A NEEDS ASSESSMENT OF THE SENIORS IN A FRIENDLY VISITING PROGRAM

BY

Hai Luo

A Practicum submitted to

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In Partial Fulfillment of the Requirements for the Degree of

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ABSTRACT

This needs assessment attempted to find out: 1) what kinds of services are most demanded by the seniors involved in the Friendly Visiting Services at Age and Opportunity, 2) whether the current programs and services meet the seniors' needs, and 3) how the agency and professionals could best support the seniors. The study was designed with a mixed methodology that combined both quantitative and qualitative approaches. The program population's profile, the seniors' perceptions of their current lives, and their experiences with the Friendly Visiting program and other social services were examined and presented. A variety of factors, such as the seniors' limited mobility and their relationships with children, had a tremendous impact on the seniors in terms of insufficient social contact. Although some seniors reported that their lives had been negatively affected by inadequate social connections, many of them had an optimistic attitude towards their current lives. The seniors indicated their interests in a wide range of activities and expressed their concerns and expectations regarding the Friendly Visiting program and other services. The implications of the study are discussed and recommendations are offered to practitioners working with and for seniors.

CHAPTER 1

INTRODUCTION

Life expectancy has been increasng in most of the world. In Canada, older adults constitute the fastest growing population group. According to Health Canada, the population of Canada is expected to age more rapidly than the populations of other industrialized countries in the coming decades, as the "baby boomers" (born between 1946 and 1965) enter their senior years. In 2001, 12.5% of the overall Canadian population was 65 years of age or older. The portion of the population in this age group is expected to rise to nearly one in four (23%) by 2041 (Health Canada, 2003). Research findings show that most seniors reside in private households, and 29% of them live alone. In the case of seniors who rent their dwelling, nearly half live without anyone else in their residence (Health Canada, 2003). Therefore, nearly one-third of the elderly in Canada live alone either in their own houses or in rental apartments. Social isolation appears to be a critical issue among this population and calls for the concerns and efforts of professional workers.

The Friendly Visiting Services program is operated by Age and Opportunity in Winnipeg, Manitoba. Approximately 170 seniors are currently enrolled in the Friendly Visiting Services program citywide. The majority of the seniors in this

program live alone in the community with little social contact. The factors that confine seniors' social contact include limited mobility due to health conditions, lack of access to services, lack of affordable transportation, lack of family support, etc. In the Friendly Visiting Services program, clients and volunteer visitors are matched based on their mutual interests, hobbies, backgrounds, available time, and other personal characteristics. The volunteer visits the senior according to a schedule decided upon mutually, and their interactions provide opportunities to develop a positive and supportive friendship. The friendly visitor "functions as a new, and usually temporary, social relationship for the elderly person, providing social stimulation, companionship, advice, and a listening ear" (Korte & Gupta, 1991. p.404).

Despite the fact that a considerable number of seniors have been identified as isolated individuals, little is known about the population's problems, needs, and demands (Aging in Manitoba Study, 2000; Bennett, 1980a; Hall & Havens, 2001; Mulligan, 1980). While the chief executive officer and the community manager of Age and Opportunity were working with the student to identify the purpose for the practicum, they expressed their concerns about the clients in the Friendly Visiting Services. They suspected that, with the seniors' advancing age and the fact that many live alone, the clients of the Friendly Visiting Program may have other unmet needs, e.g. nutrition, daily activities – shopping, medical appointments, etc. It was suggested that a comprehensive needs assessment could assist in identifying

unmet needs and consequently provide new program/service opportunities.

Learning Goals

The student's learning goals are as follows:

1. To acquire a comprehensive understanding of socially isolated elderly people by undertaking a review of existing research and studies.
2. To become familiar with the theory and application of needs assessments through a critical review of the literature.
3. To develop skills and techniques of implementing a needs assessment, i.e., conceptualization, research design, proper sampling, and data analysis.
4. To develop skills in face-to-face interviews with seniors

Intervention Goals

The student has identified three intervention goals are identified:

1. To obtain an overall profile of the target population and compare the degree of well-being (e.g., demographic data, health status, socioeconomic status, etc.) of the service receivers with that of the general population of Canadian seniors.
2. To acquire an increased knowledge and understanding of the unmet needs of the target group, i.e., what are their particular needs with respect to the type of program being considered (e.g., Friendly Visiting Services and other

services available in the community)?

3. To develop an assessment instrument that will elicit comprehensive information about the target population, which would allow for a better understanding of the seniors' needs and problems.
4. To identify the kinds of services that are likely to be helpful to this particular population and different ways of enhancing service delivery.
5. To produce a meaningful report about the needs of isolated elderly, with recommendations for expanded/enhanced agency services and for an improved delivery system for socially isolated elderly persons.

The Benefit of Using a Needs Assessment in Social Work with the Elderly

A thorough needs assessment is mandatory for effective program planning (Hudson & Grinnell, 1989; Rossie and Freeman, 1999). Large agencies providing social services frequently conduct specially focused needs assessments on a regular basis, for instance, every one or two years (Witkin & Altschuld, 1995). For example, the Area Agency on Aging in Berkshire, Massachusetts conducts a needs assessment every two years. The results of the surveys help inform the agency for decisions about how to allocate the limited resources available for programming to satisfy the different needs of local seniors (Berkshire Senior Online, 2003).

Needs assessment is the first stage of program development and evaluation.

It usually takes place as part of a planning process before a program is actually implemented or while it is being re-assessed. The purpose is to assess the feasibility and need for establishing certain services (Hudson & Grinnell, 1989). Rossi, Freeman, & Lipsey (1999) state that needs assessment helps service providers to determine if a certain need exists in the community and, if so, what programs would best meet the need of the target population. A needs assessment is necessary for designing a new program. However, it is also critical to established program services because people's needs are not static. They change over time depending on people's health conditions, socioeconomic status, the consensus of living standards, and other personal and environmental factors. Very often "it cannot merely be assumed that the program is needed or that the services it provides are well suited to the nature of the need" (Rossi, Freeman, & Lipsey, 1999, p. 119). It may be also difficult to "gauge the magnitude of a social problem" (Rossi & Freeman, 1985, p. 107). Professionals and others who are concerned about the issue tend to exaggerate the degree of the problem. In some cases, although a problem is obvious and serious and affecting a large group of people, no significant data are available for addressing the severity and distributional characteristics. A good needs assessment can offer sufficient information, leading to an accurate description of existing problems, which could help prevent wasting resources on unnecessary programs and avoid misidentifying target population, target problems and their severity (Rossi, Freeman, & Lipsey, 1999).

Thus, a needs assessment study is essential for social workers to develop a successful program or service and deliver it in an efficient and effective way. Needs assessments help verify that a problem exists within a population to an extent that warrants the existing or proposed service. To do this, we must use carefully designed studies to produce precise estimates of the nature and distribution of the problem we believe exists (Hudson, J. & Grinnell, 1989).

In this practicum, the student conducted a needs assessment of the senior clients of a Friendly Visiting Services program at Age and Opportunity, Winnipeg, Manitoba from September to December, 2003. The final report is composed of seven chapters. In Chapter 2, the literature on needs assessment and socially isolated seniors is reviewed. The design of the practicum and the methodology of the study are described in Chapter 3. The results and major findings are presented in Chapter 4 and Chapter 5. Chapter 6 contains the discussions and implications of the findings, as well as the recommendations to service practitioners. Finally, the practicum is evaluated in Chapter 7 by rating each objective of learning goals and intervention goals.

CHAPTER 2

LITERATURE REVIEW

Key Concept: What is need?

There are many different perceptions on what constitutes need. Mui and Domanski (1999) chose to use a "marketing and economic perspective" of need, demonstrated by Mckillip (1987), in which need is defined as a "demand for a service for which the target populations are willing to trade something that the agency values" (p. 79). Witkin and Altschuld (1995) view "need" in a different manner, according to the two meanings of the word. Need as a noun refers to the gap between a present situation and a preferred condition or future state. In this respect, a need is like a problem or a concern. When need is used as a verb, it means that someone wants to obtain something to solve some problem. In this sense, need is like a solution to an underlying problem or a concern. They further explain that three levels of need exist:

Level 1 (primary): needs of the service receivers

Level 2 (secondary): needs of the service providers and policy makers

Level 3 (tertiary): needs of the organization

According to the authors, needs assessments can determine the needs of the subject(s) on any of the three levels.

Kettner and Moroney (1990) provide a more comprehensive analysis of need

and of how to identify a need based on the definition in Title XX or Title XX Amendments to the US Social Security Act, in which a need is defined as:

> ...any identifiable condition which limits a person or individual, or a family member in meeting his or her full potential. Needs are usually expressed in social, economic or health related terms and are frequently qualitative statements. Need assessment refers to the aggregation of similar individual needs in quantified terms. (Kettner & Moroney, 1990, p. 44-45)

The above definition will be used in this study. However, the concept of need still remains somewhat ambiguous and difficult to operationalize. Need has two dimensions: qualitative and quantitative. Qualitative statements require the description and labeling of a current situation as a problem; whereas quantification of needs is based on the assumption that similarities can be identified among "people or groups of people who are experiencing problems, and these problems can be translated into needs that can be categorized and aggregated" (Kettner & Moroney, 1990, p. 45), and then services and delivery structures can be developed accordingly.

Kettner and Moroney (1990) suggest that the theoretical understandings of need are established in the works of the two theorists: Ponsioen and Maslow. Ponsioen (1962) suggests a relative notion of need such that no one should fall below a certain level, and that the responsibility of a society or a community is "to meet the basic survival needs of its members, including their biological, social, emotional, and spiritual components" (Kettner & Moroney, 1990, p. 43). Maslow

(1954) argues need in hierarchical terms because only when the "lower" levels of needs (i.e., physiological survival needs, such as food and shelter) have been satisfied can higher ones be acquired (e.g., the need for love or self-development). Although Ponsioen's ideas are more applicable to the social work value that all people should be offered the opportunity to achieve their holistic well-being, the two theories are not necessarily contradictory. It is commonly known that physical or material needs are fundamental to, but do not necessarily guarantee, psychological well-being and mental health, but that efforts to improve the overall health of people should be made without discrimination.

Important assumptions about needs are that they are elastic and relative, they change over time, and they differ from one circumstance to another. Therefore, a needs assessment can only assist a professional in estimating what need exists at a given point in time. Kettner and Moroney (1990) conclude that three factors from environmental considerations are likely to influence changes in needs and people's perceptions of them. The first factor is the *standard of living*. An example of this is the demarcation of a poverty line that varies in different times and places. The second factor influencing the definition of need is the *sociopolitical environment*. Public attitude and consensus are not static. For instance, in the early stage of elderly welfare history, only housing or financial supports were available for seniors under certain conditions, and physical survival was considered the single need that the older adults might require. Now people realize

that many other kinds of needs are as important as material necessities, and a wide range of services is provided to seniors to ensure their mental health, psychological adjustment, and social connection. The third factor affecting how need is defined is the *availability of resources and the existence of technology.* If people do not know or believe that adequate resources are available to meet the particular needs, they are unlikely to seek resolutions and take actions. The definition of need will change as resources are enriched (e.g., more funding, more staff or volunteers, more nearby community centers, etc.), technology evolves (e.g., more convenient communication means, better transportation conditions, etc.), and the possibility of filling the gap between present and preferred states increases (Kettner & Moroney, 1990).

The authors further demonstrate four perspectives of need: normative need, perceived need, expressed need, and relative need (Kettner & Moroney, 1990). *Normative need* implies a standard or some criterion for evaluating the quality or quantity that characterize a situation. *Perceived need* is "what people think their needs are or feel their needs to be" (p. 49). Sometimes, a need exists, but people do not actually attempt to obtain a service to meet the need. *Expressed need* occurs when individuals actually translate a perception into an action – seeking help. Other writers (Rossi & Freeman, 1999) also recognize the distinction between "need" and "demand", and they emphasize the different treatments of the two types of information. *Relative need* is defined as the difference between the

services offered in one community and those available in similar communities or geographic areas. Given limited resources, priority ought to be set for populations in greater need of services. In this study, all four perspectives of need were included in the needs assessment, because limiting the selection to a single perspective would in turn restrict the comprehensiveness of the researcher's understanding of the socially isolated seniors

Literature on Needs Assessment

Definition of Needs Assessment

Researchers have put forward various definitions and understandings of needs assessment (NA). Rossi, Freeman, and Lipsey (1999) regard NA as "an evaluative study that answers questions about the social conditions a program is intended to address and the need for the program" (p. 118), and its purpose is to identify social problems, their extent, the target population, and the nature of people's needs (Rossi, Freeman, & Lipsey, 1999). While Rossi and his co-authors emphasize the meaning of NA on the "problem" side, Witkin and Altschuld (1990) focus on the "solution" side. According to them, NA can be defined as

> a systematic set of procedures undertaken for the purpose of setting priorities and making decisions about program or organizational improvement and allocation of resources. The priorities are based on identified needs. (p. 4)

In Neely's writing (2002), he chooses to use the definition employed by

Reviere et al. (1996), which is from the perspective of utilizing assessment outcomes. They state that NA is "a systematic and ongoing process of providing usable and useful information about the needs of a target population – to those who can and will use it to make judgements about policy and programs" (Reviere et al., 1996, quoted in Neely, 2002). There are other definitions of needs assessment. The United Way of America (1982) defined it as "a systematic process of collection and analysis as inputs into resource allocation decision with a view to discovering and identifying goods and services the community is lacking in relation to the general accepted standards, and for which there exists some consensus as to the community's responsibility for their provision" (quoted in Neely, 2002). McKillip (1987) defined it as a "process of evaluating the problems and solutions identified for a target population" (p. 20).

Based on the existing understanding and explanations of needs assessment, the notion used in this paper consists of the following characteristics:

- It is a systematic approach, with established procedures and methods;
- It aims at exploring problems of the target population and at addressing the gap between existing services and needs;
- It helps professionals and advocates set priorities for making decisions about program or organizational improvement and for allocating resources. In short, it can provide suggestions on solutions.

A Historical Review of Needs Assessment

Since the 1960s and 1970s, needs assessment has been widely used in health, mental health, and human service program planning. This growth happened due to the demands expressed by various funding sources upon evaluating grant applications, the demands by the public and private sectors for professional accountability, and the demands by service recipients for different services (Mui & Domanski, 1999). A variety of techniques and methodologies have been transplanted from other disciplines to this type of social research. For example, Witkin and Stephens (1968, 1973) adapted a system analysis and design method, called Fault Tree Analysis, from such fields as aerospace engineering, nuclear reactor studies, and highway safety, for use in educational and social research systems (Witkin & Altschuld, 1995). Another example of the evolution in needs assessment has been evident in the last decade, as the utilization of qualitative data has increased in the social research area, and the value of narrative information has been recognized as a complement to quantitative data for addressing the in-depth causation of problems (Fischer, 1994; McKillip, 1987; Rubinstein 1994). Methods for analyzing qualitative data have also been developed accordingly.

Although needs assessment is popular for measuring community problems in many social settings, it has been criticized for lacking construct validity (Mui & Domanski, 1999). As argued above, "need" is a value-related notion such that no

clear conceptual boundaries can be set to satisfy the purpose of every study and match the ideology of every individual. Needs assessment turns out to fall in a wide range of operational definitions, methodologies, and techniques. The critiques have given rise to the call to standardize instruments and operational notions (Mui & Domanski, 1999).

A Three-Phase Process of Needs Assessment

The model developed by Witkin and Altschuld (1995) is useful for clarifying the key components for assessing needs, and it integrates other authors' contributions to this kind of research. Witkin and Altschuld's model (1995) includes pre-assessment, main assessment, and post-assessment. *Pre-assessment* aims to determine what is already known about the population, possible problems, and the context. Preparatory work has to be done at this stage, for example, to measure the evaluability of target problems, and to study relevant literature. The assessor must design a thorough methodological plan for assessing needs, the core of which is developing the measurement instrument (either an existing instrument or a questionnaire compiled by the assessor) and a plan for gathering data in phase 2. Criteria should also be established to evaluate the whole needs assessment. Time, cost, and personnel inputs should be carefully considered and managed in order to carry out the assessment successfully. Besides, a pilot survey may be applied to a small number of community representatives if surveying instruments need to be

pre-tested.

The *main assessment* occurs in the second stage. This is the implementation phase. Researchers go into the community to collect information regarding the problem and the population, using the chosen or developed instrument. This phase can be very time-consuming and money-consuming. Some modifications may be made due to unexpected problems, without hurting the main purpose and design of the whole assessment.

The third phase is the *post-assessment.* Gathered data is analyzed and reported in this stage. Recommendations to services and organizations are provided based on the findings of the assessment. In addition, the entire assessment action is evaluated to identify its effectiveness.

Methodologies for Needs Assessment

The literature offers assessors various types of methodology and data gathering, and they can choose the one that best suits their research. The needs assessment methodology is generally comprised of surveys (by mail, telephone, and face-to-face survey), group methods (e.g., nominal, delphi, focus), and public hearing/community forums. Data can be categorized as primary (first-hand) and secondary (second-hand).

According to Witkin and Altschuld (1995), there are three general types of data resources: archival, communication processes, and analytic processes.

Archival material, which some authors call secondary data or existing statistics, refers to data gathered for other purposes by different researchers or institutes. The second type of data is gathered through "methods for seeking information directly from people rather than from examination of records" (Witkin & Altschuld, 1995, p. 47). These communication processes are used to collect the respondents' direct knowledge or opinions about issues and needs. A third category uses special techniques (e.g., causal analysis, trend analysis, task analysis, etc.) for analyzing data collected from archives and/or through communication processes (Witkin & Altschuld, 1995). Assessors should select suitable means to obtain different types of data because various data sources can be accessed through certain methods.

Kettner & Martin (1990) explore five methodologies for gaining access to data sources. They are: 1) extrapolations from existing studies; 2) service statistics; 3) resource inventories; 4) conducting a community survey; and 5) holding public forums. They also argue that none of these methods can be considered better than the others. Rather, each has its own strengths and limitations. The methods are mutually inclusive and can be used collaboratively in needs assessments. The literature provides rich resources for choosing proper research approaches for this study. Details on methodology will be presented in Chapter 3.

Literature on Socially Isolated Seniors

Definition

Social isolation is a term generally used to indicate "an absence of social interaction, contacts, and relationships with family, friends, neighbors, and society at large" (Kahana, 1995). The term *isolated* is defined in the Oxford English Dictionary (2nd ed., 1989) as "placed or standing apart or alone; detached or separate from other things or persons; unconnected with anything else; solitary." Based on the consensus in the literature, *social isolation* is viewed by social scientists as "the cutting off or minimizing of contact and communication with others and attempts to measure it in populations by such indices as anonymity, spatial mobility, location of friends, frequency of participation in groups, etc." (Jaco, 1954, quoted in Gould, J. & Kolb, 1964, p. 356). Generally, a person is said to be isolated if he or she has hardly any interaction and/or connections with the community or society, and little communication and/or few relationships with other individuals or groups.

Statistics (Health Canada, 2003) show that about 30% of Canadian seniors live alone in self-owned or rented dwellings. Even though living alone does not necessarily lead to the social isolation of aged people, nevertheless these seniors often experience the typical characteristics of social isolation--fewer physical activities, less social connection, and reduced community involvement--as common consequences of decreased mobility due to age-related health conditions,

in particular if they have insufficient assistance to go outside (Feit & Cuevas-Feit, 1996; O'Neill, 2002; Tunstall, 1966). Social isolation among the elderly has long been recognized as a critical problem requiring the efforts of society to help them maximize their well-being (Korte & Gupta, 1991; Tice & Perkins, 1996;Tunstall, 1966).

It has been found that social isolation is associated with problems of premature institutionalization, poor physical health, and low morale (Korte & Gupta, 1991). Older adults who are isolated and lonely are also candidates for alcohol abuse (O'Neill, 2002; Schenk & Holosko, 1996) and suicide (Knight & Maines, 2001; Tice & Perkins, 1996). For both older men and women, it is believed that social isolation is an underlying cause of many physical and psychological problems (McInnis-Dittrich, 1999; O'Neill, 2002).

Late-life isolation has been attributed to childless status, poor health conditions, mental illness, environmental changes, social role losses, etc. (Kahana, 1995) Seniors with limited mobility tend to withdraw from social and family activities, as well (Tunstall, 1966; Tunstall, 1966). Moreover, isolation in old age is seldom voluntary. In a large-scale study, it was evident that only 1% of older respondents were voluntary isolates who chose to stay in a situation characterized by the absence of social interaction (Atchley, 1994).

Social Theories of Aging

Since the early 1960s, a variety of voices have emerged in the field of theories regarding aging and old age. Atchley (1989, 1999, 2000), Bengtson and Schaie (1999), Cumming & Henry (1961), Friedrich (2001) and other researchers have contributed numerous thoughts in building theoretical structure for social gerontology. The social theories of aging are summarized in Table 2.1 (see page 27).

Table 2.1 Summary of Social Theories of Aging (O'Neill, 2002; Friedrich, 2001; Rathbun, 2001)

Theory	Basic Premise	Key Figure
Activity Theory	Staying socially more active leads to better adjustment to aging	Havighurst, Neugarten, & Tobin (1963); Kleemeier (1961); Hillier & Barrow (1999)
Disengagement Theory	With aging, people tend to withdraw from the social system and step aside from younger community members	Cumming & Henry (1961)
Continuity Theory	The ability to maintain continuity with previous life roles and activities helps one achieve healthy aging. Healthy aging means to force neither activity nor disengagement on an individual	Atchley (1989, 1999, 2000); Covey (1981)
Social Disruptive Events Theory	Disengagement is due to negative life events, e.g., loss of loved ones. Disengagement is undesirable, but inevitable.	Tallman & Kutner (1970); Brown (1974)
Reconstruction Theory	Older people accept the negative labels and stereotypes of them as weak and dependent. They tend to incorporate society's views, but this reinforces the stereotypes.	Kuypers & Bengtson (1973)
Age Stratification Theory	The natural process of aging, i.e., physical and mental changes, and external events, causes differences among individuals	Riley (1971)
Modernization Theory	One loses status as one ages, and loss is universal regardless of economic, religious, political or social traditions. The losses occur following the modernization of the society.	Cowgill & Holmes (1972)

Among all the theories of aging, activity theory and disengagement theory are essentially the opposite of one another, like "opposing grand metaphors for successful aging" (Atchley, 1995, p. 12). *Disengagement theory* assumes that social withdrawal and psychological disengagement are normal parts of aging and that social isolation and mental health issues are natural (Rathbun, 2001). Because of "the awareness of the shortness of life, a perception of a decreasing life space, and lessening of adaptive energy" (Tobin, 1995, p. 284), this withdrawal is intrinsic. Therefore, nothing can be done or should be done to alleviate these problems. Besides, disengagement does not lower older adults' morale (Tobin, 1995). Disengagement theory has been undergoing extensive criticism from many perspectives. Obvious evidence used against the idea of adaptive nature of disengagement is that the theory contradicts what we know about older adults staying active both physically and intellectually (McInnis-Dittrich, 1999). While patterns of withdrawing from society can be found among some seniors, those are rather individual adjustments to getting old, not the patterns of life that are generally accepted by the majority of the older population (McInnis-Dittrich, 1999).

The *activity theory* is most widely followed by social service professionals. It was initiated by Havighurst and his colleagues in the early 1960s. Activity theory assumes that activity produces successful aging "through the relationship between activity and life satisfaction or subjective well-being" (Atchley, 1995, p. 9). Havighurst (1963) states that "the older person who ages optimally is the person

who stays active and who manages to resist the shrinking of his [or her] social world" (quoted in Atchley, 1995, p. 9). Supporters believe that activity leads to improved life satisfaction, higher morale, and better mental health. Research indicates that regular engagement in social and physical activity is associated with high levels of late-life satisfaction, better health, longer life, and lower rates of institutionalization (Kelly, 1995).

However, the activity theory fails to acknowledge the physical changes and socio-economic limitations that face most seniors as they age and have less income resources compared to their younger counterparts. Older people with disabilities, living in poverty or lacking energy or time may be unable to remain active in the ways the activity theory implies (McInnis-Dittrich, 1999).

With a strong linkage to the activity theory, *continuity theory* claims that older people continue engaging in the activities of their younger years to a substantial degree (Atchley, 1999). The elderly do not develop an entirely different way of living in old age, rather, they are "simply more of what they were when they were younger" (McInnis-Dittrich, 1999, p. 70). According to Atchley's research (1999), the elderly are most satisfied when they manage to maintain their longstanding structures of activity. He reports that while the elderly who experience functional limitations have to reduce their overall level of participation in activities, nonetheless they preserve the *patterns* of activity of their younger adulthood (Atchley, 1999). McInnis-Dittrich (1999) points out that supporters of continuity

theory ignore the potential for change among seniors in the adaptation process of aging. The possibility always exists for people to alter their activity *patterns* or the extent to which they participate in certain activity, even in their later adulthood.

Many older people go on doing the same activities they did in their younger years, but now they seek a different balance when they are doing the same activities in later life. According to John R. Kelly (1995),

> The balance includes activities that are demanding and demonstrate skill, and those that are restful and relaxing; those that involve communication with other people, and those that offer withdrawal and disengagement; those that take regular time slots during the day and week, and those that punctuate periods with some change or novelty. (p. 5)

Factors affecting choice of and rate of participation in activities include access, transportation, communication skills, and an atmosphere of inclusion (Kelly, 1995). When designing and developing programs directed at reducing isolation for seniors, professional workers should keep these principles in mind in order to understand better the needs of the elderly and better serve them.

Rationale for doing a NA of isolated seniors

We believe that the elderly, like people of other ages, want to retain a quality life as long as possible and be healthy in both mental and physical domains. They want to feel competent in carrying out life tasks, and have the sense of living in society. Many seniors have spirited lives, are involved in various constructive

activities, are taking care of their health needs, are making social contacts, and are leading healthy lifestyles (Lesnoff-Caravaglia, 2001; O'Neill, 2002). But some others may feel that life is lonely and boring.

The growing consensus about older adults is that the ones who stay active can age successfully (Beaver & Miller, 1992; Knight & Maines, 2001; Korte & Gupta, 1991; McInnis-Dittrich, 1999). A comprehensive, multi-disciplinary research project on identifying the positive aspects of successful aging shows that seniors who retained strong cognitive and intellectual abilities made an active effort to use them everyday (Rowe & Kahn, 1998). Both the brain and the body need exercise – "use it or lose it" (McInnis-Dittrich, 1999, p. 73). It is also important to do different activities designed for various purposes and on the basis of the individuals' specific needs (McInnis-Dittrich, 1999).

Social network and support have long been identified as constituting one of the most essential factors that affect older people's life satisfaction and well-being. Knowing that concerned people are available for emotional or instrumental support can soothe the tough experiences of a variety of difficulties and losses in later life. It has been found that social isolation is an influencing risk factor for both mental and physical health (McInnis-Dittrich, 1999). Seniors need to have something to do and someone who cares about them. The elders in the research mentioned above were also able to identify what was important to them, who cared about them, and what activities helped them to maintain a high morale and self-confidence (Rowe &

Kahn, 1998). In the senior years of life, we still need activities to keep connections with others and identify ourselves as worthy and capable people, although older adults do select, replace or start activities.

Activities essential for maintaining a positive health condition and reducing risk factors include: exercise, a healthy lifestyle, nutrition, regular medical checkups, social network, and so on (Beaver & Miller, 1992). Social workers can initiate different kinds of actions to strengthen the elderly person's well-being: counseling on depression and crises, providing social connections and support, facilitating transportation, helping out with housing issues (e.g., homesharing, repairing) and daily life (e.g., home care, grocery shopping), offering information and referrals on legal and welfare concerns, and educating the public on age-related topics (Beaver & Miller, 1992; Feit & Cuevas-Feit, 1996: Korte & Gupta, 1991).

Some people may argue that institutional care can provide thorough services to the aged population. Recent consensus has placed emphasis on helping elderly people to continue living in their own homes and staying in the community. Evidence indicates that elderly people are happier and healthier if they live in their own homes (Bulter & Lewis, 1982, quoted in Beaver & Miller, 1992). Thus, one of the important purposes of social workers is to assist the elderly to remain in the community and live independently as long as possible, and to prevent pre-mature institutionalization.

This needs assessment has attempted to find out what kinds of services are most demanded by the socially isolated seniors, whether the current programs and services meet their needs, and how the agency and professionals can best support the seniors. When social workers design or operate programs for reducing the isolation of the elderly, we provide them as many opportunities as possible to get involved in activities, but with genuine respect for their own choices (McInnis-Dittrich, 1999).

CHAPTER 3

PRACTICUM DESIGN

The Context

The organizational context of the practicum

Age and Opportunity is a social service agency offering services to older adults through its head office and network of senior centres. With the involvement of older adult community groups and other committed people (e.g. volunteers), Age and Opportunity "takes action to improve the quality of life for older adults in Winnipeg through advocacy, education, and service delivery" (Age and Opportunity Annual Report 2001 - 2002). The agency's objectives include: 1) to develop and provide high quality, evidence-based services and programs that support the health and well-being of seniors; 2) to enhance and share the skills of seniors; 3) to educate the community in all aspects of aging; and 4) to advocate for appropriate policy and program development on behalf of seniors and the needs and issues of aging. A & O provides a variety of programs aimed at enhancing seniors' health and social well-being, including educational and recreational programs and on-site social work counselling, as well as Friendly Visiting Services, legal assistance, and information and referral.

The Friendly Visiting Services program was developed in response to a 1957 report entitled, *Age and opportunity*, and with the aim of dealing with the feelings of

loneliness and isolation many seniors experience due to life events such as a move, deteriorating health conditions, loss of loved ones or a separation from family and friends (Aging in Manitoba Study, 2000; Hall & Havens, 2001). The Friendly Visiting Services reach out to these older individuals (exclusive of personal care homes) by matching them with suitable volunteer visitors. Program coordinators conduct in-home assessments with individuals. Information on interests, hobbies, and background is collected to ensure good matches. The Volunteer Coordinator meets with the volunteers to gather similar information and a criminal records check. Then a match can be set to establish a supportive relationship between the senior and the volunteer.

The role of the student in the practicum setting

The student initiated the contact with the Age and Opportunity staff and expressed the intention of doing the practicum there. Several meetings were held between the student and the field instructor, Michelle Ranville, who was responsible for supervising all social work students at the agency, to discuss the possible support from the agency and the feasibility of the student's goals and plans. A schedule was set for the student to become familiar with the practical setting and the staff through getting involved in the agency's routine work, such as intake phoning, counselling, home visit, staff meetings, and the process of the

Friendly Visiting Services program. The field work was scheduled for a full month prior to the implementation of the student's research project.

The Practicum Design

Purpose of the Needs Assessment

The purpose of conducting a needs assessment at Age and Opportunity arises out of the recent findings of Aging in Manitoba (AIM) studies, which reported that seniors are generally in satisfactory physical health, but they require increased attention to deal with isolation and loneliness (Hall & Havens, 2001; Sylvestre, Hall, & Havens, 2002). Sylvestre, Hall, and Havens's (2002) longitudinal study indicates that seniors' need for proximity to friends, family, and community remained high from 1971 to 2001. Friendly visiting and congregate meal programs were cited to be successful approaches to alleviate older people's isolation and loneliness (Aging in Manitoba Study, 2000). In order to serve this population better in their own homes, the agency needs to develop a better understanding of the particular challenges these older adults face. This study will enable the agency to develop and provide other complementary services to isolated clients. Some examples are outreach to offer them assistance in completing forms or door-to-door transportation services. It is very likely that these people would also benefit from other programs such as a telephone reassurance program whereby they would receive a daily greeting.

The objectives of the needs assessment are identified as follows:

1. To obtain information that will describe the experience of isolation among the older adults in the Friendly Visiting Services;
2. To identify the needs and wants of this population in terms of isolation alleviation;
3. To provide recommendations for ways to improve the situations that the isolated seniors face.

Age and Opportunity will receive a final report of the needs assessment at the end of my practicum, which the agency could use:

1. For agency workers, especially Friendly Visiting Services program workers to better understand the problems and difficulties experienced by this group of clients. For example, what are the critical reasons for their isolation? How severe are their isolation situations? The exploration of causes and ground information will help workers address problems and set priorities.
2. For the agency to obtain a more comprehensive understanding of the needs and wants of this population. What types of services, other than friendly visiting, would be appreciated by the elderly? Would there be areas in which the elderly would have demands and which the agency workers considered important? The agency may initiate or modify some services for isolated seniors on the basis of the findings and recommendations of the needs assessment.

3. For the agency to utilize its resources more effectively and serve as a gateway for referrals to other service providers/professionals. With the information provided by an accurate assessment of the seniors' problems and needs, the workers could refer clients to suitable organizations or professionals that could provide them with the aids that correspond to their needs.
4. For policy advocacy and fundraising by the agency. If current services and resources do not satisfy the clients' presented needs, the service providers would be able to advocate on behalf of clients by using the research findings to justify or support requirements for policy.

The methodological framework of this study

Researchers usually must decide on the methodological framework they will use in the design stage: qualitative, quantitative or a combination of both. Qualitative methods have been increasingly accepted in the arenas of both gerontological research and needs assessment (McKillip, 1987; Rubinstein, 1994; Wallace, 1994). Rubinstein (1994) suggests that researchers acknowledge the wide range of perspectives from which we can select appropriate methods for specific study goals. Thus, qualitative and quantitative techniques complement one another in research activities.

Qualitative methods are fundamentally different from research using closed-ended questions or standardized questionnaires. Because of the nature of closed questions, standardized tools shut down the possibility of exploring a wide range of responses to the concerned topics. Yes-or-no questions, scaling, and/or multiple choice questions only require or allow short answers. This may discourage participants from discussing personal perceptions and from providing in-depth meanings. Some researchers find that qualitative methods are the only ones suitable for the study of process and meaning (Kaufman, 1994; Wallace, 1994). Indeed, open-ended questions offer the investigator an opportunity to learn "not only what is pertinent to the individual about those topics, but also something about the identity of that individual and how he or she defines or constructs the self in relation to the subject matter at hand" (Kaufman, 1994, p 125). In in-depth interviewing, people generally enjoy talking about themselves and their lives. Kaufman (1994) claims that qualitative research approaches could be "extremely powerful" when interview questions are carefully designed to address research questions or cover assessment areas.

Quantitative approaches undoubtedly have their strengths and are able to contribute greatly to needs assessment. In the context of a qualitative study, standardized instruments of various types may be included. The use of quantitative methods can offer "a resource of validation with the qualitative or

narrative materials elicited" (Rubinstein, 1994, p.70). Moreover, it allows the sampled population to be compared with other samples or the general population.

Therefore, a combination of both quantitative and qualitative methods was used in this needs assessment. Closed-ended questions and standardized tools were employed to collect profile data of the target group, including demographic data and general personal information. However, personal experience and perceptions of social isolation and its effects on life constituted the major focus of the study, which was investigated through in-depth interviews with structured open-ended questions.

Who are the informants?

Although the literature includes the elderly, caregivers, professional workers, and community leaders as potential informants in needs assessment, the purpose of this study is to focus on the seniors' perceptions of themselves. Because no specific document exists that expresses the voice of this particular group, their perceptions and concerns should be the first things made known to the public. Since most isolated seniors live alone, caregivers are not available. Professionals and community leaders may have a global idea of the problems of the population, but when detailed information is required about needs and the best services for addressing them, the seniors themselves are the experts. Professionals often develop programs or services on the basis of their own knowledge and beliefs

about what people want and need, which may have little attraction to the target population or even may unexpectedly cause undesired stress on them. Thus, this study concentrates on better understanding the perceptions of the isolated seniors about their own conditions, needs, and demands.

What types of data have been collected and/or used?

From the perspective of nature, there are two general kinds: opinions and facts. Assessments should clearly differentiate what people think and what the reality is, even though both types of data are necessary in a needs assessment. Perceived and expressed needs are people's opinions, while demographic information and problems can be treated as facts. Obviously, a needs assessment requires both kinds of data in order to generate a thorough understanding of the population.

Three categories of data, the required resources for collecting these data, and the means of obtaining the data are identified in the following table (Table 3.1):

Table 3.1 Categories of Data Needed in the Study

Category of data	Resource	Obtaining method	Type
Demographic data & general information	Agency intake records	Get access with consent from the agency	Secondary & primary; fact
Social indicators	Health Canada, Statistics Canada, existing studies and documents	Search and locate	Secondary; fact
Personal experience, perceptions, & expectations	Interviewees	Interview	Primary; fact & opinion

The survey instrument

The areas I consider relevant to understand the needs and problems of isolated seniors are as follows:

1. Background information: age, gender, marital status, living arrangement, language most commonly spoken, health conditions, reason for referral, family member(s), etc.
2. Measure of degree of social isolation (to identify the relatively objective degree of social isolation)
3. Seniors' perceptions of quality of life in relation to the isolation
    - Whether the respondent feels isolation is a problem
    - In what way the isolation affects him/her

- Whether he/she wants to change his/her isolating situation
- What he/she thinks would make the change(s) occur

4. Satisfaction and expectations about services/service providers:
    - Whether the friendly visiting affects her/him and her/his life, and, if yes, in what way
    - Whether the respondent would like to see a change of the service, and, if yes, what kind of change
    - What other services or community activities the respondent is aware of and/or involved in
    - Why she/he participates in or does not participate in that service or activity
    - What she/he thinks about the service(s)
    - Anything else the respondent can imagine that she/he would like to participate in and which might help to alleviate the isolation

Data regarding the items in category 1 were gathered from the assessment/intake forms of each client at the agency. One questionnaire (Appendix I) was developed to address all the items of the other three categories. The extent of social isolation (category 2) was measured with the Past Month Isolation Index (Bennett, 1980a). This index measures the number of role relationships in which an individual was involved in the preceding month and is

constructed with possible scores ranging from 0 to 10. Five types of social contact are measured: active membership in organizations, relationships with children, siblings, friends, and relatives. In consideration of the limited range of relationships in which an elderly person has been involved in the past month, a maximum number of 2 points is allotted for each type of contact.

The instrument has been found to have a satisfactory level of reliability and face validity (Bennett, 1980a, 1980b). The reliability was found by a two-year test-retest measure and obtained a correlation coefficient of .62. The face validity was indicated by measures of central tendency of seven studied groups presented in Bennett's research report (Bennett,1980b) .

Data required in category 3 and 4 were gathered through both open-ended and closed-ended questions in the questionnaire. Open-ended questions were designed according to the principles presented in the literature (McAuley, 1987; McKillip, 1987; Russell, 1999; Rubinstein, 1994; Kaufman, 1994; Tunstall, 1966):

1) Questions should not suggest the dimension of response, e.g., try "How does this affect you?" instead of "Do you find it helpful?"
2) Questions should presuppose that the respondent can give answers, but should avoid using "why?" Try "what kinds of barriers keep people from using ...?" instead of "Are there reasons people don't use ...?"
3) Ask one question at a time but do not ask questions that can be answered dichotomously.

4) Let respondents use their own terms.

The questionnaire was developed with the input of the student's Practicum Committee and was pre-tested with a few targeted group members before implementation. It was revised based on the feedback and comments.

Pre-Test of the Survey Instrument

Two seniors of the target group were recruited by the Friendly Visiting Services program coordinator to participate in testing the survey instrument. The interviews were scheduled at the seniors' homes for their convenience. Both interviewees went through the entire designed procedure, including reading the Letter of Informed Consent, signing on the Consent Form, the conversation being recorded by audio-tape, and every item in the questionnaire being discussed. Each senior was requested to offer comments and advice about the content and the questioning strategy. The feedback was very positive: both seniors considered the questionnaire covered everything quite well regarding the isolation issue. However, a few amendments were made on the basis of the researcher's observation during the interviews. For example, one of the pre-testing seniors was very concerned whether she would be required for any commitment in the study beyond the present interview because she was afraid of making efforts to go out. The confirmation of a one-time commitment (the interview) was then explained in an

explicit manner in the Letter of Informed Consent.

Ethical issues in research

Informed consent. Consent in writing was obtained. Please see Appendix II for the Letter of Informed Consent and Appendix III for the consent form. The interview explained the nature of the study and subjects' participation in the study by reading the Letter of Informed Consent by the interviewer to the subjects before requesting their agreement to participate.

The secondary data in category 1 are essential to this study because they describe the profile of the target population and offer the background information for in-depth analysis. All clients of Age and Opportunity had signed consent forms for release of information, indicating their permission for Age and Opportunity to share clients' information or release it to individuals or agencies whenever Age and Opportunity considers it appropriate. Students doing their practica and/or studies at Age and Opportunity were allowed to obtain access to clients' information under the supervision of agency staff.

Deception. The study did not involve any deception.

Feedback and debriefing. A copy of the final report of the study will be provided to Age and Opportunity and made available to clients, agency workers, students or concerned individuals to use in accordance with the agency's policy. The subjects involved in the study were informed that they could request access to the research results and findings at Age and Opportunity.

Risks. There was no risk to the study subjects or a third party.

Anonymity and Confidentiality. In order to preserve the anonymity and confidentiality, no individual names were recorded in data entry, but only identical numbers assigned to each individual. The data of category 1 were sorted to describe the profile of the studied population and provide background information for further analysis. A file number was assigned to each of the interviewees, their recorded tapes, and corresponding transcripts, as well. The files of their identity information, such as names, addresses and phone numbers, were kept separate from survey data in order to ensure confidentiality.

The completed questionnaires, the tapes of the interviews, and their transcripts were stored in a locked file kept safely by the principle researcher. The tapes will be erased upon the completion of the study. The research records are kept strictly confidential. In any publications, the researcher will not release any participants' identifying information. The ethical application of the study was approved by the Joint-Faculty Research Ethics Board, University of Manitoba.

Sampling

All the clients involved in the Friendly Visiting Services program (173 seniors) are the sampling frame for this study. The background information (Category 1) was collected from the files of assessment forms in Age and Opportunity, which covers the background information of the entire population. For in-depth interviews

that yielded the information of Category 2, 3, and 4, a random sample was drawn from all senior clients involved in the service who met the following criteria:

- Were not currently hospitalized or institutionalized;
- Had no serious communication barriers and no resources were available to facilitate;
- Were willing to participate in this study.

The Friendly Visiting coordinators were requested to pull out client files randomly and make the initial calls to potential subjects to introduce the study and encourage them to participate. Whenever a willing and qualified respondent was found, the name and phone number of the respondent were provided to the researcher. The researcher then called the potential subject to set up an appointment for the interview.

There are no fixed rules about sample size in qualitative research, because the sufficient number of respondents is in relation to the conceptual consistency of the data and thematic pattern saturation (Rubinstein, 1994). The question of sampling in a study with a qualitative nature is: "Are there enough subjects to empower the researcher's variables?" Very often, researchers do not know beforehand how many respondents will be needed to understand thoroughly a particular group and their problems, and yet they do know when it is enough (Rubinstein, 1994). "Inquiry stops when patterns become repetitive and materials

are thematically saturated" (Rubinstein, 1994, p.79). That is, sampling and data collection continue until new cases add little additional insight to the phenomenon of the study (Wallace, 1994). Rubinstein (1994) explains that the reason qualitative inquiry does not follow traditionally statistical sampling techniques is because

> ...the unit under study is personal meaning and experience. As such, instead of a relatively short, standardized interview with a large number of subjects chosen to fit requirements of statistical procedures, ethnographic sampling usually relies on a smaller number or informants chosen to inform in detail about personal meaning and experience. (p. 79)

Data Collection

Entry of background information data

Statistics software SPSS was chosen to arrange the quantitative data of the population profile. Given the strict discipline that no documents or copies of them were allowed to be taken out of the Age and Opportunity office, the primary data entry was carried out at the site of the agency using Excel of Microsoft Office 2000 (No computers at the site carried SPSS). Then the entered data was transported to the laboratory computer at the Faculty of Social Work, University of Manitoba, which had SPSS installed, and transformed into SPSS format for further analysis.

Face-to-face interviews

A face-to-face interview was conducted with each individual participant by using the questionnaire composed of both closed and open-ended questions. Prior to the beginning of the interview, the researcher introduced herself to the senior, and then the senior was asked to read the Letter of Informed Consent. In two cases, the researcher read it aloud to them because of the seniors' visual impairment. Once they were finished, the researcher summarized the content of the letter and emphasized the confidentiality and anonymity, the voluntary nature of the study, the purpose of the audio-tape, the risks and benefits of participating in the interview, and referral information if they had any concerns about the study. The subjects were also offered the opportunity to ask questions or express concerns. Then all the participants were asked to sign two consent forms, one for the study records and the other for the interviewee's personal records. The interviewer administered the interview by asking questions to the respondent and provided clarifications if misunderstanding was evident. The interviews were recorded by audiotape for the purpose of analysis. No names were recorded either on the audio-tapes or on the questionnaires; each individual interviewee was assigned a number as research identity.

Although the face-to-face, researcher-administered survey is commonly known to be costly and time-consuming, its advantages are obvious, even crucial, for the study of this particular group. First, among the common types of surveying,

mailed surveys are just simply not appropriate to this population. Telephone surveying may be risky because the respondents may hang up if they feel bored or tired. A more realistic risk is that it may be difficult to develop sufficient rapport to gather data effectively. Face-to-face interviews may seem friendlier to the seniors because the researcher does not just "exploit" them for information, but also wants to meet them and talk to them. Second, many older adults have eyesight and hearing problems, and reading questions to them can avoid these problems. Third, a high rate for completing the questionnaire and high accuracy of responses can be achieved. Fourth, because the survey has some open-ended questions regarding the perceptions and expectations of services, the interviewer can help the respondents identify and clarify their thoughts and opinions.

Data Analysis

A parallel mixed approach was applied to analyze the data in the present study. Parallel analysis of qualitative and quantitative data is also called triangulation of data sources in social and behavioral sciences (Tashakkori & Teddlie, 1998). Researchers combine both qualitative and quantitative data collecting in their studies and use appropriate processing methods to analyze different types of data. Results are generated from the combination of the two. The application of the parallel mixed approach was two-fold in the present study. Firstly, the data management in the research had two major parts: population profile and individual

in-depth interviews. In the former part, only quantitative analysis methods were used because the data gathered from client intake/assessment forms were solely quantitative in nature. In the latter section, qualitative analysis was the focus. Secondly, when the survey interview data were being managed, closed-ended responses were analyzed statistically whereas narrative content was analyzed with qualitative methods. The quantitative results can provide an idea of the occurrence proportion of certain phenomena among the respondents, while the qualitative findings may offer tentative explanations and suggestive consequences of the phenomena. Through collecting and analyzing data with a parallel mixed approach, the study is more likely to draw an accurate and meaningful picture of the seniors in the visiting program and their perceptions of their lives and of the services being provided.

Quantitative data of background information

The computer software SPSS was employed for the statistical analysis of the profile data containing 173 cases in total. The major functions of SPSS used in analysis are descriptive statistical methods, including frequencies, central tendency, and cross tabs.

Qualitative and quantitative data from interviews

All the interview tapes were transcribed verbatim. In order to make qualitative

data manageable, data should be reduced and coded. Ferguson (1989) suggests four general steps that can be followed to do data reductions: 1) reducing information from the transcripts, 2) condensing and collapsing any individual's repetitive response, 3) reducing the length of specific response, and 4) reducing the number of categories of response. Interview data in the present study were analyzed based on the following coding sources:

1) Some of the concepts in the raw data emerged as being broader and more comprehensive than others (Strauss & Corbin, 1998);

2) Concepts in the literature;

3) Categories and questions were used in the questionnaire; and

4) Issues from discussions with agency staff and the practicum advisors.

The basic coding method involved analyzing a whole sentence or paragraph (Strauss & Corbin, 1998). When coding a sentence or a paragraph, the major idea was summarized and conceptualized carefully.

Altogether 20 categories and approximately 50 themes were identified by the researcher in consultation with the principal practicum advisor. For example, the category of "seniors' perception of current life" was adapted from the question "How would you describe your present life in general?" in the questionnaire, which had generated abundant information for understanding the seniors' perceptions of their lives. Three themes emerged under this category: the seniors' positive perceptions of their lives, their negative perceptions of their lives, and their

attitudes towards aging. Between categories are a variety of correlations and causalities. For instance, *chronic conditions, transportation* and *social contact* are separate categories. However, the seniors' means of managing transportation is related to the impact of chronic conditions on their lives (many seniors are incapable of traveling by vehicle on their own, so they have to rely on someone picking them up and dropping them off). In turn, the problem of transportation affects their participation in social activities and the amount of contact with other people. Therefore, when the researcher analyzes the data, he or she has to pay attention to the relationships between categories and themes in order to track down the valid causality.

The quantitative data yielded by the close-ended questions, such as self-rated general health and scores of Past Month Isolation Index, were also sorted and analyzed with descriptive statistical methods.

CHAPTER 4

PROFILE OF PROGRAM POPULATION

Demographics

There were 173 clients across the city of Winnipeg currently registered in the Friendly Visiting Services program. Approximately four out of five (80.2%) were female, and 19.8% of the population was male. The population ranged in age from 53 to 100 years old, with the average length of life of 83 years (SD = 9.133; mode = 85). Nearly half (46.5%) of the seniors were over 85, one-third were between 75 and 84, and the others (21%) were 74 or younger. The gender distributions in different age groups (i.e., 85+, 75 - 84, 65 - 74, 64 -) were similar to the gender distribution among the entire population (N = 173); that is, about one out of five seniors in the general and in each age group was male. In particular there appeared to be a bigger proportion of male clients in the age group of 64 or younger.

Table 4.1 Gender Distribution by Age

	85 +	75 – 84	65 – 74	64 -	% in the whole population
% of male in each age group	18.8	16.1	25.0	37.5	19.8 (N=34)
% of female in each age group	81.2	83.9	75.0	62.5	80.2 (N=139)
% of seniors in each age group	46.5	32.6	16.3	4.7	100

Total: N = 173

In Canada, women form the majority of the senior population. In 2001, female seniors composed 60% of the elderly aged 75 to 84, and 70% of the elderly aged 85 or older (Health Canada, 2002). The gender distribution among the seniors in Manitoba was similar to the national population, with 61.4% female and 38.6% male (Sylvestre et al, 2002). Female elders participated in the visiting program to a greater degree than their proportion of the national and provincial senior populations.

Seven out of ten seniors (N = 116, 70.3%) in the Friendly Visiting Services were widowed, 18% (N = 29) were divorced, separated or had never married. Only one in ten of the seniors (N = 20, 12.1%) was living in a marriage. Married seniors represented more than half (56%) of the national population, and less than one-third were widowed (Health Canada, 2002). As people aged, more and more of them lost their partners. For example, in the study, only 17% (N = 1) of the seniors below 64 were widowed, while nearly 80% (N = 67) of those older than 85 had lost their spouses. The marital status across age groups is shown in Table 4.2 (see page 57).

Table 4.2 Marital Status by Age

	85 +	75 - 84	65 - 74	64 -	% in the whole population
% of the Married in each age group	3.8	13.2	25.0	50	12.1
% of the Widowed in each age group	85.9	69.8	39.3	16.7	70.3
% of the Single in each age group	7.7	3.8	10.7	16.7	7.3
% of the Divorced/ Separated in each age group	2.6	12.1	25.0	16.7	10.2

Total: N = 173

Duration in the Friendly Visiting Program

The average age of the seniors when they were admitted to the Friendly Visiting Services program was 78.7 (SD = 9.442), while the most common age at which people were admitted was 85 years old. The longest duration of any senior's participation in the program was 31 years, whereas the most recently admitted client had been in the program for less than 6 months. 64 of the 173 seniors (37%) had been involved in the program for only one year or shorter. A similar number (N = 58, 33.5%) of the elderly had benefited from 1 to 3 years of service in the program. Nearly 20% (N = 36) had been in the program from 4 to 9 years, and one out of ten (N = 15, 9.8%) had participated in the program for 10 years or longer.

Living Arrangement

The majority (N = 136, 80.0%) of the seniors lived alone, while16.5% (N = 28) lived with a spouse or child(ren). A few of them (N = 6, 3.5%) reported living with a roommate, landlord or other individuals. Older elderly were more likely to live on their own, as shown by the percentage of each age group in the following table (Table 4.3):

Table 4.3 Living Arrangement by Age

	85 +	75 – 84	65 - 74	64 -	% in the whole population
Alone	88.6% (70)	81.8% (45)	64.3% (18)	37.5% (3)	80.0% (136)
With Spouse	3.8% (3)	7.3% (4)	21.4% (6)	37.5% (3)	9.4% (16)
With Child(ren)	6.3% (5)	7.3% (4)	3.6% (1)	25.0% (2)	7.1% (12)
Other Arrange-ment	1.3% (1)	3.6% (2)	10.7% (3)	N/A	3.5% (6)

Total: N = 173

The proportion of the seniors in the visiting program who lived in single-detached houses (43.9%, N = 68) was lower than that (61%) of the general population (Health Canada, 2002). Almost half (48.4%, N = 75) of the clients were residing in apartments, while only 28% of their national counterparts lived in apartments (Health Canada, 2002).

English was reported to be the most often spoken language among the

seniors. Yet one out of three (N = 51, 33%) were bilingual or multilingual. The five most often spoken languages besides English were Ukrainian (N = 22, 12.7%), German (N = 11, 6.4%), French (N = 9, 5.2%), Polish (N = 8, 5.2%), and Russian (N = 3, 1.7%). Other spoken languages included Dutch, Italian, Finnish, and so on.

Health Condition

The average number of chronic health conditions the senior had was 2.28. This is close to the finding of 2.23 illnesses reported by the same age group in the 1998 National Population Health Survey (Lai et al, 2003). Less than one-tenth (N = 11, 7.3%) of the users of visiting services reported they were free of chronic health conditions, whereas nearly one-fifth of general population (18.3%) claimed no chronic conditions (Health Canada, 2002). 39.1% (N = 59) of the seniors living at home suffered from one chronic health condition, more than half (N = 77, 51%) reported having 2 to 4 chronic conditions, and a small number (N = 4, 2.6%) suffered from more than 5 chronic conditions. In 1996, the proportion of seniors having a chronic condition was slightly higher among senior women than senior men (Health Canada, 2002). No significant difference between men and women was found in this study. However, the results show a slightly higher proportion of senior women than senior men in the categories of more than one chronic condition. All four seniors who reported more than 5 chronic conditions were women, while nearly 20% of men and only 5% of women reported that they were

free of chronic conditions. Table 4.4 (see page 58) illustrates the distributions.

Table 4.4 Number of Chronic Conditions by Gender

	1 condition	2 condi-tions	3 condi-tions	4 condi-tions	5 + condi-tions	None conditions
roportion within male	39.3% (11)	21.4% (6)	17.9% (5)	3.6% (1)	0	17.9% (5)
roportion within female	39.0% (48)	26.8% (33)	20.3% (25)	5.7% (7)	3.3% (4)	4.9% (6)
Total	39.1% (59)	25.8% (39)	19.9% (30)	5.3% (8)	2.6% (4)	7.3% (11)

Total: N = 151

There were no notable trends in the relationship between the number of chronic health conditions and age, except that, surprisingly, more seniors at the age of 75 or older reported having no chronic conditions than their younger counterparts.

Table 4.5 Number of Health Conditions by Age

	1 ondition	2 condi-tions	3 condi-tions	4 condi-tions	5 + condi-tions	No condit-ions
Proporti n within 64-	57.1% (4)	0	14.3% (1)	14.3% (1)	0	14.3% (1)
Proporti n within 65 – 74	37.5% (9)	29.2% (7)	12.5% (3)	12.5% (3)	.3% (2)	0
Proporti n within 75 – 84	39.2% (20)	29.4% (15)	23.5% (12)	.0% (1)	.0% (1)	3.9% (2)
Proporti n within 85 +	37.7% (26)	24.6% (17)	20.3% (14)	.3% (3)	.4% (1)	11.6% (8)

Total: N =151

Marital status did not show a significant relationship with the number of health conditions that the seniors had. However, it was striking that a small proportion of the widowed or single seniors indicated they were free of health conditions, whereas none of the other groups did so, including those living with spouses.

Table 4.6 Health Conditions by Marital Status

	1 condition	2 condi-tions	3 condi-tions	4 condi-tions	5 + condi-tions	No conditions
Proportion within married	33.3% (6)	27.8% (5)	33.3% (6)	5.6% (1)	0	0
Proportion within widowed	37.5% (39)	26.0 % (27)	19.2% (20)	5.8% (6)	1.9% (2)	9.6% (10)
Proportion within single	55.6% (5)	22.2% (2)	11.1% (1)	0	0	11.1% (1)
Proportion within divorced	36.4% (4)	27.3% (3)	18.2% (2)	9.1% (1)	9.1% (1)	0
Proportion within separated	50.0% (2)	25.0% (1)	25.0% (1)	0	0	0

Total: N = 151

The majority of the seniors reported they were on at least one type of medication. Nearly 60% (N = 80) frequently used 1 or 2 types of medicine, 34% (N = 45) were on 3 or more medications, and 6.7% (N = 9) reported no need of medication at the time of being assessed.

Caregiver

Most seniors in the Friendly Visiting Services had access to more than one type of care giving resource (Table 4.7). They took care of themselves most of the time in their daily lives, but their children sometimes helped them with more demanding life activities such as banking, shopping, and going to a doctor's appointment. The seniors received care basically from themselves and social services, including home maintenance services, health services, transportation, and many others. The discussion of the utility of the services and the seniors' perceptions of them will be presented in Chapter 5. Children were another important group of caregivers to the seniors. Details on the relationships between the parents and their children will be addressed in Chapter 5, as well. It may be worth noting that even though 12.1% of the seniors lived in marriage, only half of them (6.4%) were able to receive care from their spouses.

Table 4.7 Primary Caregiver

Self as caregiver	71.1% (N = 123)
Social services provide care giving	63.6% (N = 110)
Child(ren) as caregiver	54.9% (N = 95)
Friend/neighbour as caregiver	18.5% (N = 32)
Spouse as caregiver	6.4% (N = 11)
Other family member(s) as caregiver	3.5% (N = 6)
Sibling as caregiver	2.9% (N = 5)

Total: N = 167

Daily Life Activities

While 66.7% of the seniors (N = 112) were assessed as having average to excellent mobility, the mobility of one-third of them (N = 56, 33.4%) was recorded as poor or dissatisfactory. The definitions of different levels of mobility and their distributions are demonstrated in the following table.

Table 4.8 Level of Mobility

	Description	Frequency	Percent	Cumulative Percent
Excel-Lent	goes out without assistance or using walking assistance devices	29	17.3	17.3
Good	sometimes uses cane	21	12.5	29.8
Average	uses cane often and sometimes uses walker	62	36.9	66.7
Unsatis-factory	uses walker often/inside, uses wheelchair sometimes/outdoors	47	28.0	94.6
Poor	uses wheelchair most of the time, needs assistance most of the time	9	5.2	100

Total: N = 134

Only 37% (N = 50/135) of the seniors cooked most of their own meals, and 63% (N = 85/135) did not cook frequently and regularly. More than half (N = 78/132, 59.1%) were able to handle the bathroom routine by themselves, and the rest (N =

54/132, 40.9%) needed some help on certain routines such as bathing or showering.

Sources of Referral and Utility of Services

The sources of referral for the seniors to the Friendly Visiting programs varied. Professionals (e.g., social workers, nurses, home care workers, etc.) in other area of social services were the most common sources of referral for the program. Self-referral and being referred by their children were also frequently reported as sources of referral. Table 4.9 shows the distribution of referral sources for all the seniors participating in the program.

Table 4.9 Source of Referral

Professionals/Service workers	56.9% (N = 95)
Self-referral	19.8% (N = 33)
Referred by child	18.6% (N = 31)
Referred by other family member	2.4% (N = 4)
Referred by friend	1.8% (N = 3)
Referred by spouse	.6% (N = 1)

Total: N = 167

Loneliness (N = 104/161, 64.6%) and isolation (N = 99/161, 61.5%) were the most common reasons for referral to the visiting program as shown by the

assessment data. But the reasons provided by the assessment forms may not be statistically convincing because the categories were not mutually exclusive. For example, limited mobility (N = 33/161, 20.5%) may lead to isolation; in turn, the feeling of loneliness might occur.

74.6% of 142 FV clients (N = 106) reported that they had never used counselling services. 65% (N = 106/163) had never had the experience of adult day care or day hospital, but the majority (N = 127/164, 77.4%) were using or had used the Home Care services.

Client's Preference in Friendly Visiting Services

Many seniors identified conversation/talk (N = 98/135, 72.6%) as their primary expectation for the Friendly Visiting Services. Company (N = 61/135, 45.2%) and hobbies (N = 39/134, 29.1%) were the second and third greatest concerns. Social activities or outings were also mentioned occasionally as being appreciated.

Regarding the gender preference of their volunteer visitors, most of the seniors (N = 77/118, 65.3%) preferred a visitor of the same sex, one third (N = 38/118, 32.2%) did not care, while a very small proportion (N = 3/118, 2.5%) declared they would like a visitor of the opposite sex. More women preferred visitors of the same sex, and more men considered the visitor's gender unimportant (Table 4.10).

Table 4.10 Client's Preference for Gender of Visitor

	Gender preference for friendly visitor		
	Same Sex	Opposite sex	Doesn't matter
Proportion within male	30.4% (7)	8.7% (2)	60.9% (14)
Proportion within female	73.7% (70)	1.1% (1)	25.3% (24)
Total	65.3% (77)	2.5% (3)	32.2% (38)

Total: N = 118

Compared to their national counterparts, seniors in the Friendly Visiting Services were generally older, more of them were women, and more lived alone without a partner. The majority of the seniors had been using the Friendly Visiting Services for more than one year, and 10% of them had been associated with the program for more than 10 years. Professionals in other social service areas, self-referral, and referral by their children were reported as the most common sources of referral to the Friendly Visiting program.

More seniors in the program than in the general elderly population resided in apartments (48.4% vs. 28%). All Friendly Visiting clients spoke English, yet one-third stated they were bilingual or multilingual. The overall number of health conditions of this group was evidently similar to that of the general population. However, a smaller proportion of this group than of the general aged population enjoyed an illness-free condition (7.3% vs. 18.3%). It was found that the number of

illnesses the program population had was not associated with gender, age or marital status. Almost all seniors in the Friendly Visiting Services reported they were on some type of medication.

Many seniors were able to take care of themselves in terms of daily life activities. But only one out of three seniors reported they cooked most of their meals, and many of them needed assistance with bathroom routine. Social services and children played important roles in the seniors' lives, especially in more demanding activities such as domestic chores, transportation, yard work, banking, etc. The majority of Friendly Visiting clients had used or were using the Home Care services.

Finally, conversations, enjoying other people's company, and hobbies were reported as the three most preferred activities the seniors liked to do with their friendly visitors.

CHAPTER 5

RESULTS: THE INTERVIEWS

Every interview was fully audio-taped after the interviewee had signed the informed consent. The interviews ranged from 1 hour to 2 hours and 15 minutes, and the average length of interview was about one and a half hours (1.56). The interviews were held individually in the seniors' homes between September and December, 2003. The audio-taped interviews yielded 175 pages of typed, single-space transcripts.

Demographics

The sample of in-depth interviews consisted of 10 elderly clients of the Friendly Visiting program. Gender distribution of this sample (8 female, 2 male) was consistent with that of the program population in that 80% were female and 20% were male. The seniors ranged in age from seventy-one to ninety-two years (mean 81.5; population mean is 82), with 20% (N = 2) in their 90s (population 18%), 50% (N = 5) in their 80s (population 45%), and 30% (N = 3) in their 70s (population 28%). All ten interviewed seniors lived on their own and were either widowed (90%, N = 9) or divorced (10%, N = 1). The duration of widowhood or divorce ranged from 5 years to 53 years, the average length of living without a partner was 23.44 years. Three out of the ten seniors had been living on their own for more than 40 years,

including one who had divorced 44 years before and never remarried. Another three had been widowed for 14 to 20 years, and the other left three had lost their spouses in the previous 10 years. Both male interviewees' widowhood had been for less than 10 years, while all the seniors who had undergone the longer periods of widowhood were female.

All the seniors lived on their own except one who lived with an adult daughter who had moved in two years before due to the daughter's life transitional situation. Most of the seniors (N = 7) lived in apartments (with size varying from bachelor to 2-bedroom), two in their own houses, and one in a condominium.

Although all interview subjects were Caucasians and reported English as the language they spoke most often, they were not necessarily native English speakers. In fact, 3 seniors (30%) were first generation immigrants from European countries (Northern Ireland, Germany and Finland), and 2 of the 3 started learning English when they arrived in Canada as young adults. Another two seniors sometimes spoke other languages than English at home (Ukrainian and Italian), especially with their spouse when they were alive.

Self-Rated General Health

Half of the interviewed seniors rated their general health as *fair*, while only 16% of the general population in the same age group and living at home reported their health as fair in the 1997 national census (Health Canada, 2002). The other

half perceived their health as good (30%, N = 3), very good (10%, N = 1) or excellent (10%, N = 1), whereas more than three-quarters of the general population viewed their health as good, very good or excellent.

The majority (70%, N = 7) of the interviewed seniors considered their current health about the same as it had been one year before. Three of them reported their health was "going down" and somewhat or much worse than it had been a year before. It is ineresting that two of the three who rated their health *worse* over time also reported their general health condition as *good,* including one who was paralyzed and must use a wheelchair all the time. This could be because their health had indeed been *excellent* a year before or their self-rated health reflected their desire to enjoy good health rather than their actual perception of their health. As the question ("Compared to one year ago, how would you rate your health in general now?") brought their attention to comparing the facts at two points in time, they might have realized that there were some activities they could no longer do. Thus, the comparison question might have provided them a more objective perspective for viewing their current health conditions.

Last Month Isolation Index

The interviewed seniors' scores on the Last Month Isolation Index (LMII) ranged from 0 to 7, and the average number of individuals or organizations they contacted during the month prior to the interview was 3.5. Half (N = 5) of them were

below the average, as four seniors reported contact with only two individuals in the last month and one senior reported no contact at all. Siblings and relatives other than children/grandchildren tended to be the people with whom the seniors had the least contact (Table 5.1). One reason is that many of the seniors interviewed were the only person alive from the older generations in the family, so they might no longer have any siblings or relatives. The majority of this group of seniors seemed to be not active in organizations such as social clubs, seniors centres or churches, although two (20%) reported involvement in two or more organizations in the past month. Children were the people with whom the seniors had the primary contact. Also half of the seniors appeared to maintain good connections with friends as another source of social contact. The results of the Last Month Isolation Index are summarized in the Table 5.1 (see page 72) and will be discussed further with the qualitative data gathered with the open-ended questions in the following parts.

Table 5.1 Summary of LMII Results

	Reported number of contacted individuals/organizations			
	0	1	2	mean
Number of seniors reporting involvement in organizations	6	2	2	0.6
Number of seniors reporting contacted children	2	1	7	1.5
Number of seniors reporting contacted siblings	8	2	0	0.2
Number of seniors reporting contacted friends	5	0	5	1
Number of seniors reporting contacted relatives	8	2	0	0.2

Three content themes emerged from the in-depth interview data: 1) seniors' current lives and their perceptions of them, 2) seniors' experiences and expectations of Friendly Visiting Services, and 3) seniors' experiences and comments on other services available in the community. Findings from the three themes are elaborated on here.

Seniors' Current Lives

Mobility

As presented previously, most of the seniors (N = 139/168, 82.7%) in the Friendly Visiting Services reported they had to use assistance devices (cane,

walker or wheelchair) to go out. They did not go out often and when they did, it was usually not far from home. A typical trip for them was to walk with their walker to the closest shopping mall on a mild morning to get some light groceries and have a cup of coffee afterwards. Children, friendly visitors or other people took the seniors to medical appointments or to dine out once in a while. Environmental factors were another obstacle that prevented older people from going on outings. Winter and night were addressed as the two circumstances in which the seniors would not leave their homes at all. Three of the interviewed seniors had chronic health conditions, as one was legally blind, another was paralyzed and the third must wear a nasal respirator for breathing in everyday life. It appeared to be very difficult for those with severe conditions to leave home without assistance. Overall, the mobility of this group of people was very limited. In turn, the limited mobility restricted the extent of their social contact with other people. Some examples are demonstrated as follows:

Senior 1: The things is, I have to take me on the wheelchair, loaded it into tank, ... all those junk. It's too much for anybody. I don't go out very often, because just my granddaughter takes me on wheelchair, and my daughter, too, into her car, very difficult.

Senior 2: Now, I, I wouldn't think of going out, doing anything. You know. But something I haven't given up, I really haven't. But it's too hard for me to go out! You know. I can't...I gave up license , I don't have a car, I can't go for groceries, depending on somebody to pick me up and send me home.

Senior 3: I'm afraid, the slippage or something, and I don't

like evenings. I go out, I go out in the morning, and I come back before four.

Senior 4: I just worry, now, if they (the program in a day hospital) call me, December now, how can you go there in the cold, cold weather? 3 months, December, January, I can't, I can't walk out to the snow. ... No, I can't. I can't. If they got a nurse, they pick me, and home, that's different. That would help. But sometimes in the morning, whistling, snow, that kind of thing.

Senior 5: I can't make friends because I won't go out at night. I, I'm too nervous at night. My balance isn't good. And I cannot ... I go out during the day, but I can't go out at night. My health won't ... I read instead. I read a lot... my life now.

Senior 6: I broke my ankle 5 years ago, very, very bad, they had to put the plaster, slings. And I didn't walk for 6 months. I am terrified of slippage in winter, I'm terrified.

Senior 7: I don't go out very much. I get tired easily. ...I can't walk very far, I'm short of breath. ...to walk across Portage Ave to get the bus, that causes short breath. I have to push myself. I find I make myself to do it, I do it.

The means of transportation that the seniors used included public transit (bus and Handi Transit services), taxi, getting rides from family members, friends, the program's pick-up/drop-off service, and/or driving by themselves.

Senior 1: I know that some people who do this (drive), they say, the only thing they do is for grocery shopping, still drive. And...finding going by bus, the bus is kind of convenient, I think.

Senior 2: One thing I like about that is you go in a bus. They (the senior building) have a bus, they hold 16 people, and not even that many go to the pop concert.

Senior 3: We have exercise for an hour, then we have a luncheon, and then play bingo, and I'm picked up, and back home.

Senior 4: I get up for breakfast, and I get out to take the bus and go some place. I have a monthly pass and I go all over Wpg. But now I don't like it so much. I'm older and buses are a little bit more complicated than it used to be, you know.

Senior 5: I have a cab, a taxi phone, I use that. If I'm not feeling like getting into the bus, I'll call a cab.

Involvement in Social Activities

This population did not demonstrate active social involvement in organizations, social clubs, senior centres, churches or other forms of social activities. The seniors who maintained a more positive attitude reported more involvement in social activities. The activities seniors usually took part in included attending continuing education, participating in day programs run by clubs or day hospitals, going out and watching entertainment (e.g., symphony, opera), and having meals with fellow residents in the building. The following are some examples:

Senior 1: I have been going to the what's it called? Senior courses at the University of Winnipeg, 55 Plus, and each year I take about 2 things each time. I'll have different things in January, or something. Two things next time, and you know, everybody, everybody now is senior, although some are quite young people turn out to be between 55 and 60. ...So you take what you want, no assignment, very different. Very good. Because I went to university myself when I was young.

Senior 1: I do belong to the university reading club. With that you can, you

can belong to certain groups. There's no pressure with that. There're groups that encourage people become a member. ...I'm in the second reading group, which through Creative Retirement, principles the same. And we share the books. You first read the book, and pass on to me. We do that.

Senior 2: I just go for the lunch here. I don't take any other meals. ...This is the only activity, social activity I have. ...Well, I am friendly with 2 people that I have lunch with, same people, I have contact.

Senior 3: So everybody that lives here has the meals, either dinner or supper. ... A lot of people who do that don't want to go down. I've been doing that now.

Senior 4: It's an Italian club. ...We go for there for..eh...we have exercise for an hour, then we have a luncheon, and then play bingo, and I'm picked up, and back home.

Several seniors mentioned they were not going to church any more. One person thought it was too bothersome for someone to give her a ride every Sunday since she was unable to drive to church. Another respondent stated that the church was not supportive and helpful when her husband passed away, so she decided to stop going. Seniors also reported memberships in certain associations focusing on serving people suffering from particular types of disease. For example, one senior belonged to the Canadian Institute for the Blind (CNIB), and another had memberships in Veterans Affairs and the Canadian Diabetes Association. Older people who fall into the associations' admission criteria can receive services and benefits, but there is hardly any meaningful social contact within these services such as a nurse coming in from Diabetes Association once a month to prepare pills

or using the CNIB library. In the present study, this form of involvement in organizations is regarded more appropriately as services the seniors receive, a topic that will be discussed later, rather than social contact.

Connection with Children

Adult children were the people with whom that seniors reported having most contact. Children help their senior parents in various aspects of life, from psychological well-being to everyday activities. Seniors rely on their children to drive them to doctor's appointments, banking and paying bills, going for grocery shopping, and joining family gatherings on holidays. Most of them also reported keeping active connections with their children via telephone. One senior said that when she felt depressed she would phone her daughter and "she usually drives, come down, here is me, Mom, smile, you know, she tried to cheer me up".

However, at least three themes related to children emerged from data analysis as factors that negatively influenced the seniors' lives. The first theme is family crises of the adult children. Because of the long life span of the population, the seniors' adult children are usually elderly themselves. Some of the children had already gavin up their driver's licenses, like their parents, due to health concerns; some were facing their own life transitions such as retirement and divorce; while others were undergoing critical diseases or had even died of terminal illnesses.

The domestic crises suffered by the younger generation created a considerable amount of emotional burden on the older elderly.

> Senior 1: my son has cancer, he got lung cancer. Now affect to the brains, now they say it goes to two brains, and now they're working on his lung, hours of radiation ...They come to talk to me this week. They told me the radiation was burning his figure. That really upset me. I don't want my son ... He's really been influenced, not able to eat. So that kind of upset me, you know. And he's only 49. I don't want to lose my son, you know.
>
> Senior 2: I don't see too much of my family because my daughter has a surgery, and she's on wheelchair. She can't get here anymore, back and forth. I have to give up my car, because I can't shoulder check any more. So I gave up my car when I was 67, and she gave up hers several years ago. So that makes it tough, you know.
>
> Senior 3: I did have 3 sons, but kind of sad that my youngest son died of brain cancer at the age of 50. That's quite a few years ago now. 2 years from January. His wife cried off, nearly cried off. And they have 3 children...
>
> Senior 4: She's got some exercise for her legs, and she's...
> She has, she keeps regular routine, going to bed like 10 every night. Because the pills she was on it. She has to keep her routine. So makes it tough.
>
> Senior 4: When my daughter come home, she's married, she divorced, And she come here, I know her right. She live in Toronto. I know it is Ok they don't live any more together. But I, the problem is don't tell. And maybe, maybe that's bad when too much to keep in?

The second factor that affected the connections between the parents and adult children was geographical inaccessibility. The younger generation was scattered across Canada, from Vancouver to Montreal, as well as in the United

States. Also many opted to settle down in smaller towns in the Prairies such as Selkirk, Steinbach, Thompson or Thunder Bay. The seniors, therefore, had very little chance to maintain face-to-face contact with their children except through major family gatherings.

Senior 1: [The didn't come visit me in the past month] because they're too far away. I got a girl in Ontario, a boy in Thunder Bay, and this one here in Winnipeg quite often when she can (the daughter could not visit her at the moment due to an operation), get around and come.

Senior 2: And my children, unfortunately, are either in the States, or in the East. They went where their jobs took them. And I don't think anything bad to them for a minute. This is their life.

The third significant finding from analyzing the interview data is that the frequency and quality of the care the seniors had received from the younger generations was inconsistent with the seniors' expectations of close parent-child relationship, caregiving, and communication.

Senior 1: My son is gonna come. And, he can't come right now. He's busy with a lot of work, you know, but...so...He'll come and see me then. But.. there's nothing he can do.

Senior 2: Now Christmas day, I'm all alone on Christmas day. Because my daughter, she goes to her husband's place. Somebody had to be left out. So I'm left out. Kids are all gone now. I'm sitting here by myself.

Senior 3: I don't know, when maybe I get weak, and I need to look after. And she never look after, it's hard to look after. And she works, that's she... If I can't any more do everything, keep myself, then we both live

together. I'm a daughter of others. Then you go so weak, nobody can take care like that. I give my parents care, I give my parents care, so. They don't do any more like that. They're young people, young people. ... I have my parents. I look after my parents, have daughters, spend, busy, busy all the time. That's ... I don't know. ... More like look by yourself up, that kind of thing.

Senior 4: I know is it Ok they (the daughter and her husband) don't live any more together. But I, the problem is don't tell. And maybe, maybe that's bad when too much to keep in? There's nothing to keep in, she can't keep from her family. Keep in, but that I'll spell it out. And maybe, maybe I'm too open? Maybe talk with the family what is it like? My daughter, I talk about the day how are they doing, what they like and stuff, so I keep it too much in...

Most of the widowed seniors, mainly older women, had a child-centered life since their partners passed away. They had to work hard to support the family and raise the children during the majority of their younger lives. When their children grew up and founded their own families, the seniors were confronted with painful emptiness when the offspring left the household as the following respondent described:

But it's, you feel you get old, and you know, they (the children) have their own life, that's, that's all people feelings. ...Although they told they call me every Sunday. Last Sunday, yesterday he didn't call, I don't know why not. So, they have their life, you know, you think you have your daughter living in MB, they have their life, they have smaller kids in high school, in grade 7, grade 5, they have. It's not my life any more. My life is all empty.

Seniors might also have experienced the difficulties of understanding the younger generations in daily life, which caused enormous confusion and pressure on the

seniors, who felt they were limited in making efforts to flatter the young people due to lack of energy and strength.

> Last year, even I can't get the present, the mother picked up the present. Now another girl, November 15, she or, maybe send the present. She is: That's the same as my cousin's. That's they say. So, I can't go any more this. I go one time to store, I pick something I like. They say, you pick up, you don't know what the girls like something. Now Christmas come, I ask again, you, the store you pick up something. So, and the, and I say, the mom say that's the last present, I can't pick up, you need to pick up. She said that's the last present. I'm old, I couldn't pick up any more, and ask the mom to pick up the present, that's not the ... I want to give something. ... so and now Christmas come, I need to give ... Only ask the mom to buy present for the daughter. Well, I think that's nice thing any more. And you can't do it by yourself. That's you can't do it by yourself. But you like to do it, think that would be nice. That would be nice. That would be nice present for birthday, and so.

Expectations for more visits from and contacts with children were also evident in this population.

> Senior 1: I wish my daughter to come and see me more often, just drives down. They're in Charleswood. They can just pop around Perimeter in a minute, and have a cup of coffee in the evening. I mentioned that to my daughter the other day. "Oh mom," she said, "such an effort when Garry gets home from work." They've got 9 dogs, she's got dogs to feed, and take for a run. Yeah, Siberians, he runs sleighs in the winter. She said he's all in by the time he does all that, feed the dog, and we go for a walk every evening.

> Senior 2: I hope the children could be close around more, then I'll be OK the day all the time

In spite of some unsatisfactory expressions about their children, a number of respondents were able to express a positive attitude towards the parent-child relationship and tried to view life first without a partner and later without children from a different angle:

> Somebody had to be left out. So I'm left out. Kids are all gone now. I'm sitting here by myself. I don't feel sorry for myself, because my son phoned me from Thunder Bay, my daughter phoned me from Ontario, my niece phoned me from the States, and ... So I don't feel sorry for myself. I'm, I'm happy! Warm comfortable little house I did. It's small, but it's home. I love it! I just love. Like I say it's a little bit small, but I don't need a bigger place. I'm quite happy with this. I just love it. It's my home, and I love it. And if there's love in the place, you have everything.

Many of the seniors interviewed also mentioned that they sometimes had to depend on their grandchildren for daily activities, especially those seniors whose children had critical health conditions. One senior used to pay her grandchildren to do housework and grocery shopping for her since "they needed extra money". Another senior claimed that she now relied heavily on her granddaughter to take her to necessary appointments and other daily activities such as banking and grocery shopping. The work of taking care of the elderly lady used to be the responsibility of the young girl's mother, but the youngest generation picked up the responsibility from the middle generation since her mother had undergone an operation and was now using a wheelchair herself.

Some of the seniors reported they had good relationships with their grandchildren. The young offspring came to visit their grandparents during holidays, and sometimes those who lived far away stayed with the grandparents for a few days or weeks. But overall the seniors reported they did not have regular and frequent contact with their grandchildren. Some of the respondents complained about the ignorance of their grandchildren among them.

> Senior 1: Their mother call they should visit me ... They come to visit me [once] a couple of weeks.
>
> Senior 2: I never heard from him from they went there (California). The first year I phoned, all the time, and he never phoned me ever! So this year, I get mad. I told him and I said, Alan, you have to call me next time I call you. And I said I, you don't call me, I'm not calling you. And I haven't. The last time I heard, I phoned , it was his birthday, last January. And he's 16 this January, and he's old enough to call me. So I don't know they just don't want to bother me any more or what?
>
> Senior 3: I got a grandson and a granddaughter. But I never see them.

Connection with Siblings

The interviewed seniors did not report much contact with their brothers or sisters. One reason was that they no longer had any siblings in their current lives. Three seniors reported that all their siblings had passed away and that they were the only one left in the family. Interestingly, one of the three seniors was the oldest child, one was the youngest, and the third was the middle one. In addition, one of the ten seniors was the only child in her family. It was also common for the seniors'

brothers and sisters to have poor physical health. When all living siblings were house-bound due to health conditions or limited mobility, there were few opportunities for them to meet one another in person. Another reason for insignificant connection with siblings was geographical distance. Most of the seniors' siblings resided in other cities or even another country. Communication by telephone was their most common way of keeping in touch with each other. One senior had telephone conversations with her older brother, who lived in another city, "every night, we talk to each other every night. He's got quite a sense of humor, couldn't get along without that." Another senior also had frequent phone calls with her brother back in her original country, Germany. In addition, one senior reported that he kept regular meetings with his brother, which he enjoyed very much.

Connection with Friends

The survey showed that half of the seniors managed to maintain and enjoyed the relationships with their friends, but the other half appeared to have deficient social contact with other people than family members. One senior, who reported the greatest involvement in organizations, also claimed to have the most friends and satisfactory relationships with them:

Researcher: Have you seen any friends in the past month?
Senior: Yes, we do. We do different things. We go for lunch together,

always one group. There was 3 of us, we take another person out on her birthday. One of us still drive, so that's all, whatever. I guess she has to drive carefully. ... I also go to the Manitoba Opera. And a friend I go with. So she has to give her, she gave her ticket this time so I took my daughter. I'm quite a friend of hers, it's nice to do that.

Other seniors also described that they and their friends have good times together in day-to-day life:

Researcher: How about friends? Did you see any friends in the past month?
Senior 1: I see them, I see them downstairs when we have anything here. Every 1 or 2 weeks we have something going on here.
Researcher: Mm-hm. Do you see them often, regularly?
Senior 1: Oh yeah. I see them quite regular, everyday or so.

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Senior 2: And there's a lady upstairs comes and visit, we tell jokes, and laugh. And then, (laugh) a cup of coffee. So, once awhile. ...She used to come Friday nights. So, sometimes we sit down and laugh. She's been a very nice lady to me. She's still 60. We have a good time together. She's very jolly. I like her so much. And she's so funny.

Besides the company in day-to-day life that friendship offers to seniors, respondents stated that friends were also helpful in tangible daily life activities:

But Bev (the friend) is very helpful to me, too, and then, I have a friend, over another building, Bill, was my cousin's boyfriend. She passed away and Bill said, if anything you need. He takes my garbage out for me, and helps me with the garden, water my plants, stuff. So, you know, you help people, you become friends.

However, not every senior was able to enjoy connections with friends for various reasons. One senior complained that she did not feel comfortable talking about her family issues to the friends with whom she sometimes had gatherings. She described the friends as having a closer relationship among themselves than with her. The friends sometimes picked her up to join their birthday party, but "you go into their car, you don't talk with my [your] family's problem". A limited sense of belonging or acceptance is an influencing factor that decreases the quality of friendship in a senior's life.

Another significant problem that caused the lack of friendship was degenerating physical health, as had happened to the seniors' siblings. Some friends moved and some had limited mobility because of their inability to drive. Overall, the seniors stated that maintaining active relationships with friends was very difficult to do.

Senior 1: But two of them just moved away, right cross the street. There is one down the street here, but she's quite sick. She's 2 years older than me. So I don't see her right now.

Senior 2: I have friends, some of them aren't healthy, some of them don't drive, you know, so...

Senior 3: Most people at my age...like the girl I worked with, I use the term "girl" loosely, but the women I worked with, um, there's only two of them that I'm living with. So...and they live with their children. And one of them is on wheelchair, and the other has a surgery, very, very bad. They can't get out and go around, and I certainly can't go out to visit them or whoever in the city. You know.

Senior 4: They're over, they all dies out, they dies out.

One senior was grieving for a close friend's death, whom she considered as the last social connection in her life:

> The friend, take me for dinner...come up... and ...but...that's my last friend. ...Until April, I would say I had a good life. But now my friend died. He's my last ...(*tearful*) connection with people, go out for dinner with... and...And he just lived by me here, next to me, as a matter of fact. And, we've been friends for 25 years. ... And we're independent, very independent. We lived on our own, but we had dinner together a lot. And we liked music, and we used to play music, just sit there and listen to nice music at night, made me very happy, you know. Heart attack is ...how...I don't know...the diseases...He just, maybe 5 weeks, he's just gone. He had cancer. Yeah...(tearful)

In consideration of the perceived difficulties in forming new friendships, as described previously, the loss of old and close friends caused immense pain to the people who lived alone in their later lives.

Seniors' Perceptions of Their Current Lives

Many of the seniors described their lives as lonely. Several examples are included as follows:

> Senior 1: You know, lots of lonesome, lots of lonesome...It's dull, you know. No, you can't go out, you're not strong enough to go out. So the time, so stay inside, it's a lonely life, even with 3 daughters, grandchildren. ...They [grandchildren] come to visit me a couple of weeks,

relax, they care of me. So, but, you lose a lot of things. You, you are old, that's you. You feel quite empty, you know. (*non-native English speaker*)

Senior 2: Lonely person, I'm lonely for sure.

Senior 3: I got lonely some days. I cry. But I think everybody has a blue day. You know what make me don't feel good? That I think nobody loves me, here I am all alone. I'll die on my own, you know.

Senior 4: Well, it's hard of course... at night.

Senior 5: Lousy. No, I guess very lonely, very lonely.

One senior described that his life was "tolerable". When asked what he meant by this term, he said "I guess I live in a quiet desperation". Crying and depression are common consequences of feeling lonely and other negative emotions towards life in old age, as the following senior stated:

I have been on medication for depression for a long time. Maybe it's just being unhappy, it's depression. I see a psychiatrist for 5 months, Dr. S, ...I guess depression is quite common at my age. (Researcher: Do you think the medication help you eliminate the depression?) Not much, you know. ... I'm not actively depressed, but I'm unhappy, you know.

The respondents' attitude towards aging and aging life varied. Some seniors tended to passively accept the way life was. One senior stated she would not bother to go anywhere for activities even though she was alone, thinking she would "be Ok the way I'm". People missed the days when they were healthy and active, but also realized that

...you're not strong enough. You may even ..., and that you can't do any more. And I not so strong any more. Anyway, I'm healthy, whatsoever, but I'm not any more like a people can do everything, everything.

Another senior stated several times during the interview that she was "too old to go out to make friends" and making news friends requires too much effort for her. "At 90, 91, you don't get out and make friends. Believe me." One senior expressed mixed feelings about aging, "I guess I'm denying I'm old. I am old, but I don't like to admit it".

On the other hand, some interviewees perceived their lives in a very optimistic manner and considered life enjoyable and satisfactory.

Senior 1: I think my life is wonderful. I said before I'm quite happy of what I got. Everything is in my own. I don't owe anybody a nickel, I like to cook my meals, last week I made a pie. I took a piece across the hall. Made a cake, Saturday, biscuits, what more do I need? ... It's not an easy life. But yet I'm happy the kids are all good, have helped me to stay around me and so. So I got things to be thankful for, too. I look for that, rather than something to be complained about. I stop and I think: no, I'm very fortunate, to be thankful. (*This respondent was the oldest of the interviewed subjects.*)

Senior 2: I feel I'm very fortunate, and I 'm lucky. I can hear very good. Now this is something I'm signing here. Other people here they have to accommodate me. ... But some of them can't hear very well. I get a lot of fabulous clue. Let's act on that! That's good. And I, I hate to say this, but my eyes aren't good, but I don't cry myself. I love, I just feel I'm lucky. (*This respondent was visually impaired.*)

Senior 3: I'm quite happy the way I'm living.

Senior 4: There're some times that I feel comfortable. (Researcher: What makes you feel comfortable?) Programs that I'm looking forward to, TV, or something I read.

Senior 5: Now I'm sick. I read a lot, I read, and read and read. But... I have a lot of tapes, I use tapes a lot. Music. And, I got all the music tapes there. And, I'm quite contented, I make myself. I figure, If you gonna be miserable, it's your fault, you know. Lucky that I'm not. (*This respondent was the second oldest interviewed subject.*)

Widowhood

Widowhood was a critical issue for this group of older people. Despite the survivors enjoying longer life expectancy, many of them were confronted with painful emptiness when the loved one who had been in their lives for decades passed away (Rathbone-McCuan & Hashimi, 1982). The female elderly expressed how much they missed their husbands and the life of a couple, which, in turn, had strengthened their negative emotions and perceptions of current life, especially those who became widowed in the last 10 years. Nevertheless, neither of the two male respondents reported significant pessimistic feelings about losing his spouse. A senior whose spouse passed away 5 years before was constantly tearful during the interview and was immersed in the memory of their happy marital life without paying much attention to the researcher's questions, which made the interview very difficult. "Since he passed away," she said, "there's no life any more." The following quotes outline the tremendously destructive impacts of widowhood on the senior:

(*Episode 1.*The interviewee is sobbing, showing me the poem collection she made for her husband.)
Researcher: This looks great.

Senior: We'd married for 59 years. He never called me name, he never hit me. The only thing he said is to kick my ass. (Long pause since the interviewee is sobbing.)

(*Episode 2*)
Senior: It's from inside. I'll be doing, if I get lonely, I go each way, got a tea, and then when I look at (long pause), nobody to talk to. (tearful)

(*Episode 3*)
Researcher: The special program, they had the music played. ... So I just pick thing up, and that I went. I couldn't stand it.
Senior: What happened?
Researcher: I couldn't stand the music ... it's very special, when we met the first time. (cry) I don't know. People just walk hand in hand ... you see people ... but all, all ...

(*Episode 4*)
Researcher: So you have the album with you everywhere.
Senior: He goes everywhere I go, never left behind. I talk to him. First year, you wouldn't believe that I went so many times to the S cemetery, the first year. Now this year, only went 3 times so far. ...

(*Episode 5*)
Senior: I don't sleep without a light. I've got night lights on ever since he's gone. I've got all the lights, lights on. It's very, very hard to be alone, for so many years, for your old age. If I was younger, yeah, but not now.

Not only the newly widowed found life without a partner miserable, but women who had been widowed for decades also addressed the difficulties of re-adjusting their lives after the death of a spouse.

Senior 1: But when you lost a partner, you lost everything. I didn't mind when the kids are at home. They kept you busy all the time. Now when they are married, all on their own, and I don't see them that much. That's the time I'm lonesome. I can't say I'm lonesome, but yet, you know what I mean, sort of dump. (*Widowed for 53 years*)

Senior 2: Saturday and Sunday, yeah. My husband and I used to go out a lot on Saturday and Sunday. But right now... (*Widowed for 41 years.*)

Senior 3: I got miss travelling, and make socialized with my husband, because I got widowed for 20 years now. So that, you know I'm used to being on my own for that.

On the other hand, some seniors seemed to accept the reality of losing their partner and have adjust pretty well to the solo life, as the following example demonstrates:

Senior: My husband had been dead for 51 years. It's all right. That's life. Nobody can do anything about it. Only myself. I'm the only one keep myself busy and do everything forget about it, it has to be. Man couldn't live when health gave up. Life was taken, so what could you do about it? I don't want to meet a jerk and get married. I don't want that. I have 5 kids, and I was 39.

Researcher: So it's not easy.

Senior: No. It's not an easy life. But yet I'm happy the kids are all good, have helped me to stay around me and so. So I got things to be thankful for, too. I look for that, rather than something to be complained about.

Divorce may have caused a similar effect as widowhood on the seniors in late life. Feelings of loneliness and regrets about not being able to maintain a

satisfactory relationship are the most notable characteristics of the impact of divorce in late life, as the respondent stated:

> But overall it's lonely life. I divorced when I was 28 years old. And I didn't meet anybody I could marry. And so, I've been with only my 2 children, and it's been a lonely life, you know.
>
> I think sometimes you think things that you get in the past that you wish haven't and I start crying and think what a miserable [person] I am, and just things in general, you know. And then I think if I had a decent marriage, ... just, it's a hard thing to explain.

Language/Ethnic Issues

The ethnic background of the research subjects is not a focus of the study, however, the data do show that ethnicity or original nationality might be a influencing factor in the current lives of the seniors, as well. One senior, whose mother tongue was Finnish, believed that the language barrier prevented her from establishing meaningful friendships with people because she felt she was unable to express herself well. The respondent reported connections with a few acquaintances, but did not consider them friendships since she could not talk about her problems and family issues with them. Another interviewee complained that the residents in the building where she used to go for lunch were not friendly to her, because "they all come from the same country, Germany, when I came down, they sat together talking in their language, they must be talking about me."

The language/culture/ethnicity issue obviously caused some obstacles both psychologically and physically. Seniors whose first language was not English might feel unconfident and/or uncomfortable in communicating with others. In certain situations they might feel isolated while other people were speaking a language with which they were not familiar. In our multicultural environment, sometimes not being able to speak languages other than English could cause language barriers. However, language/ethnic issues might not be solely responsible for the seniors' problems. The lack of suitable activities to integrate seniors might have also contributed to their dissatisfaction concnering interactions with others.

Independence

Although the majority of the seniors received some kind of help with housework and personal chores or health-related home care services from either personal sources or social services, the ability to maintain one's sense of independence was a crucial concern for them.

(*Episode 1*)

Senior 1: I'm so independent, I'd rather do my own. I want to do it, first thing in the morning. I like to do my work. ...When I knit the cloche there, busy myself, don't bother anybody else. It's wonderful. ...I don't want to be out everyday all the time. I used to when I was younger. I could go on my own. But to bother somebody else, no, that's not for me.

(*Episode 2*)
Researcher: Just use your imagination. Do you like any other services that you could use?
Senior 1: No, no. I don't need nothing. (laugh)
Researcher: (laugh) You're too independent.
Senior 1: I'm born this way, I'll die this way. (laugh)

(*Episode 3*)
Senior 1: You can't always have your kids.
Researcher: No.
Senior 1: Depend on them, 'cause they have their own lives to live, eh? And that's what we want. We want, I don't want to be dependent on anybody, if I can help myself.
Researcher: Yeah, you're very independent.
Senior 1: I'll be as independent as I can, believe me. (laugh)

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Senior 2: It's just sometimes I wasn't brought up for people to wait on me. I used to wait on, you know, other people. It's hard to phone and ask sometimes...

****

Senior 3: I can do all my own work. I can do ...well... I have a girl to clean, you know. But I get my milk, I look after my cat, I go to the store everyday. I don't go shopping everyday, but I walk there.

****

Senior 4: My husband passed away, I don't want to live with my sons. If I am able to, I would like to stay here. I would do (move into a senior house) later. Right now, I want to stay here as long as I can. If I get sick, you know, I can't manage (living) along, I would have home care.

But on the other hand, sometimes the seniors had to compromise upon recognizing they could no longer mannage some activities or that certain situations

were beyond their ability to control. For example, a senior stated that she now "depends on my granddaughter more than anything else", and

> my family, have all my credit cards, they got my interact cards. My daughter has one, granddaughter has one, I don't get to spend any money. They do the shopping. They buy the grocery, they bring me a few dollars to have at home.

Another senior expressed that she could only wait passively for her children and grandchildren to come visit her because "It's all like you can't go and you can't deal your life yourself, it's just depends on somebody else, just depends."

Social Contact

The results of the answers to the question, "How often do you feel that you would like more contact with other people in your everyday life?" are mixed and somewhat contradictory to the findings emerging from the narrative data gathered with open-ended questions. Five (50%) respondents reported *none of the time* (n = 3, 30%) or *a little of the time* (n = 2, 20%) they desire more contact with other people, whereas the other five indicated they feel they would like more contact *some of the time* or *most of the time*. However, the seniors who stated they would not like to have more social contact, similar to most of the other respondents, in fact identified their amount of social contact with others as insufficient and expressed immense emotional stresses such as depression and feeling lonely due

to their lack of contact with people.

Senior 1: I just can't go out and talk to anybody, you know. (cough) Pardon me, my voice. I like, you know, it would be nice, like I say it you have that game, playing cards here (same floor within the building), I can walk down to.
(*Most of the time feel like more contact*)

****

Researcher: You also mentioned you don't see people, and you feel lonely, very upset.
Senior 2: Yeah, I cried.
Researcher: Cried.
Senior 2: But I just, I think you feel sorry for yourself. You know.
(*Most of the time feel like more contact*)

****

Researcher: How do you feel the lack of enough contact affects your life?
Senior 3: (sigh) Inside, it's hurt.
Researcher: Emotionally?
Senior 3: It's hurt.
Researcher: Could you say more about it?
Senior 3: The feelings. I don't know, hurt, what else I can say? Loneliness, loneliness.
(*Some of the time feel like more contact*))

****

Researcher: When you don't see many people, how would that affect you?
Senior 4: Yeah, yeah, it's affected [it affects me]. You feel lonely, you feel sadness. So you start thinking what happen, believing, learn about the life, be company and so. And it's not easy. It's loneliness. Yeah, even when they talk, the children they come, and you miss them. They come, you miss them...
(*Some of the time feel like more contact*))

****

Senior 5: If I am going out, I am fine. Or if somebody ..I have someone to talk to, I am fine. But let's say I stay at home, I don't see anybody for a couple of days, then I do get lonely.
(*Most of the time feel like more contact*))

Researcher: In what way has this lack of social contact with others affected you?
Senior 5: Sometimes I have depression.
Researcher: How would you describe when you have the depression?
Senior 5: If I don't see anybody, I feel very lonely, I feel alone. So I would say depression.
(*None of the time feel like more contact*))

****

Researcher: Could you imagine that how your life would be if you're without the social contact you're having right now?
Senior 6: Oh I don't... I think I'll get very depressed. ...You don't want to be depressed by you.
(*None of the time feel like more contact*)

The reasons for insufficient social contact have been described above as related to various issues, including health conditions, mobility, family members, friends, and organizations. Some seniors also indicated that weekends were the worst time for them, when they felt loneliest or saddest.

Senior 1: His (a close friend) death was very sudden. It's over night. And I haven't picked up again with any body, you know, friend. Most friends here, unfortunately, all have their families. Sunday the families come and pick them out. ...But...They have their children here. And my children, unfortunately, are either in the States, or in the East. They went where their jobs took them, and I don't think anything bad of them for a minute. This is their life.

Senior 2: Some times I am OK. Like today I was busy. I was talking to my visitor from Age and Opportunity, so that was great. She comes every Saturday night, which is great because Saturday night somehow is the saddest, loneliest day for me. ...Saturday and Sunday, yeah. My husband and I used to go out a lot on Saturday and Sunday. But right now...

The seniors not only expressed their hope to have more friends, but also stated their concerns and expectations about the quality of social contact they had gained and would gain.

Senior 1: You say hello, you talk a little bit, left, somebody say joke a little bit, then you say no, it's not right, and something. It's up to you. That's not enough, that's not contact.

****

Senior 2: I know people down the hall. They'll speak if I get out on the hall. They see me and usually I go out in front of the door, get the mail, and they say "Hey! Sheryl, how are you", drop by for Christmas, knock at the door and say merry Christmas or something. They're all very friendly, very nice people. You say hello and shut the door (laugh). You know, they don't really...

Researcher: Very meaningful?

Senior 2: No, no, they don't come in. And like the one lady who I got familiar when I first came here, that we both smoked at that time, and she still smokes and I don't. I can kind of smell her now. Speaking to her at the door the other day – power gone off, she showed me how to switch to get my washing machine work. Phew! I'm so glad she left because she smelled badly.

Nonetheless, there were seniors who stated that they were quite satisfied with the amount of social contact they had and would not like any change. Some reported they were too busy with the current activities in which they were already

involved. Others seemed to prefer a relatively small amount of connections with people because of their personality.

Researcher: Would you say you feel you have enough social contact with other people?
Senior 1: Oh yeah, almost too much! (laugh)...Like I said, this lady drives me to the church. I said, her name is Ruth, and I said Ruth, I'm not afraid of not knowing any, or not knowing people there, and the activity. I worry about not having enough time on my own.
Researcher: Sure. Well, do you feel you would like more contact with other people?
Senior 1: No, no. (laugh) Not me, I need some quiet time. ...I go to enough programs. Sometimes two things happen at the same time, I have to make a choice! (laugh) I'm like terrible!
(*This respondent reported involvement in more than 6 social activities or programs.*)

****

Researcher: Do you feel you have enough contact as you like?
Senior 2: Yeah, I got, yes, that's it. That's enough for me. I'm not, I don't know. I don't want to be out everyday all the time. I used to when I was younger. I could go on my own. But to bother somebody else, no, that's not for me.
Researcher: Ok, well, would you like to have more people to contact with?
Senior 2: No, no.
Researcher: So you just feel like it's OK, it's fine?
Senior 2: I'm fine of my life the way it is. I'm quite happy the way I'm living.
(*This respondent reported only social contacts with fellow residents and the friendly visitor in the month prior to the interview.*)

****

Researcher: Do you feel you have enough social contact with people?
Senior 3: I'm not a very sociable guy. ...Occasionally I want to see more people. Yeah, I'm not that anti-social.
Researcher: Would you like to see any change in your social life?
Senior 3: I don't think so. As I've said, if I want to see people, I can ring

them up and go see them.
(*This respondent reported only one contact with the sibling and contacts with the friendly visitor in the month prior to the interview.*)

Helping Others

Helping other was not a commonly mentioned topic during the interviews, but it is worthy of shedding light on how and what seniors perceived they could contribute to other people, rather than only receiving help from others. One respondent claimed that she would like to volunteer at working for other seniors, such as being a friendly visitor like the one assigned to her.

> I would like more social contact with people. I would even like to volunteer if someone picks me up, and takes me home, especially in winter.... I want to be with somebody like me. You know, live alone and have nobody, want a friend, just like the visitor I get. I would like more of that.

Another senior, who was the oldest interviewee and maintained a very optimistic attitude, had been providing constant help and company to her paralyzed neighbor, who was 40 years her junior.

> I baked a pie and took a piece across the hall. A gentleman lives right across the hall. He's all crippled up, he's only 47 years old, but he's all crippled up. ...when I make, cook something my own, I take him some and he's so happy about it. And I feel good, too. Because I feel I'm doing something for people. Otherwise you sit here, you think you're good for nothing, don't do anything, but I do more than I think I do. ...I feel so sorry for him. I would like to do more for the man, but I can't, you know.

Preferred Activities

When asked what kind of activities they would like to do to enhance the amount of social contacts or when they described the routine of their lives, the seniors were usually able to identify their preferred and non-preferred activities. One senior stated that "this choice kind of thing, I think when you get, when you live, quite a few years, should be able to know what kind of thing is good for you." The seniors' preferred activities varied from formal to informal social contacts, from personal activities to interpersonal interactions, and from focusing on individual interests to broadening their attitudes toward different kinds of programs. Some respondents liked simply being with people and enjoying casual talk:

> Senior 1: You know. I'm an active person, I like to ..., I like people, I like to get out, and I can talk. I used to talk a lot with children, at work.
>
> Senior 2: I like being with people.
>
> Senior 3: Then, then, you talk with lots of people, I say together, you know. And it's not in your own, say any like my family, or I say my family, 2 grandchildren, 4 grandchildren, I hate that a bit, like talk. No in the family, secret or something. I'll be happy. I'll be happy OK. I like coffee, I don't like the sandwich, I better have sandwiches or something, like likely. Even they put a loaf or something, something enjoying. All the coffee today nice. Something like, something like easy talking.

Some preferred a walk every day or some other form of exercise:

> Senior 1: I go there every day, just for a walk, and walk back home. I

figure if I don't walk, my legs will get worse.

Senior 2: And then we go to exercise room. I'm all happy, exercise, I say. Everybody on chair, and each, each joint is touched, and then you walk in the hallway, 10 minutes, you walk and exercise again. And this is it. I think they a little play the game, and then the van come, and two o'clock you go home, and they bring you home by then. I enjoyed it.

Senior 3: Like you're walking around in a group, you walk around, see how people do, what people do, better do. And maybe I can do that good. I can see how they do, how you do it, how you do is nice. Mine isn't that good looking. Things like, things like.

The seniors' interests in activities were not restricted to traditional types of exercises, but also recreational or non-traditional activities.

Researcher: Usually what kind of program do you choose to come?
Senior 1: Well, all over the years I've been there, things have been different, you know. Meditation, yoga, that's quite awhile ago, the yoga type. Let me see now, uh, anything that interests me, you know.

****

Senior 2: Dancing? I love dancing, but nobody to deal with. You got to have a good floor to dance on, without carpet, you got music, got a man to dance with.
Researcher: I think they have such dancing clubs.
Senior 2: Yes, but they have line, I don't care for the line dancing thing. I don't like the way they dance now. I like my old time dances.

Some seniors were fond of reading, listening to music or watching preferred TV programs. For example, one senior held memberships in two reading clubs and participated in their programs regularly. One senior described that " we (the

respondent and a friend) liked music, and we used to play music, just sit there and listen to nice music at night, made me very happy, you know." Another respondent reported that "programs that I'm looking forward to on TV, or something I read" would make him "feel comfortable". One elderly woman said that she spent most her leisure time on knitting in her apartment. Knitting kept her busy and made her feel contented. The most active senior among all the interviewed elderly also demonstrated great interest in intellectual self-development such as attending a workshop on current global issues and registering in a formal continuing education program offered by a local university.

Card games and bingo may be regarded as common activities seniors would be fond of and frequently play. But the interview data showed a mixed attitude about card and bingo games.

> Senior 1: I love playing cards, any kinds, or crafts, anything like that. But you need people to deal with.
>
> Senior 2: They have a lot of things, but bingo, bridge, I don't do any of those. I don't say that, I think people shouldn't be doing that.
>
> Senior 3: They have a shuffle board. They go down every night to play cards like bingo twice a week, Wednesday and Saturday. There's bingo, I don't go. Because that doesn't appeal to me. ... No, too boring for me.
>
> Senior 4: I don't want to play bingo, bowling, and other things. I don't really do very much (of the activities in the building).

Finally, seniors also expressed that they did not hope for "big changes" in their lives

through doing the activities they preferred.

> It's just, just more or less like you have somebody to talk to on my age. And, you know, somebody that wants to come over, close senior, you know, interested in anything like that. I'm interested in craft, and anything. I love to play cards. Because I really. I'm not interested in making any great big changes. Just, just, I like to talk. (laugh)

Friendly Visiting Services

How did the seniors learn about the Friendly Visiting Services

The sources through which the seniors learned about the Friendly Visiting Services included professionals in other social service areas, friends, hospitals, and the police.

> Senior 1: I went to grief counselling first, 14 years ago. And I think it was them who told Age and Opportunity to contact me.
>
> Senior 2: Somebody told me (about the program), in another block, I don't know. I think it was one of the nurses here.
>
> Researcher: Would you tell me that why you decide to participate in the program? How did you get to know it?
> Senior 3: I just said it's a good idea, you know. ...might be... L. W. (*Home Care coordinator*).
>
> Senior 4: They told me in the hospital, the Grace Hospital. They said that if you'd like me to, like them to contact about the volunteer program. Yeah.

Senior 5: Police got in touch with Age and Opportunity (after the respondent's break-in incident), and so, they phoned me, they contact me ever since then. And they mentioned this visiting, and I took it up.

Senior 6: She (*a friend of the respondent*) contacted Age and Opportunity, and I didn't know the name either, Age and Opportunity. But I didn't use any of the services. I don't know anybody work there, I think so. It happened so. It just happened to me, I think if I can get somebody for reading things (*the respondent was legally blind*).

Effects of the Friendly Visiting

The seniors' perceptions of the effects of the Friendly Visiting Services varied from *haven't changed any thing* to *make me feel much better.* The majority (n = 7; 70%) of the respondents perceived that having someone visit them once a week made them feel better. One reported the friendly visiting did not have any significant impact on her life, while another two seniors gave mixed evaluation of the visiting program.

The perceived effect of the Friendly Visiting Services showed a strong correlation with the personal relationship between the senior and the matched volunteer visitor. The seniors who indicated the positive impact of the program frequently described their visitors with approving terms like *friendship, love, support, sharing, expecting, nice, wonderful, company, understanding,* etc.

Senior 1: And the particular person I have now, we have more than that. We're friends now. She thinks that way about a person, she has, too. And she says, she's so glad because you're already a friend that I can talk about books with, she says. Ah...she said, she's not that interested that

she can't even talk about it with them. ...I feel better because it is a friendship now, really and, it's so wonderful. Because she feel she same way on a lot of things too. That's really, really wonderful. I mean, you know, no one would know it's gonna work out like that. She just come in you know, we're just more like friends.

****

Researcher: So like having such a visitor makes you feel better or worse? Or the same?
Senior 2: The same.
Researcher: The same?
Senior 2: No, better. Better, because I look forward to her coming the way. You know. So, but I don't want anybody and more.

****

Researcher: How do you think have the visitor make you feel? Make you feel better, worse, or the same?
Senior 3: A little bit better. I so waiting when she come, I think so. Because I'm waiting when she comes, I like she comes. ...I like she coming in. I prepare in the afternoon. I got a coffee or tea, we talk and, how she's doing.

****

Senior 4: I have P (the volunteer visitor) who comes and see. She comes Mondays, plays cards with me. I love her to death. ... We had a great time together, too. ...I'm happy! Yeah, happy when I, and things we talk about. She's got 3 grandchildren, too. We talk about the kids. We talk about our own kids. How mad we're at times and ... With somebody older, you can discuss things with, but your family doesn't know about, you know (laugh)... Just to get an idea how to handle, maybe in a different way than I handle, you know. Just give some suggestions. ...P, I met her, and you know right away you'll be a friend, too. You know, you just understand that fast. You just get that feeling in your heart, and they gonna be nice people, and you wanna see them. P phoned me when she was in England for 3 weeks. She phoned me every Sunday.

****

Senior 5: She feels good, I feel good. We're just like family lately.
Researcher: Has having a friendly visitor made you feel better or worse, or hasn't changed anything?
Senior 5: Better.
Researcher: Can you tell me why?
Senior 5: Because I have company. ...Just imagine you are alone in this house, and not seeing anybody. You have to see somebody. You know what I mean? That's just what I can describe.

****

Senior 6: I just want socializing with people, you know, see what they're thinking, and talk about my own thoughts, feelings. ...We (the respondent and the visitor) don't have a lot in common, but he's a, a connection, a social contact, I guess.

****

Senior 7: I've got a couple take me out all the time from Age and Opportunity. Oh, they are nice, the loveliest couple you ever meet. My ... I think they probably are almost my age, or early 80's. They are open. They are just more fun. Oh, yeah, they are great. ...We go for dinner, every Sunday night. And I have them up here for sandwiches or something at noon. ...We got similar interests, you know, and, the children are children. We talk about our kids. ...I really appreciate for what I get. And, I should be thankful to the Friendly Visiting about what they do.

A few seniors agreed that friendly visiting made them feel better, but stated that having a visitor coming in once a week had not produced a significant impact on their current lives, either psychologically or physically.

Researcher: Does the visiting help you with your loneliness?
Senior 1: Yeah, at the point, sure. But after you get back in here, come back to the place, the same thing. Well, sure, it's not... I don't sleep without a light. I've got night lights on ever since he's gone. I've got all the lights, lights on. It's very, very hard to be alone, for so many years, for your old

age. If I was younger, yeah, but not now.

****

Researcher: How has visiting made your life different?

Senior 2: Not very much different, no. ... And then I think even if I be living, like I've be living for 18, 19 years by self, so in the house by own. I don't think so. They coming just sit for an hour and a half, I don't think so they make me. Maybe like I can't go or walk around the house, maybe.

****

Researcher: But does she help you feel better?

Senior 3: Well, in a way, you could say yes, yes because I look forward to her coming, you know. She says the same thing. She says she looks forward to coming too. Because it make week so long when she doesn't come in. It turns out she can't make it another week. For I'm not feeling well, they go for walk or something.

Researcher: But on the other hand, does she make much difference in your life?

Senior 3: No, no, no.

The activities the senior and the visitor usually engaged in included talking, hobbies, outings, and/or shopping.

Senior 1: She comes on Wednesdays. This Wednesday we go have tea. She wanted to know if I want to go any place, she asked any place you want to go to, you know.

Senior 2: It all depends on what we have to do. If we go to some place, we got out, maybe want to go to Zellers, look around. I have paper towel there. She says you wanna go to Sears for anything? But I don't always go, 'cause nothing to buy, I don't need anything, my closet is quite full.

Senior 3: She comes Mondays, plays cards with me.

Senior 4: There was a guy coming every Wednesday to listen to music,

classic music.

Comments and Expectations

The majority of the interviewed seniors did not provide direct information in relation to the item, "suppose you could now make a decision to change the services, what would you like the most to see to be changed?" Their first reactions were "I can't answer that", "I've no idea" or "I don't know" because "they are doing what they can." Nevertheless, through probing, the seniors were able to come up with some comments concerning the Friendly Visiting Services. Some seniors said they would like to have more visitors:

> Senior 1: I would, I would like more contact, a couple of times a week, you know.
>
> Senior 2: Yes, just more...or even has an exercise program, which they can pick us up and take us home.
>
> Senior 3: Don't know what could make it better. I really don't unless somebody wants more visitors or something. But I don't.
>
> Senior 4: I don't know if I could have more than one volunteer a week, so I've never said it. ...You know there's a lot of people around like me. I feel bad if they don't have any...I just tell you what I feel, I'm not asking for anything else. ... Yeah, they want, other people want.

Some seniors hoped for someone who could go out with them or accompany them to necessary appointments:

Senior 1: Now I have to go to ultrasonic, which is 26 of September. Now I am on my own, you know, I have to go alone. I would like a person come in with, being with me, and bring me home.

Senior 2: I would like to have someone that I could go out with once a week. To get, like seniors to get together.

One senior stated that "I think people like one lady who, who I go exercise with, ... and we talk on the phone, and she say can't go anytime out. Her daughter come, take her out. So the Friendly Visiting is good for this lady who can't get out of her home. I guess so." This respondent indicated that she preferred going to seniors clubs and participating in group programs. She considered herself quite capable of going out on her own, however, the severe winter weather conditions had prevented her from doing so. Additionally, one senior described the visitor he was matched with as "not particularly congenial" and said that they "don't have a lot in common." Another mentioned that she and her visitor had not had too much to talk about until she happened to find out they shared an acquaintance.

Social Services

The present study also intended to address the seniors' perceptions of other services available in the community for elderly people. Their awareness of the

services, the reasons why they did or did not choose certain services, and their comments and suggestions about the services were explored.

Awareness and Utility of Other Services

Each interviewee was requested to examine an inclusive list of most services relevant to seniors' lives and well-being and to mark checks to indicate the services they were aware of and the services they were currently using or had already used (*Awareness and Use of Other Services* section in the survey questionnaire, Appendix III). The list was compiled on the basis of the resource information at Age and Opportunity. Half the respondents checked the list orally while the interviewer read aloud the name of each service to them. The types of community services included counselling, housing, living assistance, health resources, legal resources, grocery delivery, senior centres, associations for certain disease, and other services at Age and Opportunity. The services the seniors reported they knew about and had used are summarized in Table 5.2. Assistance programs for daily living represented the most well-known and commonly used services. Agencies and programs related to health were also popular among the seniors who lived alone. They reported that they were not aware of some services such as Klinic Crisis Line, Community Financial Counselling Service, and Senior's Abuse Line.

Table 5.2 Awareness and Use of Community Services

Service	Number of senior reporting	
	Awareness	Use
Home care	10	4
Handi Transit	8	4
Health Links	8	3
Canadian Diabetes Association	8	3
Manitoba Society of Seniors (MSOS)	6	2
Health Calls	6	2
Senior Job Bureau	5	2
Victoria Lifeline	4	2
Senior Information Line	3	2
Society of Manitobans with Disabilities	6	1
Safeway Grocery Delivery	5	1
Community Home Services	4	1
Veterans Affairs	4	1
Creative Retirement	3	1
Canadian Institute for the Blind(CNIB)	3	1
55 Plus	2	1
Arthritis Society	6	0
Canada Red Cross	6	0
Canadian Cancer Society	6	0
Heart and Stroke Foundation	6	0
Legal Aid Manitoba	5	0

	Awareness	Use
Good Neighbors Senior Club	5	0
Cantor's Grocery Delivery	4	0
Harry's Food Store Delivery	4	0
Manitoba Housing	4	0
A & O Arts & Crafts programs	4	0
A & O health programs	4	0
Doctor's Hotline	3	0
Residential Tenancies Branch	3	0
Law Phone-In and Lawyer Referral Program	3	0
Gwen Secter Creative Living Centre	3	0
St. James Assiniboia Senior Centre	3	0
Stay Young Centre	3	0
Transcona Senior Centre	3	0
A & O computer programs	3	0
A & O dancing programs	3	0
A & O fitness & movement programs	3	0
A & O game programs	3	0
A & O meal program	3	0
A & O Counselling	3	0
A & O Seniors Housing Directory	3	0
Riediger's Delivery	2	0
Seniors Directorate	2	0
The Public Trustee	2	0

	Awareness	Use
A & O Educational programs	2	0
A & O Elder Abuse Services	2	0
A & O English for Seniors program	2	0
A & O Legal Services	2	0
A & O Older Victim Services	2	0
A & O Volunteer Program	2	0
Self-Starting Creative Opportunities for People in Employment (SSCOPE)	1	0
Workplace Ventures	1	0
Shelter Allowance	1	0
A & O ABCs of Fraud Program	1	0
Mobile Crisis Unit	1	0
Klinic Crisis Line	0	0
Community Financial Counselling Service	0	0
Senior's Abuse Line	0	0

How They Learned about the Services

The sources from which the seniors had learned about community services were similar to the sources from which they had received information about Friendly Visiting Services. They included their children, friends or acquaintances, hospitals, nurses, media, and so on.

Senior 1: Because here the people that I meet, everything to, they, you know, they're going to something.

****

Senior 2: I haven't gone to any of them. But I heard people talking about it, say you might need to consider to go.

****

Researcher: But you know about them (Home Care services)?
Senior 3: Yeah, yeah. Lots of them coming here for other people, not me. I get away of my own. (laugh)

****

Senior 4: I think I've heard of it. Somebody worked as a volunteer there. So, I heard about that.

****

Senior 5: I was sick, and before summer time she (*the respondent's daughter*) get the social worker for me. Because until 3 years ago, [didn't have] any contact, I [didn't] have any contact. So social worker, even I don't know when she do this. She get it and say: Mom, you need social worker so and so.

****

Senior 6: They (Health Links) advertise on radio or TV, tell you, you know. If you want to know more about this or ... But I never have the occasion to use it.

Another notable relationship the seniors had with the organizations was through donations or sponsorship. Three of the ten interviewed seniors (30%) reported that they sent donations to several disease-related associations such as Arthritis Society, Canadian Cancer Society, Canadian Diabetes Society, and Heart

and Stroke Foundation, etc. A number of seniors also expressed their somewhat disapproving attitude towards the organizations' fundraising:

> I mean, something I know about them. Some thing came up, you know. Of course you know about them, because they all ask you for money. (laugh) They have fundraisers all the time, donate, you can't help to know.

Effects of the Services

Overall, the seniors indicated that the services they had used or were using had benefited their psychological and physical well-being. For example, the seniors regarded the services of Handi Transit as critical so that they could continue living in the community, and many seniors approved of the quality of service.

> Senior 1: I phoned Handi Transit. And when a number coming up, you have to book 2 days ahead. But now very further ahead. 2 days is good for me. And the day before you phone, they, they first tell you what time you've requested, but then they tell you what time they can give you, and you know there was people all over. And I, I find the drivers just great. They're so interesting! (laugh) They've just really wonderful, even some of the customers, 'cause they pick up people from other places where they organized it. And they probably try to do in different area ... actually they'll come in right for you, and they come in for you in the university. They take you in!
>
> Senior 2: I think they're very good. They do wonderful jobs. They have their rules, other people they don't ... they complain all the time, sometimes get somebody lined up, and get complained and the driver's having hard time. But not often. Just like everything else. So it's very good. I am glad I still use it now.

Senior 3: Handi Transit helps me to go on living. My husband used to drive me... I have my sons at work. ... I use it for medical, once for awhile. But I don't use it like to go anywhere, only for medical. And sometimes if I have to go shopping, buy a dress or a blouse, you know, I also use it, once in awhile. But more for medical appointments. And I have to use it next week or a couple of weeks, to go to the hospital. ... It costs a little more, but it's worth it. From door to door! And in the winter, they come and help me down the stairs, when it's slippery. I told them on the phone, and the man came to the door.

Home Care Services received similar praises, as well:

Senior 1: Think the services I get are very good, I really do. I only get one service that is the cleaning. But it's very good, very good. They give recommendation that your fridge is dirty, and what else? They say let's do the fridge this week, and they take out everything in the fridge, defrost it, scrape all down, and clean. Throw out the junk, they say, you don't need this, throw out. They clean all these. And when they leave, it's all cleaned, you know.

Senior 2: They help me. They vacuum, I can't do any more. And they vacuum it well, all over the place. And I have 2 bedrooms, and they're all carpeted. They vacuum every room.

Senior 3: I've a wonderful home care worker, C, a couple of years now. She's terrific.

Home maintenance services were also highly appreciated by those seniors who remained in their own houses:

They shovel my snow, cut grass, pick the weeds. Because I won't be able to do it. I have high blood pressure and backache. I have health problems. ... I like to do things on my own. But I do need help for clearing the yard. The yard work I

can't do. Because if I bend, I get the headache, my blood pressure shoots up. I like doing it, but I can't, you know, I can't do it. They do maintenance, help me clean the house. I have the community home services, which is excellent. Without them, I may have to give up the house. ...The community home services are wonderful, they help me maintain the house, do the yard work, clean the house. I do cleaning, too, but not the heavy work.

The seniors' appreciation was strongly related to their desire to continue living independently in the community. As one senior expressed, "I find it hard....If you move from a house to a small apartment, the only thing holding me back is apartments are too small. I have to give up my furniture. I'll have no room for this." She further explained that she would like to remain in her house because "I know I'll find it very hard to sell this house. Very hard...(Tears in eyes.) I've been here for 43 years, right here, in this house... I brought up my sons here..."

Additionally, a number of seniors reported health-related services were critical to their lives. For example, Health Calls provides free home visits by doctors and prescriptions for those who do not have their own doctors. The following are a few other examples:

Researcher: How about Victoria Lifeline? Do you have that?
Senior 1: Oh yeah.
Researcher: Does it help?
Senior 1: Yeah, I fell 2 or 3 times.
Researcher: Ok. So did they send anybody to come?
Senior 1: Yeah, ambulance. But if I can get up, I get up. That's why I got that. I got a good 2 years to get it (a pole for assisting getting up from chair).

****

Senior 2: Health links sometimes take care of my medication. And she tells me how to take them, when to take them. Just have someone to make sure, you know. Depression pill, I have a bunch of such...

In general, the seniors stated that the services available in the community made their lives more manageable and more enjoyable.

Senior 1: They can help, you know. That was one time you don't need anything for senior, in the younger age group. And don't have, don't run into physical trouble and so and so. Oh yeah, oh yeah. Great, it's great that they're there.

****

Senior 2: We go for there for..eh...we have exercise for an hour, then we have a luncheon, and then play bingo, and I'm picked up, and back home. ... I did enjoy it.

****

Researcher: How would you say in general have the services affected you?

Senior 3: Made me happy. They make me happy.... Yeah, yeah, I feel good Monday, I look forward to a visit from, Monday, S, my nurse, I look forward to her coming. Yesterday C (home care worker) caught me at the bed. The door bell rang, and "what is that?" "Hello?" "Hey! C!" "What?!" I jumped out of my bed, ran into the bathroom, put my cloth on, got to the door, and unlocked it, and ran back to the bathroom before she saw me. (laugh) Oh dear, I'm sorry C.

****

Senior 4: I visit the club, Golden Links. And come home, and I feel better. You know. I feel better, come home I feel better. Even the next day I feel

better than. Talk, a couple more, the younger, they know more. And I enjoyed it. I enjoyed it. Company, I enjoyed it. I like people. ... It made me happier, like not, not so much depressed. You know. That no feeling of depression, you know.

****

Senior 5: It should be kind of really great freedom. Because not having to cook, or even clean, I do a bit clean, that kind of thing, you have time to go to many interest groups. (laugh)

The seniors also regarded some of the services they had not yet used as essential, and they wanted them to remain available in the community.

Senior 1: No. I haven't used it (Mobile Crisis Unit), but I know about it. I think it's a really good thing. In cases of people they use it. They haven't been see seniors; the 2 cases I've heard about. But I know they do have that.

Senior 2: Yeah, I've heard of that (Health Calls), but haven't had to use it. But I do know people use, who has no chance for a doctor to come, 'cause it's expensive, and so and so. This age group, really hard that, ... people don't understand they can't be looked after by your own doctor in the hospital.

Reasons for Using the Services

The most common reason for using community services was that the respondents were no longer able to perform certain daily life activities. Some examples are as follows:

Senior 1: If I want a bigger order, or something heavy, like I order wanted

soap, for washing machine the other day. They're pretty heavy I can't do that. So I made a point of making a list of other things, that I could use as filler for the winter and I'll have that on hand. And they sent soap. And my order. And they told me that you ordered 25 dollars worth with me, the soap already takes 10 dollars. It didn't take me very long to make 25 dollars, you know. So that's out. Safeway check is over. (*Grocery Delivery*)

Senior 2: They shovel my snow, cut grass, pick the weeds. Because I won't be able to do it. I have high blood pressure and backache. I have health problems. ...I like to do things on my own. But I do need help for clearing the yard. The yard work I can't do. Because if I bend, I get the headache, my blood pressure shoots up. I like doing it, but I can't, you know, I can't do it. (*Community Home Services*)

Disease-related conditions were the primary reason why the seniors kept stable relationships with certain organizations that focused on research and treatment development and on helping people with particular health conditions.

Senior 1: That happened when I lost the vision and that's something They don't... There's no treatment at present, not after you had it for a little while. So I go occasionally meetings there (*The Canadian Institute for the Blind*). They'll tell you how it's gonna be changing library system, something like that.

Senior 2: The Diabetes Association? My monitor was not working, I phoned them, and they send me a new monitor. Health links sometimes take care of my medication. And she tells me how to take them, when to take them. Just have someone to make sure, you know. Depression pill, I have a bunch of such...

Senior 3: I belong to them (*Canadian Diabetes Association*). ...that's why I have to eat at certain time, 'cause I have diabetes. .. They help me with the pills. ... There's a lady comes Mondays.

The seniors sometimes decided to participate in certain programs or to go to specific agencies because they simply wanted to obtain more social contacts by meeting people through group activities. As one senior described, "I like learning about things, and I like, go there and meet other people there, and that's my sort of thing." Some seniors seemed to choose certain services based on the availability of low or reasonable service fees.

Senior 1: They (*the senior club the respondent used to go to*) charged just, just I think that transportation. ... But very little. Very little. Maybe taxi, if you go with taxi, I cost much more. Yeah, maybe cost same... And that they bring back. It's good.

****

Senior 2: They (*a health agency*) sent me a book, but everything was so expensive.
Researcher: So you decided not to participate?
Senior 2: No.

****

Researcher: And they (*Handi Transit*) charge reasonable?
Senior 3: Right! It costs a little more, but it's worth it. From door to door! And in the winter, they come and help me down the stairs, when it's slippery.

****

Senior 4: They (*Senior Job Bureau*) have own prices. If you agree with, you know, to do that. ... They tell you what it is, you agree or don't agree with, but oh yeah, that would be a little lower (than market price). It depends. Because some places cost a lot to have such a thing.

Reasons for Non-Use of the Services

There were a wide variety of reasons why the seniors had not used some of the social services, including personal and environmental conditions. A number of seniors claimed they did not need or desire to use certain kinds of services.

> Senior 1: 'Cause I don't need it (*Senior Directorate*). I haven't, so far. (Laugh) ...I heard about that. But I've never used it, you know. 'Cause you're wondering about something, you know, you go there.
>
> Senior 2: They (*Health Calls*) advertise on radio or TV, tell you, you know. If you want to know more about this or ... But I never have the occasion to use it.
>
> Senior 3: Nah, I don't need anything, garbage. ... Because I don't need them. I don't require them (*Community Home services, Seniors Information Line, Senior's Abuse Line*) at all.
>
> Senior 4: Well, I don't see any advantage (of the *Handi Transit*). I can just get on to the bus, I go ... many buses. ...I have a cab, a taxi phone, I use that. If I'm not feeling like getting into the bus, I'll call a cab.

Personal interests or hobbies represented another factor that affected seniors' decisions whether to use certain services or not. This was especially evident when seniors chose to take part in programs run by different senior organizations or residential boards. As described previously, some seniors preferred reading, listening to music, hobbies like knitting and crafts or personal intellectual improvement, rather than playing cards or bingo, which they reported as the main activities available in the buildings where they resided. A number of seniors

reported that they did not participate in the activities offered in the buildings where lived because they did not like the nature of the activities. On the other hand, two of the ten interviewees claimed they liked card games and would like someone to play with them. However, neither of them resided in the senior buildings where such activities were offered, as one lived in her own house and the other had very limited mobility and hardly left her condominium.

Some seniors did not take advantage of community services because they had access to the necessary services through other professionals, individuals or agencies, such as family doctors or own lawyers.

> Senior 1: 'Cause I use other people for that (*Community Financial Counselling*). ... No, haven't used home care. I had a cleaning woman, and then after, what happened to her, and then I paid my grandson to do it. He needed extra money.

****

> Senior 2: (*The educational program*) at Age and Opportunity? I Haven't used it, because I'm using Creative Retirement, and the university, so...

****

> Researcher: How about the Residential Tenancy Branch?
> Senior 3: We have own manager downstairs. That's where we put all our complaints in here. He's here every morning.

****

> Researcher: Handi Transit?
> Senior 4: I have used that once or twice, but not very often. 'Cause like I said, my daughter takes me.

****

Senior 5: Oh yeah. I've heard of legal aid, yeah. I don't trust anybody else. I've a lawyer on my own. I have him for a few years. Now he looks after my will and house stuff like that.

****

Senior 6: Whenever I had a heart attack, I called ambulance (instead of community health resources), it's covered by Blue Cross.

In order to access certain services, seniors had to meet program or agency criteria, particularly for those offering financial assistance to seniors. A respondent complained that "I heard a lot of these things (like Shelter Allowance). But I've my old age pension that if you want any help from them, they always say you're over qualified, you've got too much money or whatever. You know. You're too good to me!" Another senior had been enjoying her participation in an adult daycare program until she was told she was no longer eligible to take part in the program because her health had improved.

I joined the River-view Club for awhile. I enjoyed it very much, and I am very disappointed. But you have to have something wrong with you to stay on. And I went in as my leg was bad, and, but after I has all the examinations and doctors went through everything, they said, you're quite capable on your own. That's it. So I was dumped. You know. I haven't got over that yet. They didn't say when I signed up for it, you have to be cripple or anything, or sick. And I enjoyed that so much. I went there everyday, played... I went all the time. And one day all of a sudden, they said, well, your leg isn't that bad, your can manage on your own. And, that'll be it. ...you have to have something wrong with you. I didn't know that when I joined it. They didn't tell me. But... I did have

something wrong, my leg..., you know. But they said, you can do things.

A third senior had a similar experience when she participated in a 3-month exercise program at a day hospital and found the program benefited her significantly. Nevertheless, when she tried to sign up for the program a second time, she was rejected because since the program aimed to serve "new people," rather than those who had already benefited from the service. The senior also expressed strong disappointment at not having the chance to enjoy the activity she preferred.

Occasionally some services were unavailable or demand exceeded supply, according to the interviewees. Therefore, the seniors could not access the services they wanted.

Senior 1: Last time I phoned them (*Senior Job Bureau*), didn't have anybody, during the time of the year, and you know, so...

****

Senior 2: They (*exercise program at a senior club*) not take me in, too many people.

****

Senior 3: Yeah. In summer, OK. I can walk, if the health keep like right now. Like right now, I can walk, and walk. That's different. That's I can.
Researcher: But you mentioned they (*a senior club*) are closed in the summer?
Senior 3: I think so. They closed July-August.

As mentioned earlier, reasonable and minimal charges for services were an influencing factor on whether the seniors chose to use a specific service. Moreover, concern about fees could prevent the seniors from attempting to access community services.

> Researcher: You know about Safeway delivery, right?
> Senior: Well, they charge too much.
> Researcher: Ok. How much do they charge, do you know?
> Senior: I don't know how much they charge, anything would be too much for me, 'cause I take my little cart there. I go on my own.

Comments and Suggestions about Social Services

When asked the questions, "what are the other services that you would like to be available for you?" and "do you have any suggestions on the services?" most of the interviewees could initially raise no direct concerns, which was similar to their first reaction to the question posed to seek comments about the Friendly Visiting Services (e.g. "I've no idea", "I don't need anything else", etc.). Nonetheless, the seniors were able to express their concerns and comments in the other narrative data gathered from the interview. First of all, the seniors addressed their comments regarding the quality of some of the services they had experienced or heard about. For example, the respondents most frequently used the Handi Transit services, and they offered much praise about them. However, the same services

also received the most complaints inclusively, including long waiting time, lack of necessary assistance, and being late for appointment sometimes.

Researcher: Handi Transit, you don't use it?
Senior 1: No. You know why? I phoned them, and sure they take care of wheelchair and, but, when you are finished shopping for an hour, they might not be back to pick you up for 3 hours and bring you home. Because they've got all the other people too.

****

Senior 2: To go there, it's OK. But to come back, you have to wait 3 hours They have their schedule.

****

Senior 3: The Handi Transit isn't that good. They don't help you at all, you have to look after yourself. See I'm not very good on my feet. When I get into the car, I need a little bit help, to get in the door, and that, they don't do that.

****

Senior 4: The other day he was taking me up for theatre of Wpg. ... I don't want to get half an hour behind. I wasn't late or anything, but he came probably a little bit late. I just came down right on time. And, it was a long way to get to the theatre.

Other comments expressed by the seniors specifically concerned the services of Home Care, Health Calls, and Meals on Wheels.

Senior 1: They (*Home Care* workers) go to other places. They go to the next door first, neighbor, do her first. You know. And then somebody else had to go to do theirs. So they can't go to one person first thing in the

morning all the time. I understand that.
Researcher: So it's not convenient to you?
Senior 1: Yeah.
Researcher: Because you have your own schedule?
Senior 1: Yeah. I like to do my work in the morning.

****

Senior 2: Gosh, I phoned them (*Health Calls*) once. It came out , I had a Insulin injection, and he came out and I told him. Oh, he says, I can't do nothing about that. But he was dirty, a man I've ever seen. Dirty old rain coat, he wasn't shaved, he's grabby look. I looked at him: You're a doctor? I don't think so, bye-bye. I thought the guy, you touch me? He wasn't, he was a real old man. And I wonder if they're hiring retired doctor or something?

****

Senior 3: And he gets Meals on Wheels. They're impossible, you know it's like a little bit, like home cook. They can't give too much. I can understand them, too.

Finally, one senior showed great concerns about the accessibility of the programs she wanted to participate in since she needed a wheelchair to go out.

See our admin building is out there across the street there, so I can't even go to the library, or the pictures, shows, you know. If there's no stairs, I can walk over there. ...And I can't go! I can meet a lot of people if I could go there, but there like I said it's all stairs. And I can't climb stairs. ... You know. Any entertainment they have, they have cards something like that. I love playing cards, any kinds, or crafts, anything like that. But you need people to deal with.

The data collected from the in-depth interviews reveal that the seniors who were Friendly Visiting Services clients did not rate their health as highly as their national counterparts had rated theirs. More respondents of the study rated their

health as *fair* and less respondents rated it as *good, very good* or *excellent.* The seniors interviewed reported that their children were the people with whom they had most contact. Only a few said they were active in the programs offered by the organization.

In the seniors' current lives, limited mobility prevented them from going outside, travelling far from home or going out in the evening and under harsh weather conditions. It appeared to be very difficult for them to go out without assistance, particularly in the case of those with critical health conditions such as visual impairment, paralysis, etc. The seniors used public transit, taxi, rides from family members, and/or program pick-up/drop-off services as their major means of transportation. The social activities the seniors often attended included continuing education, day programs in agencies/clubs, meal programs, entertainment, and so on.

The seniors interviewed reported that their children or, in some cases, grandchildren provided their primary support. The assistance provided by their children varied from supporting their psychological well-being to helping with their daily life activities. Nevertheless, three factors related to their children evidently caused negative impacts on the seniors' lives: 1) the domestic crises experienced by their children, including illnesses, retirement, and divorce; 2) low geographical accessibility; 3) the inconsistency between the seniors' expectations and the quantity and quality of the care they received from their children. Besides, the

subjects talked about a number of difficulties they experienced in communicating with the younger generations, but most of them showed great understanding and respect for the choices their children had made in their lives.

A few respondents reported they maintained relationships with their siblings, and half were able to secure and enjoy the company of friends. However, in general, the seniors stated that maintaining active relationships with siblings and friends was very difficult for them due to limited mobility, deteriorating health, death, moving or feeling as if they did not belong.

The seniors described their lives as "lonely", "tolerable", "blue", "empty", etc. Crying and depression were evident to be the consequences of loneliness and other negative emotions concerning life in old age. The seniors' attitudes about aging and aged life varied. Some tended to passively accept the way life was. Some perceived their lives in a very optimistic manner and considered life enjoyable and satisfactory.

Widowhood had a crucial impact on this group of seniors. Some were suffering from painful emptiness after losing the spouses who had been involved in their lives for decades. Nevertheless, a number of the widowed appeared to adapt themselves quite well to life without a partner.

Although language was not expressed as a significant factor in the seniors' connections with others, a few respondents did report language barriers occasionally caused uncomfortable feelings in their social lives. Most of the

seniors said that the amount of social contact they had with others was insufficient, and they recognized that the stresses and loneliness they felt resulted from their lack of contact with other people. However, only half of them explicitly claimed they wanted more social contact. The other half either did not seek more social contact at all or only occasionally. The subjects also expressed concerns about the quality of the social contacts they could get.

The seniors were fond of a wide range of activities, including conversations, exercise, reading, listening to music, personal intellectual improvement, card games and bingo, yoga, dancing, and so on. Some seniors expressed that they would like to contribute to the well-being of other people by volunteering or providing company, instead of only receiving help from others.

The seniors learned about the Friendly Visiting Services from professionals in other social services, friends and family members. The majority perceived that the program had made them feel better. The positive impact of the Friendly Visiting seemed to be related to the personal relationship between the seniors and the matched visitors. The seniors also provided comments and suggestions concerning the Friendly Visiting Services.

The respondents learned about other community services from children, friends, nurses, media, hospital, police, etc. Assistance programs for daily living, such as Home Care and Handi Transit, were known to most respondents and utilized by many of them. Agencies and services related to health were also

popular among these seniors. They regarded the services they had used or were currently using as essential for helping them to continue living in the community. Their appreciation of the services was associated with their desire to keep their independence and stay in their homes as long as possible.

The respondents said they chose to use certain services for different reasons, including needing help, suffering disease-related conditions, looking for social contact, and minimal or reasonable service fees. The seniors also indicated various reasons for not using some services. They might not need the service, some services or programs might not fit their interests or they had access to other professionals who provided these services to them. Some seniors complained they could not register in programs they wanted because they were not eligible according to admission criteria. Occasionally, some services or programs were unavailable or demand exceeded supply. Comments and suggestions were offered concerning some services such as Handi Transit, Home Care, Health Calls, and so on.

CHAPTER 6

DISCUSSIONS AND IMPLICATIONS

The Seniors

In the present study, the student observed the general characteristics of the older population served by a friendly visiting program, explored seniors' perceptions of their current lives, and examined their experiences of the Friendly Visiting Services and other social services available to them.

The percentage of widowed seniors in the visiting program was much higher than their proportion in the national population of seniors (70.3% vs. 33%) (Health Canada, 2002). It was evident that the impact of widowhood caused tremendous emotional stresses such as feeling lonely and the painful emptiness of having lost their loved ones. The seniors sought more social contacts through the visiting program and other services they considered helpful for maintaining independent and meaningful living. The older the senior was, the more likely he or she was widowed and lived alone.

Statistics showed that aging was correlated with the number of chronic health conditions a senior had. Nonetheless, neither marital status nor living arrangement seemed to be correlated with health conditions. As women formed the majority of the senior clients who were using the visiting services, the sensitivity of gender

differences in term of needs and health-related concerns should be established among practitioners.

Generally, connections with siblings had positive impacts on the seniors, especially on their psychological well-being. Unfortunately, many seniors were the only members of their families still alive from the older generations, as all their siblings had passed away.

The older elderly people in this study seemed more likely to have optimistic attitudes toward aging issues and life transition. The interview data showed that they were able to focus more on the bright side of their lives than their younger counterparts. The seniors with optimistic attitudes reported more involvement in social activities such as the different programs run by various agencies. They were also able to identify the activities they were interested in and capable of doing. When they had something to do, they could feel less lonely than those without anything to do.

Those with positive attitudes towards aging and their present lives were also enthusiastic about keeping their independence. In fact, they were quite capable of maintaining their independent lives. Although many seniors demonstrated strong physical independence or at least strong intentions to be independent, their psychological dependence on loved ones, such as spouses, close friends, and children, was evident. The issue of psychological and physical independence/dependence may be closely related to the concept of *general locus*

of control (Menec & Chipperfield, 1997), which is a term used to describe the perceived ability to influence life events in general. Previous research has shown that general locus of control may be linked to the life satisfaction of the elderly (Menec & Chipperfield, 1997). Future research on the linkage of the two concepts would be helpful for understanding older people's lives.

The mixed and contradictory findings concerning the respondents' expectations for more social contact suggest that seniors might underestimate their need for sufficient contact with other people. The seniors indicated that the amount of social contact they had was limited and this caused negative psychological impacts on them. However, many of the respondents stated that they did not feel like having more social contact. The seniors also expressed a strong intention to maintain their independence and they did not want to "bother anyone else". Their worry about burdening others and their fear of losing their independence may partially explain why the seniors said they required no more social contact even though they did not have enough contact.

The Friendly Visiting Services

The findings show that many of the seniors involved in the Friendly Visiting Services benefited from the regular visits because they brought quality personal interaction into the seniors' lives. People developed meaningful friendships through the interacting process. The visits not only helped decrease stated

negative feelings of depression and loneliness caused by social isolation, but they became opportunities for sharing experiences and for receiving emotional support. It is also evident that the program benefited both parties involved, the seniors and the volunteer visitors. They enjoyed doing hobbies together like reading, listening to music and playing cards. The Friendly Visiting Services program moved participants far beyond the usual one-way contribution of volunteer activities. However, the present study did not explore the visitors' perceptions of the efforts associated with volunteering and of the benefits they gained through their participation. Future research in this area should bring a better understanding of the volunteers' needs and the difficulties they experience in order to ensure these matters are better considered in the allocation of program resources.

The research findings also show that matching the seniors with volunteers from a similar age group and with akin interests constituted an important factor in influencing the seniors' perceptions of the effects of the visiting on their lives. The seniors reported they would appreciate if the program could provide more information to both parties about the person with whom they were being matched prior to their first meeting in order for them to prepare conversation topics and initiate proper activities.

Free training to friendly visitors, such as workshops given by professionals on grief counseling and strategies for dealing with strong negative emotions, could be useful for making the client-volunteer relationship smoother and for making the

communication challenge more manageable for the visitors as they talk to older adults who have lost their partners in late life. Training activities could introduce interpersonal communication and behavioral skills to the volunteer visitors, so that their interactions with the seniors will encourage their mutual sense of belonging and feeling accepted.

Friendly visitors can be equipped with necessary information about the major services available to the seniors in the community. By recognizing the needs and difficulties that the seniors faced, the volunteer visitors could serve as sources of information, advice and recommendation for them. In situations characterized by abuse or severe crisis, the friendly visitor could initiate an appropriate referral to social service agencies.

While taking into account the volunteer visitors' choices and their practical feasibility, the visitors could be encouraged to initiate their visits with the seniors on weekends because, according to the seniors interviewed, weekends could be an especially lonely time for elderly living on their own. Most agencies are closed and few programs are run during weekends, except those offered in seniors buildings. Friends with whom the seniors usually connect may have children who could come and take them to church or family gatherings. If the seniors do not have children residing in the city or if the children are not able to keep them company, the seniors may feel very lonely and left out. The program facilitators and the matched visitor can consult with the senior about what time he/she would need company most.

Volunteer visitors can be encouraged to set their schedules in accordance with the seniors' needs and offer help when it is most wanted.

The data collection for the population profile was conducted by using four types of assessment/intake forms aimed at illustrating the reformative process of the Friendly Visiting program and the efforts made by a number of different professionals. Nonetheless, the four different assessment forms created gaps in client information recording and cataloging. The Friendly Visiting Services would benefit from assessment forms that are more consistent in the information they seek and with more quantified items. This would provide abundant, easily accessible and consistent information to support the daily work and program evaluations. A few tentative suggestions on re-formatting the present assessment form are as follows:

1. Conceptualize some notions in a more practical manner. For example: what is social contact is? With what kind of intensity can an interpersonal interaction be determined as an actual social contact?
2. Re-evaluate each item on the current assessment forms and decide on the necessity and importance of the questions asked in the intake. On the one hand, some items may need to be articulated in other ways. For instance, the records in the category, *Reason for Referral,* were mostly "isolation" and "loneliness". It is reasonably true that most seniors referred to the Friendly Visiting services feel isolated and lonely, yet the data may not be statistically

valuable if most respondents' answers are the same. Besides, the fine print of *Reason for Referral* actually describes the *source of referral* (see Appendix IV). So the new form can have two categories based on these: sources of referral and reason for referral. On the other hand, new assessment questions can be added to the intake form to gather other necessary information such as the senior's expectations or concerns on service cost.

3. Quantify and standardize the assessment items. For example, the category of *Mobility* can include a list of different levels of mobility with definitions, so that the assessor can simply check the appropriate level according to his/her observation and the client's self-report.
4. Set up an electronic database of client information and keep updating it with re-assessments. By doing so, client information could be preserved and demonstrated very clearly without risking possible confusion that could be caused by subjective descriptions that could be interpreted differently by different workers.

Social Services

In a 1996 census, 28% of the general Canadian aged population lived in apartments, while 61% lived in single-detached houses (Health Canada, 2002). Compared to their national counterparts, the seniors in this study who were older

elderly and living alone did not have houses as their primary living arrangement (n = 2, 20%). However, the respondents of this study considered assistance for home maintenance very important and highly appreciate. They indicated they want to continue living in their homes as they were concerned about life quality and they had a sentimental attachment to the houses in which they had spent much of their lives. The seniors interviewed reported that being able to continue living independently in their own homes was a powerful factor for maintaining their psychological well-being (Bulter & Lewis, 1982, quoted in Beaver & Miller, 1992). This can explain why the seniors in this study thought highly of the services that assisted them in their daily lives, such as home care services, transportation for people with limited mobility, and community home services.

Health-related services and organizations constitute another type of community resource that isolated seniors greatly need. Older people should be provided with information about free or minimum-charge health care services available in the community and they should be encouraged to take advantage of them. Potential service users should be consulted about the possible cost of programs or services before they are implemented.

A wider variety of choices should be available in programs and activities, especially those run by residential boards. Due to limited mobility, many seniors would like to participate in the programs that are offered nearby at accessible locations. In-building activities are their first choice when programs are appealing.

In fact, a number of seniors chose to take part in programs at the closest seniors club/centre. However, the majority of them had difficulty going out in the winter because of harsh weather conditions and the danger of falling on ice. Those programs were usually described as social gatherings, such as chatting while having coffee, and exercise and movement programs. It is highly recommended that the residential board implement similar activities in seniors homes so that the seniors do not need to travel to another place, especially in severe weather conditions.

Exercise and movement programs were evidently welcomed by the seniors. Yet many of these types of programs require that certain admission criteria be met, mainly concerning the seniors' health conditions. Practitioners should be aware that seniors participate in these programs not only for their physical well-being, but also, or perhaps even more so, for the opportunity to interact with fellow participants, which otheriwse they might not be able to acquire in consideration of the minimal social contact of this population. Health care workers may need to consider loosening the requirements for program admission from caring for physical health solely to caring for both physical and mental health. On the other hand, social service workers, especially those working directly with and for the elderly in senior buildings, may need to involve more body exercise content in their program design.

Despite the fact that different agencies or organizations offer different activities and perform various functions, practitioners should always have in mind that the holistic well-being of a senior cannot be achieved by efforts based on a single perspective such as physical recreation, social contact or financial security, etc. It requires the practitioners' care in consideration of all aspects of a senior's life. One possibility is that social service workers in different areas could consider including content from other areas in the design of own programs, e.g., day hospital programs could incorporate social gathering activities or residential building programs can include physical exercises. Another possible strategy is to initiate cooperation between agencies that fuflfill different functions. Seniors buildings and hospitals in the same neighborhood could develop programs together. A recreational program run by a professional from a hospital or social services agency could be offered at a seniors building, so that seniors could join other people and do some exercises while not needing to worry about transportation and the weather.

Volunteering is an important means for many Canadian elders to stay active in their communities. In 1997, nearly one-quarter of all seniors volunteered in a wide variety of community organizations, including those created by and for seniors (Health Canada, 2002). Research shows that a significant number of elderly may find meaningful social connectedness through involvement in volunteer activities (Rathbone-McCuan & Hashimi, 1982). The seniors in this study also expressed

their desire to be volunteers, yet their actual ability to participate in volunteer activities was greatly restricted by health limitations (Health Canada, 2002). Therefore, practitioners should not overestimate what an isolated senior could gain through participation in volunteer activities. It is more important to encourage and support the senior in assessing whether the volunteering could meet his/her needs and expectations. Practitioners may need to stress the following two concerns that Rathbone-McCuan & Hashimi (1982) suggested in regard to seniors with the willingness to volunteer:

1) The daily living circumstances of many seniors do not leave them with the energy to be enthusiastic volunteers because they must spend what personal resources they have on their own survival and well-being.
2) Volunteer functions may lead to one-way giving that does not contribute to self-satisfaction from helping themselves. (p. 45)

Practitioners can create opportunities for seniors to participate in suitable volunteer work that involves meaningful social contacts while contributing something to others. The volunteer work should involve two-way benefit and not require the use of the seniors' own resources. For example, senior agencies may collaborate with ESL programs available in various social entities like schools, churches, social agencies. Seniors can be matched with people who want to practice their English with native speakers. In this way both parties can contribute

what they have (company or language knowledge) to the other who has certain needs.

Public education would help enhance society's awareness on aging issues. Practitioners could design and hold workshops, make brochures to provide knowledge on aging and older people to society, to families, and individuals who have seniors in their lives. Seniors have contributed to society and their families throughout their lifetimes, and they deserve some care and concern in return for the rest of their lives.

Limitations

Due to the differences between at least four types of client assessment forms that have been used by the Friendly Visiting Services, there were minor inconsistencies in the categories and items used for gathering client information. Thus, some data are missing in the population profile. Interpreting the results should be done taking into consideration the statistical sufficiency of data in the areas missing data.

The general health level of the interviewed elderly was measured solely on their own reports, which could be exaggerated or underestimated by the seniors, according to their own perceptions of health. For example, a paralyzed interviewee regarded his health as *good,* while another, who was the only one still capable of driving among all the interviewed seniors, considered her health *fair.* The results of

self-rated general health in this study, therefore, should be interpreted taking onto account the attitude toward life and psychological well-being in old age rather than as an objective measure of actual health conditions. In consideration of the medicine being taken (the majority of this population was using at least one medicine and 34% took 3 or more), a more objective instrument may be applied to measure the seniors' physical health in order to depict a more accurate picture.

The study was designed and implemented with a focus on the seniors' perceptions of the challenges they faced and their demands for social services. However, efforts at collecting data from other informants in future research could generate information that would complement the results of the present study. Other key informants include service providers, representatives from senior communities, professionals or experts on aging and older population, significant others in the seniors' lives, and so forth. Researchers may want to gather information from them in terms of their perceptions on issues that seniors are concerned about. By designing future studies for triangulation of data source, the richness of the information and research credibility could be greatly improved, which, in turn, would allow a holistic perspective for viewing the seniors' lives and their needs.

In this study, the seniors reported a variety of emotional and physical difficulties and challenges they faced while living independently in the community.

Social services such as the Friendly Visiting Services have offered abundant support in different ways to assist seniors in maintaining the way of living they preferred. However, seniors expressed concerns and expectations on the quality, quantity, availability, and accessibility of the services. Finally, recommendations for practitioners working with and for seniors have been made on the basis of the interpretation of the research findings.

CHAPTER 7

EVALUATION OF THE PRACTICUM

Evaluating the Intervention Goals

The evaluation of needs assessment is similar to other interventions. However, the procedure may differ because of the nature of different intervention projects. The main questions that need to be answer while evaluating a NA include:

- How well did the NA meet its goals?
- What were its strengths and limitations?
- What problems were encountered?
- If a similar NA were conducted in the future, what changes in methods and other factors would be recommended?
- Were there some unexpected results?
- Did any of the predicted failures occur? Why? Could they have been avoided?

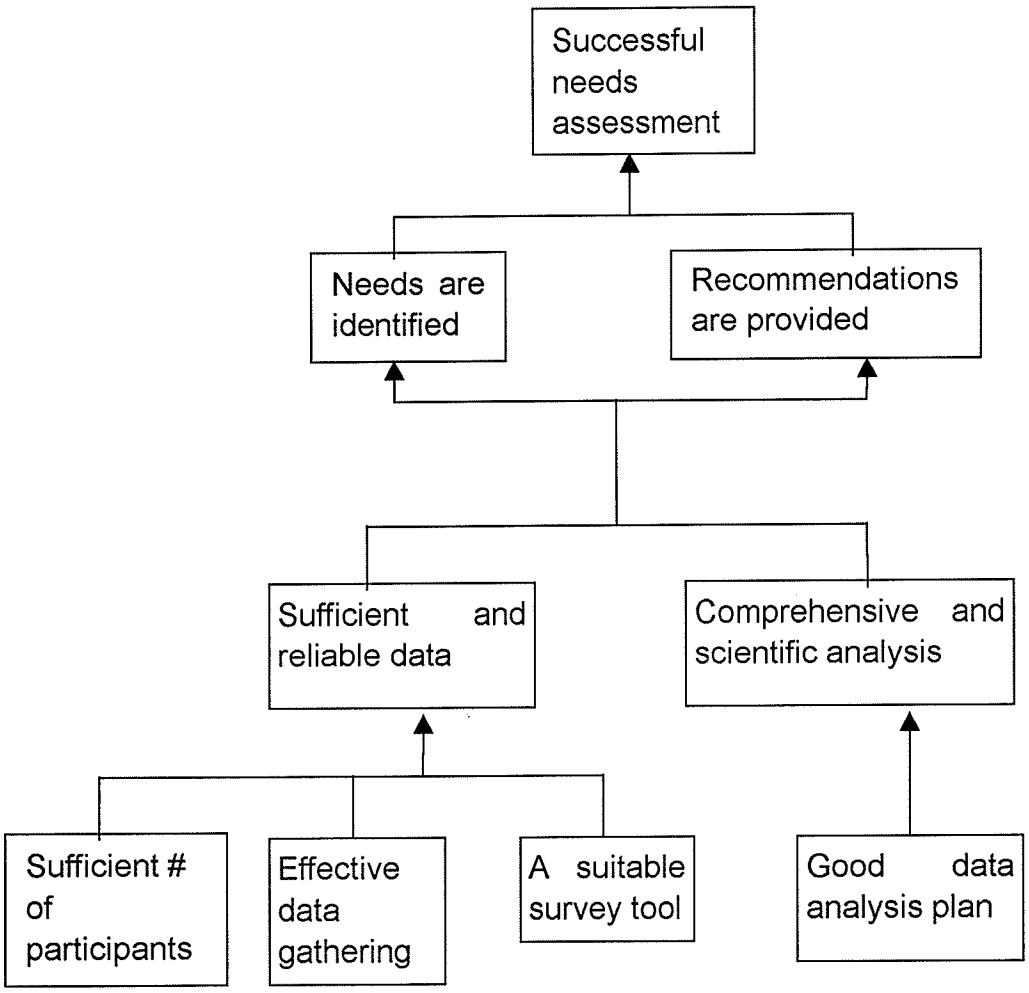
(Adapted from Witkin & Altschuld, 1995)

Most of the above questions have already been addressed in previous chapters. Moreover, Witkin & Altschuld (1995) strongly recommend an analysis technique called Fault Tree Analysis (FTA) to be used in evaluating needs assessments. According to the authors, the FTA method considers multiple

causality and links the contribution of each causal sequence to the others. The student developed a success map to evaluate the whole needs assessment on the basis of FTA principles during the post-assessment stage. In the evaluation, the degree of achievement in each of the following goals were addressed according to the following rating scale, which was also used for evaluating the learning goals of this practicum:

0 Failed to complete
1 Completed at a minimum level
2 Completed at more than a minimum level
3 Completed at an acceptable level
4 Completed at a satisfactory level
5 Completed at a very satisfactory level

Figure 7.1 Success map for evaluating the needs assessment



Sufficient Number of participants: 5

The student was able to approach 10 interviewees for the study with the assistance of the agency staff. Data analysis started from the completion of the eighth interview and patterns of saturation emerged. However, two more participants were interviewed to collect more information in order to insure major

patterns were covered.

Effective Data Gathering: 4

The student feels confident about the data gathering process and interviewing skills. During the data collection process, the interviewees were assured of ethical research concerns (e.g., confidentiality, anonymity, voluntary nature, right to withdraw, etc.) prior to requesting that they start answering questions. All questions were clearly asked and necessary probe was applied when answers were unclear or uncertain. Although a few difficulties were encountered during the process of interviewing due to certain interviewees' psychological instability or hearing impairment, the majority of the interviews were conducted smoothly and in a two-way communication manner.

A suitable survey tool: 5

At least three drafts were composed in consultation with the Advisory Committee, particularly the principal advisor of the practicum. The questionnaire was developed on the basis of previous findings in literature and the research logic of the present study. The instrument was pre-tested with two interviewees from the target population and received positive feedback. Minor changes were made particularly on wording.

Good Data Analysis Plan: 4

As described earlier, a combination of qualitative and quantitative analysis approaches was applied to data analysis. The methods for and the process of analyzing the data were clearly stated before data collecting. The student previously had limited experience with qualitative data analysis. Therefore the principle advisor was consulted for contribution to the data analysis plan to enhance research credibility.

Sufficient and reliable data: 5

Based on the foundation built within the proceeding steps, sufficient and reliable data were acquired. Both quantitative and qualitative data were gathered. Saturation patterns emerged spontaneously and were identified during the process of qualitative data collection.

Comprehensive and Scientific Analysis: 5

All the materials gathered as secondary data and interview data were examined comprehensively and thoroughly. Statistical methods including descriptive data, central tendency, and measure of correlations were used for analyzing the quantitative data in both primary and secondary materials, while qualitative methods of analysis were employed particularly in processing the information yielded by the open-ended questions in the interviews.

Needs are Identified: 5

Based on the previous steps, the target population's needs were able to be identified and summarized. Chapter 4 and Chapter 5 represent the major findings in terms of the seniors' perceptions of their challenges and needs. Ample information was yielded through analyzing the data gathered with the mixed methodology of quantitative and qualitative approaches.

Recommendations are Provided: 5

Interpretations and discussions of the research results were presented in Chapter 6 based on the information collected from the previous steps. Recommendations in regards of the Friendly Visiting Services and other community services were made and presented. Limitations in interpreting the results were also provided.

Successful Needs Assessment: 5

The student considers this needs assessment as successful because all the primary steps were accomplished at either satisfactory or very satisfactory level. All the major goals have been achieved: sufficient data were collected, analysis was done comprehensively, needs and recommendations were identified, etc. These eventually lead to a comprehensive and accurate needs assessment, according to the logic of Fault Tree Analysis (Witkin & Altschuld, 1995).

The total score adds up to 43 out of 45, indicating the needs assessment can be accepted as very satisfactory.

Evaluating the Learning Goals

The student rated the degree of accomplishment for each objective, based on the set learning goals at the end of the student's practicum. The evaluation form used is as follows (Table 7.1).

Table 7.1 Evaluation of Practicum Outcomes

Outcome	Indicator	Mark
Have conducted a comprehensive literature review Subtotal: 19/20	Have identified relevant and crucial topics/areas	0 1 2 3 4 [5]
	Have searched for and located wanted materials	0 1 2 3 4 [5]
	Have summarized the existing studies and writings about the identified topics/areas	0 1 2 3 [4] 5
	Have made thoughtful and logical critiques about the literature	0 1 2 3 4 [5]
Have understood the theoretical and conceptual issues regarding the practicum Subtotal: 19/20	Have understood the definitions related to the practicum	0 1 2 3 4 [5]
	Have understood theories underlying the practicum	0 1 2 3 [4] 5

	Have gained a knowledge about methodologies and/or models for doing the practicum	0 1 2 3 4 [5]
	Have articulated rationale for and practical applicability of the practicum	0 1 2 3 4 [5]
Have developed skills and techniques for conducting a needs assessment Subtotal: 38/40	Have been able to design a manageable assessment plan	0 1 2 3 4 [5]
	Have been able to develop a satisfactory questionnaire	0 1 2 3 4 [5]
	Have been able to pilot survey	0 1 2 3 4 [5]
	Have been able to identify and recruit sample/respondents	0 1 2 3 [4] 5
	Have been able to conduct interviews	0 1 2 3 4 [5]
	Have obtained sufficient data analysis skills	0 1 2 3 4 [5]
	Have been able to compose a thorough and meaningful report for the study	0 1 2 3 [4] 5
	Have been able to acquire the approval of ethics protocol for the study	0 1 2 3 4 [5]
Have obtained general working skills Subtotal: 19/20	Have been able to collaborate with agency staff and co-workers	0 1 2 3 4 [5]
	Have been able to work independently	0 1 2 3 4 [5]
	Have acquired sufficient communication skills	0 1 2 3 [4] 5

	Have acquired management skills including scheduling, arranging meetings, work-life balance, etc.	0 1 2 3 4 [5]
TOTAL		95/100

Note: 0 Failed to complete
1 Completed at a minimum level
2 Completed at more than a minimum level
3 Completed at an acceptable level
4 Completed at a satisfactory level
5 Completed at a very satisfactory level

The total score is 95 out of 100, thus, the learning goals have been reached at a very satisfactory level.

Overall, most objectives in the evaluation were considered accomplished at a very satisfactory level and the others at a satisfactory level. Both the intervention goals and learning goals that the student set in the practicum proposal have been achieved through the practicum implementation process.

Conclusion

This study explored the area of the needs of elderly people involved in a friendly visiting program by investigating their perceptions of their current lives and

of the services they received. A needs assessment approach was applied with the purpose of providing useful information for the program and Age and Opportunity regarding this population. The results of the study yielded a satisfactory and comprehensive profile of the target group in relation to their needs. Recommendations for practitioners working with and for seniors have been presented in the final report. The practicum experience was invaluable. New knowledge and skills were gained in the project design, implementation, and writing processes. The direct contact with the seniors was rewarding and made the study experience unforgettable.

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Internet Resources:

Aging in Manitoba
http://www.umanitoba.ca/faculties/medicine/community_health_sciences

American Association of Retired Persons
www.aarp.org

American Society on Aging
www.asaging.org

Berkshire Senior Online
http://www.esbci.org

Case Western Reserve University
http://www.cwru.edu/med/epidbio/mphp439

Health Canada
www.hc-sc.gc.ca/seniors-aines

National Council on the Aging
www.ncoa.org

Appendix I

Age and Opportunity, Inc.

NEEDS ASSESSMENT

OF THE SENIORS INVOLVED IN THE FRIENDLY VISITING SERVICE

Face Sheet

Interviewee's Number: _____

Date of Interview: _____

Length of Interview: _____

Signed Consent Form:

◎ Yes
◎ No

Interview Tape-recorded:

◎ Yes
◎ No
◎ Partly

Survey Questionnaire

General Health Condition

1. In general, would you say your health is

◎ Excellent ◎ Very good ◎ Good
◎ Fair ◎ Poor

2. Compared to one year ago, how would you rate your health in general now?
   - ◎ Much better now than one year ago
   - ◎ Somewhat better now than one year ago
   - ◎ About the same as one year ago
   - ◎ Somewhat worse now than one year ago
   - ◎ Much worse than one year ago

****

Social Contact Assessment

3. Organization:
   0. Individual does not report membership in any organization such as church, social club, or political club during the past month.
   1. Individual reports membership in one organization during the past month.
   2. Individual reports membership in two or more organizations in past month.

4. Children:
   0. Individual does not report any contact with children during the past month.
   1. Individual reports contact with one child during the past month.
   2. Individual reports contact with two or more children during the past month.

5. Siblings:
   0. Individual does not report any contact with siblings during the past month.
   1. Individual reports contact with one sibling during the past month.
   2. Individual reports contact with two or more siblings during the past month.

6. Friends:
   0. Individual does not repot any contact with friend during the past month.
   1. Individual reports contact with one friend during the past month.
   2. Individual reports contact with two or more friends during the past month.

7. Relatives:
   0. Individual does not report contact with any relatives other than children or

siblings during the past month.

1. Individual reports contact with one such relative during the past month.
2. Individual reports contact with two or more relatives during the past month.

****

Self Perception of Social Contact

8. How would you describe your present life in general?
(Encourage the respondent to use a word, a sentence, or a metaphor to give an overview of his/her life.)

9. How often do you feel that you would like more contact with other people in your everyday life?
   - ◎ None of the time
   - ◎ A little of the time
   - ◎ Some of the time
   - ◎ Most of the time

10. If you feel you don't have as much contact with people as you want, could you indicate the reasons? *(E.g., health condition(s), financial issues, family issues, etc.)*

11. In what way has this (lack of contact with others) affected you? For example, little socialization, depression, etc.

12. Would you like to see any change in your social life? What would you like to do to cause the change(s)?

****

Friendly Visiting Services

13. Would you tell me why you decided to participate in the Friendly Visiting Program?

14. Has having a friendly visitor made you feel better or worse, or hasn't changed anything? Why do you feel this way?

15. Suppose you could now make a decision to change the services, what would you like the most to see to be changed?

****

Awareness and Use of Other Services

16. Please indicate which of the following services that you are aware of, and the ones you have used.

	Aware		Use	
	Yes	No	Yes	No
Mobile Crisis Unit				
Klinic Crisis Line				
Community Financial Counselling Service				
CPP/OAS/GIS				
55 Plus				
Shelter Allowance (SAFER)				
Cantor's (groceries delivery)				
Harry's Food Store delivery				
Riediger's delivery ($3.00)				
Safeway groceries delivery				
Seniors Directorate (MB Gov.)				
Seniors Information Line				
Senior's Abuse Line				
Community Home Services				
Seniors Job Bureau				
SSCOPE (north end)				
Workplace Ventures (St. Boniface, St. Vital)				
Doctor's Hotline				
Health Links				
Victoria Lifeline				
Health Calls (doctor who does home visit)				
Home Care Intake Line				
Manitoba Housing				
Residential Tenancies Branch				
Law Phone-In and Lawyer Referral Program				
Legal Aid Manitoba				
The Public Trustee				
Good Neighbours Senior Club (775 Henderson)				
Gwen Secter Creative Living Centre (1588 Main)				
St. James Assiniboia Senior Centre (2109 Portage)				
Stay Young Centre (123 Doncaster)				
Transcona Senior Centre				
Creative Retirement				
MSOS				

	Aware		Use	
	Yes	**No**	**Yes**	**No**
Arthritis Society				
CNIB				
Canada Red Cross				
Canadian Cancer Society				
Canadian Diabetes Association				
Heart and Stroke Foundation				
Handi Transit				
Veterans Affairs				
Society of Manitobans with Disabilities				
A & O Arts & Crafts programs				
A & O computer programs				
A & O dancing programs				
A & O Educational programs				
A & O fitness & movement programs				
A & O game programs				
A & O health programs				
A & O meal program				
A & O Counselling				
A & O Elder Abuse Services				
A & O English for Seniors program				
A & O Legal Services				
A & O Older Victim Services				
A & O ABCs of Fraud Program				
A & O Volunteer Program				
A & O Seniors Housing Directory				

17. Could you tell me why and why not you use the service(s) you are aware of ?

18. How have the services affected your life?

19. What are the other services that you would like to be available for you?

****

Demographic Information

20. Gender: _____ Male _____ Female
21. Date of Birth: _____
22. Marital Status: ___Married ___ Widowed ___ Divorced
___ Single ___ Separated
23. Postal code: _____
24. Living Arrangement (alone or with someone) _____
25. Type of dwelling (house or apartment) _____
25. Most often spoken language:_____

****

Comments

_____
_____
_____
_____
_____
_____

Appendix II

AGE AND OPPORTUNITY
Friendly Visiting Services
Needs Assessment

Letter of Informed Consent

Dear Friendly Visiting Services users:

I am a graduate student in Social Work and now in my last year of master's program at the university of Manitoba. As part of my studies, I am conducting a survey of the clients involved in the Friendly Visiting Services at the Age and Opportunity. I am particularly interested in the challenges you face and the needs you may have as an older adult living independently in the community. The purpose of the study is to 1) determine what the needs of the service users are; and 2) offer recommendations to program developers and providers. The following is a list of the people involved in the research. Should you have any concerns, you may wish to contact one of us.

Principle Researcher: Hai Luo, graduate student of Social Work
University of Manitoba Tel:

Practicum/Thesis Committee:
Dr. Don Fuchs (Chair), Faculty of Social Work
University of Manitoba Tel: 474-9869
Prof. Sharon Taylor-Henley, Faculty of Social Work
University of Manitoba Tel: 474-6669
Ms. Theresa Jachnycky, Chief Executive Officer
Age and Opportunity Tel: 956-6440

If you agree to be part of the study, you will be interviewed by a researcher in person with a questionnaire about your experience of living independently in the community. The interview will take place in your home or a place you prefer. The interview will last approximately 1 to 1.5 hours. If you have any upset feelings after the interview due to recalls of unhappy experiences, please feel free to contact us

for information about help available in the community.

Your participation is entirely voluntary. You may withdraw from the study at any time or may refuse to answer any question. You do not have to give a reason. Withdrawal from the study or refusal of answering any question has no consequence on your part. The interview will be recorded by audio-tape for analysis purpose, and you can stop being taped if you wish at anytime during the interview. The completed questionnaires, the tapes of the interviews, and their transcripts will be stored in a locked file kept safely by the principle researcher. The tapes will be erased upon the completion of the study. The research records will be kept strictly confidential. In any publications, the researcher will not release any participants' identifying information.

A file number will be assigned to each of the interviewees, your recorded tapes, and according transcripts. Your identity information, such as names, addresses, or phone numbers, will be kept separately from the survey data to ensure your anonymity and confidentiality. A copy of the final report of the study will be provided to the Age and Opportunity and available for you to use under the Agency's policy.

The study is approved by the Research Ethics Board of the University of Manitoba. If you have any questions or complaints regarding the study, the procedures, your rights, or any other research related concerns, please feel free to contact the Human Ethics Secretariat at 474-7122, or the Dean of the Faculty of Social Work at 474-9869 for referral to the appropriate Research Ethics Board. Thank you!

Yours truly,

Hai Luo
Principle researcher of the Needs Assessment
of the Friendly Visiting Program Participants

MSW Candidate, Faculty of Social Work
University of Manitoba
Tel:
Email:

Appendix III

AGE AND OPPORTUNITY
Needs Assessment of Friendly Visiting Services

Consent Form

I acknowledge that I have willingly participated in the needs assessment of Friendly Visiting Services users.

I have been informed of my right not to answer any question(s) in the interview or to withdraw at any time. I understand that it is my free choice whether or not to participate in this study.

I understand that the interview will be recorded by audio-tape for research purpose, and that I can stop being taped if I wish at anytime during the interview.

I have received and read a copy of the letter of informed consent. The issue of confidentiality has been explained to me.

I permit Hai Luo to use the information I have provided, with the understanding that she will take all necessary precautions to ensure my anonymity.

I agree to take part in this study.

_____ _____

Printed Name Signature of the Participant

_____ _____

Printed Name Signature of the Witness

_____

Date

I believe that the person signing this form understands what is involved in this study and voluntarily agrees to participate in.

_____ _____

Printed Name Signature of the Interviewer