is fitted properly and taught how to use a device, participants agreed the outcome is often positive.** As two rehabilitation therapists noted, when a senior does use a device, it can be “very exciting....**you can actually see somebody’stheir world opens up. You can see that in their eyes.** They can do things they couldn’t do before. Opportunities and independence and some of them [say] okay! I can get to the liquor store, bingo hall or whatever.”

The factors and elements that influence an older person’s use of a device are complex and individual. However, some common features, that seemed to influence the successful or unsuccessful

use of a device, were noted by participants. The following sub-themes were identified:

- 4.5.1 Perception of Need and Risk
- 4.5.2 Stigma, Appearance and Pride
- 4.5.3 Learning How to Live with a Device

4.5.1 Perception of Need and Risk

The first, and for some participants the most complex element to influence use, starts with the seniors’ perception of need and their understanding and acceptance of the risks associated with that need. One participant noted a senior only used her cane because “she doesn’t want to be criticized because she is not using her cane.” In other words, social pressure rather than felt need influenced this woman’s experience. One therapist defined it as, **“It really depends on what they see as their main problem.** I find a lot of people are resistant to using walkers, certainly around the house, whereas if they have a goal in mind [needing the device to do something important to them] to be able to walk up safely to the corner store, then they are more likely to accept that.”

Another senior spoke eloquently about his experience with trying to understand his problem with walking and what contributed to his need for an assistive device, in this case an extremely expensive knee brace. His approach was - rather than going out and getting an assistive device - to try to understand what was causing him to be unsteady and work on those things first. He shared that, “if you don’t do that in the very first place, if you don’t try to look at yourself and say, and be willing to say, that I am doing something wrong hereif you’re not willing to look at yourself and say, I want to improve and what’s my best way to improve and often you’ll find that there are three or four different things.”

Some focus group participants believed that fear of deterioration of a condition would motivate some seniors to use a device. As

one senior participant noted, “even if you don’t want your cane, what happens is you walk...and you don’t walk very well...and you worsen the area where it hurts.”

Two thematic differences concerning perception of need by seniors and perception of need by professionals were identified across the focus groups.

Perception of need by seniors was first and always a personal experience that occurred within a social context. Changes in perception sometimes came slowly, sometimes suddenly. Seniors responded individually to their physical changes, and to feelings prompted by those changes, within the larger social fabric of their lives. Individuals came to terms with their need (or did not, in some cases) in a multi-layered, sometimes fragmented and highly personal way.

Seniors not only valued their own health and well-being, but they saw this well-being connected to how they appeared to others in their lives and how they felt about their own sense of self. **Image management and psychological satisfaction often conflicted with other sources of health and well-being to create a tension that was resolved in a variety of ways by seniors.** ‘Emotional logic’ played a significant part in perception and the subsequent decisions a senior would make about their risks and need for a device

On the other hand, some professionals held the view that if a senior was told about their risk factors and need, and informed about the choices and benefits of a device, they would respond in a reasonable, logical way. In professional jargon, client behaviour would effectively change through “patient compliance” (the degree to which an individual follows professional advice regarding the right course of behaviour/treatment) or patient education (the degree to which an individual is motivated to use a device because they understand the need for and efficacy of such a device).

In both of the professional focus groups, people expressed frustration at the reluctance, avoidance

and risk-extenuating behaviour of some seniors in the face of what they believed to be overwhelming evidence of need for an assistive device. Some of the professionals did recognize the extent to which seniors needed social support and were influenced by social and emotional factors, but they saw these as issues that should be addressed by explaining the reasons behind device use.

One senior offered a way to resolve this conflict. “It is so important the way you present the cane to the person who is going to use it. Using a third person can be great. You could use that veteran for example. When he discovered other people’s attitudes and how pleasant they were with him, he proudly said **‘Look what can happen when I walk with a cane’.**”

These differing perspectives illustrate how perception of need is an evolving process that develops through relationships and through an interplay of personal, social and professional contexts.

4.5.2 Stigma, Appearance and Pride

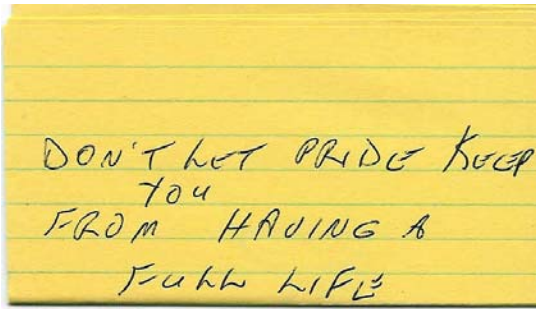
Many of the participants noted that use of a device carried a negative stigma of being old, dependent and disabled for some seniors. **For some older persons, use of a device was seen as a very public sign of decline.** Some participants thought this perception prevented many older persons from exploring the positive attributes of using an assistive device.

In addition to the perceived social stigma of using a device, several people commented that **the look and appearance of some of the devices contributed to this negative perception.** Commenting about the ‘medical look’ of a cane, one senior noted, “the cane, especially if it was not a medical looking cane, if it was something that was a little more fancy...something that provides dignity or whatever...and so it would serve the purpose both inside and outside the home.” Another shared how a senior had personalized a device

to make it appear less medical, stating, “I saw one of the veterans who was moving around in an automated chair. He’d decorated it and it made people laugh. After that, he didn’t feel so uncomfortable. Yes, the sense of humour, with things like that [matters].” By personalizing and making devices more socially attractive, some participants felt we could contribute to more successful use by seniors.

While some seniors did not state explicitly that they felt social pressure to avoid using the device in public, they believed pride and stubbornness contributed to prolonged resistance to public use. Whenever the topic of resistance to device use was discussed in the four SVC groups, at least one person said “pride” or “stubbornness”. This was immediately met with almost everyone at the table nodding their heads or voicing assent.

One participant, when asked “what single message would motivate seniors to use devices before an injury?” wrote on a piece of paper: “DON’T LET PRIDE KEEP YOU FROM HAVING A FULL LIFE.” She slipped it to the focus group leaders at the end of the session.



Additional comments about device appearance and design pertained to recliner lift chairs that were perceived to be popular with male seniors but which may be inappropriate for frail, small senior women. Some participants noted that design of such equipment should be responsive to gender differences and aesthetics. Female senior participants noted that a smaller, more “attractive” chair, that didn’t engulf them but served the same purpose, would be useful.

4.5.3 *Learning How to Live with a Device*

Some of the participants described the importance of teaching the use of a device to new users. One supplier participant indicated that, in his experience, **the best way to help clients to use devices was to understand the person’s lifestyle and identify the key activities most important for that person.** In this way, the supplier could assist the individual to selectively use and ‘trial’ the device without imposing continual use or an “all-or-nothing” compliance. As the supplier noted, “the user can define what is at risk or what his or her fear is, then I think they accept it within those perimeters...I think having a one hundred percent prescriptive kind of push is...just isn’t very effective in any kind of human behaviour.”

It appeared that teaching that supported incremental use, based on understanding lifestyle and personal need and priority activities, was believed to be the most effective way of introducing use of a device and supporting seniors to incorporate use of a device on a personalized basis.

A few participants commented that training in the use of a device - teaching that is sensitive to lifestyle and personal need - should be a mandatory component of selling all such equipment.

Overall, participants indicated the importance of being sensitive to social factors in supporting use of assistive devices. Such factors include appearance of the device, personal meaning of using the device and adapting the device to individual user lifestyles. If adopted it was believed that these factors could significantly and positively impact on seniors’ successful use of devices.

5.0 Implications and Recommendations

The findings in Chapter 4 inform our understanding about specific issues concerning the attitudes and values of seniors in relation to assistive devices. The implications and recommendations of these findings are presented and organized under the following groupings that reflect the purpose of the study. Suggested recommendations are provided that pertain to future practices, education and research. The conclusions are discussed under the following headings:

- 5.1 Seniors' and Veterans' Experiences and Values Concerning Assistive Device Use
- 5.2 Enablers and Barriers to Acceptability of Assistive Devices
- 5.3 Recommendations for Practice, Education and Research

5.1 Seniors' and Veterans' Experiences and Values Concerning Assistive Device Use

The central objective of this study was to identify seniors' and veterans' experiences and values concerning assistive devices. While interested in seniors' and veterans' awareness of any assistive device, this study emphasized three specific devices: canes, bathroom grab bars and hip protector underpants. A fourth device - walkers - was also emphasized since all of the groups frequently mentioned walkers..

The findings will help develop more effective methods of promoting use of devices to reduce the risk of falls or injury from falls.

The study was conducted across Canada not only to provide a national perspective and to see if there were differences based on locations. Care was taken to choose sites that represented differences between population sizes and rural to urban lifestyles. Additionally, a Francophone group was organized to assess potential differences related to cultural background. Each of the "user" groups had representatives from three constituencies: seniors, veterans and caregivers (SVC). In addition, two focus groups

were conducted with professionals and vendors (PV). In summary, these focus groups were designed not only to enable a larger national sample, but also to provide both intragroup and intergroup comparisons.

This section summarizes seniors', veterans' and caregivers' experiences with assistive devices, including the differences between devices and the values they attached to these devices. In addition the intragroup and intergroup comparisons are also addressed. These summaries are presented under the following groupings:

- 5.1.1 Awareness of Assistive Devices
- 5.1.2 Learning about Assistive Devices
- 5.1.3 Emotional and Social Values Concerning Assistive Device Use
- 5.1.4 Differences among Seniors
- 5.1.5 Differences among SVC groups
- 5.1.6 Differences between SVC and PV groups

5.1.1 Awareness of Assistive Devices

As expected, professionals and vendors were well versed in the different models, designs, prices, quality, efficacy and other characteristics of all the devices discussed. While knowledge among the user group members was not as sophisticated as the professionals, there were members in each of the four groups who expressed in depth knowledge of specific devices. The variation in knowledge depended heavily upon the device in question and whether the member had previously used the device.

A number of assistive devices were mentioned by all the groups. As outlined in section 4.1, participants understood the utility of many of the devices and were aware of various options depending upon the needs of the senior. Canes were by far the most familiar device to all members of SVC groups. Several members indicated knowledge that canes had different

features, for example, tripod canes or canes fitted with spikes for use on icy surfaces.

SVC group members were familiar with bathroom grab bars and several members were aware of different models, such as those that attach to the side of the tub. Several noted that while they didn't have one in their home, they had found them handy when encountered in hotel rooms and public washrooms.

Only three persons, among the SVC groups, were aware of hip protector underpants before the focus group was conducted. No one had used them. When hip protectors were introduced to the groups, reaction included outright rejection to curiosity about the product, including questions about where one might purchase them.

Awareness of walkers was also expressed in each SVC group. This awareness included knowledge of both stationary and wheeled models as well as the use of sidewalk curb lips or cuts which make it easier to navigate with a walker.

5.1.2 Learning about Assistive Devices

Knowledge about assistive devices was acquired from several different sources with varying beliefs about the legitimacy of the information. By far, physicians were described as the primary source of information for the user groups. For those seniors who had previously used an assistive device, gaining information from occupational therapists and physical therapists was also respected and valued. Less trusted, but certainly valued were retailers and specialty stores. These resources took on more value if the seniors were directed to them via a physician or other health care professional.

Consistency of information was important. Veterans were seen as having an advantage over non-veterans because they had a centralized source of information in their counsellors. For non-veterans the focal point to receive information appeared to be the physician, although using the physician did not usually result in receiving consistent information.

5.1.3 Emotional and Social Values about Assistive Device Use

Devices held symbolic value for seniors and veterans, especially those devices that were used in public. Grab bars and other bathroom fixtures, used in the privacy of the home, were discussed in more functional terms. The subject of hip-protectors elicited questions about how much they showed underneath clothing and if they made the hips look bigger. Canes and walkers were discussed in terms of fashion and style.

When viewed as a continuum, devices represented symbols of progressive deterioration of ability and health: a cane leads to a walker and a walker leads to a scooter and a scooter leads to a wheel chair. Because of this declining progression, some resisted using a cane until the "last moment" in the hopes that the beginning of the inevitable decline could be avoided or delayed. Thus, devices used in public were viewed as concrete symbols of dependency and disability. This finding is consistent with earlier research findings that canes were more associated with aging and frailty than bathroom grab bars (Aminzadeh and Edwards, 1997).

In light of these symbolic meanings, more publicly visible devices were seen as a negative symbol and a source of shame. Use of a cane or walker was associated with disability, aging and frailty, assumed to be negative attributes in society. Being able to get around without a device signified health, well-being and youthfulness, attributes believed to be regarded positively by others.

Seniors and veterans were not always direct in their discussions about these associations and stigmatizations. Rather, they spoke about seniors and veterans being too stubborn or proud to use a device. Ascribing a personal attribute, such as being stubborn or being proud, is a recognized way of handling social stigmatization.

Decisions about health and well-being take place in complex social and emotional contexts, involving conflicting tensions between physical and emotional well-being. Talk of being stubborn or proud suggests that seniors and veterans felt and understood that a tension existed between personal need for a device and social acceptance of use of the device. Their challenge was to resolve that tension in a personal and individual way that made sense to them.

5.1.4 Differences among Seniors

The results indicated that no noticeable differences were found between caregivers and other SVC group members. Caregivers expressed the same concerns as seniors and veterans, although the majority of the caregivers (7 of the 12) who participated in this study were not seniors. However, most of the caregivers were over age 45 and were living with a senior.

The differences between veterans and non-veterans focused on the mechanisms available to gain information and obtain a device. Veterans were perceived as having an easier time because of the availability of a counsellor to assist them with the complex assessment and funding procedures to obtain a device. Veterans were also seen as having more benefits available to them and thus, better access to a variety of assistive devices. The system available to veterans was also seen to provide more consistent and personalized information, something all of the seniors valued in gaining information.

However, although the veteran system was seen as more streamlined and easier to access than provincial health care, there was still confusion regarding benefits. Veteran participants noted they still required help to understand and access the benefits available to them.

When recruiting members for the SVC groups, care was taken to include both users and non-users of assistive devices. The most significant difference between users and non-users was that users knew about and respected other health care professionals, particularly occupational therapists

and physiotherapists. This is not surprising since an encounter with these professionals usually occurs after a doctor has suggested obtaining and using an assistive device.

5.1.5 Differences among SVC groups

It should be noted that no significant differences were found between Anglophone and Francophone SVC groups. French-speaking and English-speaking members expressed the same kinds of concerns, attitudes and opinions about assistive devices.

The four locations of the SVC groups can be seen as a continuum from a rural small town to large metropolitan area. In spite of this continuum, these groups held most of the same concerns, attitudes and opinions regardless of location.

One significant difference, however, did emerge concerning obtaining a device in a rural or urban location. Obtaining a device in an urban area meant going to a supplier with a prescription and shopping for that device. The largest urban area allowed for both price comparisons and trying out equipment, with the ease of returning it in person. The most rural location, however, meant depending on mail order and use of suppliers who were a day's travel away. This difference indicates the need for more effective means to access service in rural locations.

5.1.6 Differences between user (SVC) and provider (PV) groups

In addition to intergroup comparisons among the SVC groups, SVC groups and PV groups were compared. Two significant differences were noted.

First, PV group members often regarded users of devices in biomedical/behavioural model terms. The biomedical/behavioural model suggests that an expert, such as a health care professional, provides assessment, diagnosis, information and prescription for a client.

Clients, who often defer to “professional knowledge” accept the prescriptions and information as the singular source of information and then change their behaviour accordingly.

The PV focus group members often viewed their clients as reasonable people who need to be given instructions on the need for and use of assistive devices. Once this need is established through information and prescription, the client is expected to comply with the advice and use the device.

SVC group members regarded users of devices in a more holistic manner. They saw device use within an emotional, social and physical context that created a complex set of choices. Device use was not always the most appealing or reasonable choice in this complex context. Indeed obtaining a device through the information/prescriptive process did not necessarily mean that the device would be used. Several SVC members spoke of owning devices or having relatives who owned devices that were not used for various reasons.

Decisions about device use were made on a day-to-day basis. A cane might be used on days when the weather was particularly bad, but not on days when the weather was good. A cane might be chosen over a walker when the user thought they would be seen by certain people. In short, device use was not a matter of one choice at one moment, but rather was described by SVC group members as a choice that was made daily with a great many factors involved in the decision.

The second way PV groups and SVC groups differed was in their opinion of family physicians. SVC group members had considerable trust in the family physician, yet some scepticism about the availability and sensitivity of family physicians. They did not generally question the expertise of the family physician and assumed their family physician would be knowledgeable about assistive devices. Several SVC group members indicated that only a diagnosis from their physician would convince them of a need for an assistive device.

PV group members regarded the family physician as the least knowledgeable health care source for information on assistive devices. Additionally, some feared that physicians would not refer to other health care professionals with expertise in this area. PV group members recognized that seniors and veterans depended upon and trusted their family physicians. They pointed out that physicians, as the first point of entry by most seniors into the health system, are also the initiators (or not) of assistive device use. Most often, obtaining a device or receiving an assessment, requires a doctor’s prescription. This was a source of frustration for several of the PV group members.

5.2 Enablers and Barriers to Acceptability of Assistive Devices

While the primary goal of this project was to identify seniors’ and veterans’ experiences and values concerning assistive devices, it was also important to identify issues that affect early intervention. The majority of members from all the groups indicated that an injury from a fall was the event most likely to prompt someone to use or think about using an assistive device.

Since falls are the most frequent cause of injury-related hospitalizations (Langlois et al., 1996), intervention before a first-time fall injury is imperative if fall-related injury is to be reduced and seniors’ health maintained. This section discusses issues identified in the data presented in Chapter 4 that either would enable or prevent early intervention. The issues are presented under the following groupings:

- 5.2.1 Role of Physician in Assistive Device Intervention
- 5.2.2 Complexities of Health Care System
- 5.2.3 Inconsistency of Medical Model and Holistic Model

5.2.4 Paradox of Perception of Assistive Devices and Potential of Assistive Device Use

5.2.1 Role of Physician in Assistive Device Intervention

As discussed in Section 5.1.6, the role of the physician in assessing need and providing information about assistive devices was complex, even contradictory.. The family doctor can assist early intervention or, through lack of expertise, become a barrier to the senior receiving expert advice. It is not possible, from the data gathered from this study, to determine the precise role doctors play in this process. PV group members' opinions about physicians could reflect the usual professional 'turf war' that goes on in any organizational system involving professionals receiving fee for service. This includes doctors as well as PT's and OT's working in for-profit community clinics, seeing patients by referral.

Trust in physicians is part of the socialization in our culture. It is not clear to what extent physicians are trained and are knowledgeable about assistive devices. This is especially significant for the current cohort of seniors who came of age before self-help and medical consumer movements and who are uncomfortable questioning the authority of their doctor.

Without talking to and observing physicians, however, one cannot speculate on the veracity of either position. The physician's advice about needing a device carries considerable weight and they have an important role in early intervention because of the trust placed by seniors in their family physicians. This finding is supported by a 1994 study that found "having a health problem checked by a doctor" was five times as likely to be carried out as "installing a grab bar in the bathroom" (Gallagher & Scott, 1997).

5.2.1 Complexities of Health Care System

A major barrier to obtaining a device and using it correctly reflects the complexities of the present health care system in Canada. Even though

veterans were perceived to have better access to the system, all members from SVC and PV groups expressed concern, confusion and frustration with the system. As the expense and technology of the device increased, this barrier became more significant.

One positive benefit for veterans was the availability of counselling services, which provide a port of entry into the system and a 'real person' to show the way. The counsellor/advocate satisfied many of the concerns and preferences expressed by seniors in how they wanted to gather information. The advocate is a person, who provides consistent, reliable information and is not trying to sell something.

Suggesting that systems be centralized and streamlined to reduce confusion among seniors and provide trusted sources of information, is not the same as advocating a one-size-fits-all system. It should be noted that developing more effective programs for seniors to access assistive devices must include regional variations, attentive to differences such as the availability of suppliers.

5.2.2 Inconsistency of Medical Model and Holistic Model

As noted in section 5.1.6, an inconsistency exists between the ways users of devices see themselves and make their health care choices and the ways health professionals and providers of assessment devices view users and encourage health care choices.

One of the more pleasant findings was that all the members of the PV groups, including those who were definitely for-profit, were concerned about the need to provide preventive care. The PV participants were qualified professionals interested in providing their clients with the best information and they sought cooperation with other professionals rather than competition. Making a profit was dependant upon providing trustworthy,

knowledgeable assessment and service. This commitment to prevention, however, did not resolve the inconsistency between the ways the SVC group members and the PV group members viewed assistive device users and how they made choices.

This inconsistency could create barriers to early intervention and effective assistive device use. Even when the health care provider understands some of the social and emotional contexts related to assistive device use, education may not effectively change behaviour. As noted in section 4.2, the findings indicate that perception of need is both a complex and personal experience. Holistic approaches could take into consideration the behaviour of the user of the device, and fully acknowledge their social and personal experiences as well.

5.2.3 Paradox of Perception of Assistive Devices and Potential of Assistive Device Use

Possibly the most difficult barrier to resolve is the paradox that seniors' believe devices symbolize aging, frailty and dependency while providers believe that they lead to longer lives, stronger bodies and autonomy. This incongruity is a powerful barrier that is rooted in a wider social context: **the stigma of disability and aging.**

The seniors in this study expressed real concerns that going to a doctor and being told one needs an assistive device may lead to forced life changes such as moving into a long term care facility or having to hire a live-in companion. Being marked as "old" evokes real fears about decline and vulnerability. These fears are reinforced through cultural messages about elderly people that are promoted in the mainstream media and in public forums. While seniors internalize these stigmas and cope with them through various methods (including humour, self-effacement and denial), the source of the problem originates in the larger social context.

Overcoming this socially reinforced barrier will require more than simply trying to convince a

senior that they need a device, especially in relation to early intervention to prevent injury.

5.3 Recommendations for Practice, Education and Research

The central goal of this research was to identify seniors' and veterans' experiences and values concerning assistive devices and to identify issues that affect early intervention. These experiences, values and issues have implications for future practice, education and research.

5.3.1 Implications and Recommendations for Practice

- Streamline assessment procedures.
- Centralize information and provide an advocate or central counsellor to assist any senior through assessment, authorization, selection and funding of any device.
- Support practitioners through holistic education and increased program resources, to improve assessment and early intervention in the use of assistive devices. Practitioners involved in falls prevention and promoting the use of assistive devices must address ageism and the stigmatization associated with using assistive devices.
- Develop the most effective means of communicating information about assistive devices including face-to-face communication, effective written material distributed in key places frequented by seniors, using television and radio media to deliver high quality, consistent, and realistic messages about the benefits of assistive devices and how to access them.

5.3.2 *Implications and Recommendations for Education*

- Develop multidisciplinary education opportunities, involving physicians and other health care providers, to increase reflection about ageism and improve assessment, knowledge, referral and support of seniors needing an assistive device.

5.3.3 *Implications and Recommendations for Research and Policy*

- Further research should be supported to investigate how assistive devices are symbolic of dependency and deteriorating health and implications for preventive intervention. This evidence could be strengthened by studies with larger sample sizes using random samples.
- Investigate how physicians determine need for an assistive device, their knowledge about different devices and referral patterns.
- Support prevention research that involves seniors' collaboration with health professionals in the development of regional falls injury prevention networks..
- Continue to develop partnerships between community, practitioners, researchers and government, similar to this initiative, to carry forward a national falls prevention project, promoting effective use of assistive devices.
- **Public policy should support falls prevention in an aging population through improved supplemental health insurance to cover assistive devices, for low and limited income seniors.**

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