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FEAR OF FALLING AND OLDER ADULT PEER PRODUCTION OF AUDIO-VISUAL DISCUSSION MATERIAL

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A growing body of work suggests that negative stereotypes of, and associations between, falling, fear of falling, and ageing, may mean that older adults reject falls information and advice. Against a widely accepted backdrop of demographic ageing in Europe and that alleviating the impacts of falls and fear of falling are pressing health care matters, this is a critical issue. This paper describes a recent peer learning and sharing strategy that set out to iteratively produce a series of short audio visual discussion programs on falling and fear of falling. Key outcomes included older adults appreciating peer group sharing as an acceptable way of opening up the silence surrounding falls incidences, enjoying participating in a problem solving strategy, and emphasizing that falls prevention is not just their responsibility. Outcomes suggest that peer learning and sharing are valuable falls and fear of falling support strategies.

Although at least 25 years of research endeavor suggest that defining and measuring fear of falling is difficult (Arfken, Lach, Birge, & Miller, 1994; Tennstedt et al., 1998), it is nevertheless recognized as a serious and debilitating phenomenon (Scheffer, Schuurmans, van Dijk, van der Hooft, & der Rooij, 2008; Zijlstra et al., 2007). Within older adults, negative impacts may include restricting physical and social activities to reduce the likelihood of falling. This, in turn, can lead to a decline in physical and mental performance; ironically, risk of falling; and progressive loss of health related quality of life (Scheffer et al., 2008).

A number of studies suggest that fear of falling among community dwelling older adults aged 65 years and upwards is common, with prevalence ranging from 26% to 55% (Arfken et al., 1994; Bruce, Devine, & Prince, 2002; Howland et al., 1993; Murphy, Dubin, & Gill, 2003; Tinetti, Mendes de Leon, Doucette, & Baker, 1994; Zijlstra et al., 2007). A recent fall can lead to such fear, but this has also been noted in nonfallers (Friedman, Munoz, West, Rubin, & Fried, 2002). Those who have reported a fall have a higher prevalence ranging between 40% and 73%. (Arfken et al., 1994; Friedman et al., 2002; Murphy, Dubin, & Gill, 2003). Scheffer et al. (2008) found that prevalence appears to increase with age and be higher among women.

Alleviating the impacts of falls and fear of falling is a critical health care issue (ProFaNe, www.profane.eu.org), particularly so when set against a widely accepted backdrop of demographic ageing in Europe (EUROPA, 2009). Ireland has a national strategy on the prevention of falls and fractures in older adults (Health Service Executive, 2008) and the Irish government and health professionals support

comprehensive, community falls-prevention intervention programs including falls education programs. However, uptake is low (Robertson, Devlin, Gardner, & Campbell, 2001; Stevens, Holman, Bennet, & de Klerk, 2001) and this is despite some proven efficacy (Gillespie et al., 2009; Zijlstra et al., 2007).

Below we describe our peer learning strategy and reflect on the potential role and further development of peer learning and sharing in relation to falls prevention strategies. Firstly, we consider the role, use and efficacy of falls education programs from within falls prevention strategies.

FEAR OF FALLING—THE ROLE OF PEER LEARNING STRATEGIES

Currently, there are a number of falls prevention programs used by health services around the world. These can encompass multiple strategies including strength and balance exercise programs such as Tai Chi and balance training (Gavin & Meyers, 2003); environmental and home modification, (Cumming et al., 2001); clinical assessments such as blood pressure and heart status, medication modification, feet and footwear assessment (Gillespie et al., 2009); falls education through information campaigns and health promotion activities and use of assistive devices such as the correct use of walkers, canes, and scooters to prevent falls, as well as the installation of devices such as grab rails, stair lifts, and walk-in showers.

There is recognition that much of the above cannot be treated as having simple cause and effect impact. Dealing with underlying health problems, modifying the home, and improving footwear do not necessarily lead to a reduction in falls. For example, Lord, Menz, and Sherrington (2006), in their critical review of the relationship between home modification and falls in older adults, assert that effectiveness is dependent upon a number of factors, including an individual's notion of risk, their physical ability, and their interaction with their environment. Having knowledge of falls hazards is helpful. But for falls prevention strategies to be effective and meaningful, how and why such knowledge is, or is not, acted upon needs to be elicited.

Indeed Bunn, Dickinson, Barnett-Page, McInnes, and Horton (2008, p. 449), in their systematic review of older adults' perceptions of barriers and facilitators to engaging in falls prevention strategies, found that facilitators include "social support, low intensity exercise,

greater education, involvement in decision-making, and a perception of the programmes as relevant and life-enhancing.'' That said, the authors also point to a degree of ambivalence. For example, there is research to suggest that social support, particularly joining a group, can be a barrier (Allen & Simpson, 1999). Bunn et al. (2008, p. 466) also noted that while a number of researchers found that health professionals ''emerged as important social referents for older people (Aminzadeh & Edwards, 2000; Commonwealth of Australia, 2000; Grossman & Stewart, 2003),'' a study by Stead, Wimbush, Eadie, and Teer (1997) suggested that health professionals may not always be seen as reliable sources of information such as advice on exercise. Bunn et al. (2008), therefore, call for further research that explores reasons for this ambivalence.

Yardley, Donovan-Hall, Francis, and Todd (2006) ran a number of falls prevention focus groups with a cohort of fallers and nonfallers. They found that barriers to falls prevention advice include unwitting, authoritarian, and patronizing delivery. There is also the potential for health professionals to use a ''risk discourse,'' which may lead to older adults feeling individually responsible for their fall; although, some older adults suggest that falling is something that just happens (Ballinger & Payne, 2002; Yardley & Todd, 2005).

Peel and Warburton (2009) also found that connotations around terms such as 'falls prevention' and 'falls' also led to a fear of being stigmatized as ''old'' and ''at risk.'' Yardley and Todd (2005, p. 2), in their *Help the Aged* report that explored why older adults may be resistant to advice on preventing falls, noted that some consider a fall to be caused by a ''momentary inattention'' rather than a reoccurring problem. Thus, advice is not for them. Others might suggest that falls prevention information is for others perceived to be older and more vulnerable to falls (Ballinger & Payne, 2000, 2002). Negative stereotypes of falling and ageing may, thus, mean that older adults reject falls information and advice (Bunn et al., 2008; Yardley & Todd 2005; Yardley et al., 2006).

The World Health Organization's (WHO) report on *Falls prevention in older age* (WHO, 2007) outlined the recommendations of the Psychological Aspects of Falling thematic group of the Prevention of Falls Network Europe (ProFaNE, www.profane.eu.org). This European-Commission-funded collaborative project, promotes best practice in research aimed at reducing the physical, social, and psychological negative impacts of falls on older adults. ProFaNe's recommendations include the following: promoting benefits that fit with a positive self-identity; utilizing a variety of forms of social encouragement to engage older people; ensuring that the intervention

is designed to meet the needs, preferences, and capabilities of the individual; and encouraging self-management rather than dependence on professionals by giving older people an active role.

One way of endorsing ProFaNe's recommendations and addressing some of the challenges of professional falls-advice delivery, is to consider using peer learning strategies. For example, Peel and Warburton (2009, p. 10) provide a review of the efficacy of using peer educators in falls prevention programmes. They suggest that: "Same age role models can encourage people to accept information, help break down ageist stereotyping and empower older people to challenge the belief that falls are an inevitable part of the ageing process."

Peel and Warburton (2009) also stress that peer educators should not be regarded as substitutes for health professionals; expert advice is warranted. Rather, peer educators add relevance, may bring personal experiences, and can act as positive role models. Allen (2004) reported on a peer education program in the north of England that included delivering one off falls-prevention information sessions and demonstration of simple balance and strength exercises. Evaluation of the program highlighted reluctance on the part of older participants to report falls to health professionals or to seek advice. This suggests that peer learning strategies may facilitate communication between older adults and professionals.

Our peer learning strategy did not involve designated peer educators. Rather, as a multidisciplinary research team, we facilitated peer group sharing of falls and fear of falling histories as well as experiences, knowledge, and understanding of falls-prevention intervention strategies. The strategy was completed as part of a wider program of research within the Technology Research for Independent Living Centre (TRIL, www.trilcentre.org). The research team included an ethnographer, an industrial designer, a clinical research fellow, a research assistant, and a project manager who was supported by a geriatrician with specialism in falls, a digital health engineer, and a design ethnographer.

OUR STRATEGY

Following intensive ethnographic inquiry with 11 TRIL participants who had histories of falls and being granted ethical approval, we invited these participants to form a falls expert panel and to work with us to develop some audio-visual discussion programs on falls and fear of falling. The audio visual programs would form part of

the daily broadcasts that would be featured within a TRIL pilot study. These broadcasts would explore the use of home-based advanced telephone technology to ameliorate social isolation (for further information, see Wherton & Prendergast, 2009).

FORMING THE EXPERT PANEL AND OUTLINING THE PEER STRATEGY

Seven of the original ethnography participants agreed to take part, and this included the husband of one who had not experienced falling. The group presented with a wide range of falls-related events and experiences, from self-reported falls, to problems with balance and dizziness, to one participant not associating herself with falling although she had a history of falls. There were four women and three men, aged from 70 to 84 years of age. With the research team, it was agreed that we would run an exploratory focus group. Ideas generated from this session would be tentatively incorporated into short, 6- to 10-minute audio-visual contents. These contents would then be given back and presented to the expert panel to be further refined and developed. This would be followed by a final evaluative focus group. It was also agreed that it would be useful to demonstrate the audio visual contents to a group of TRIL participants with histories of falls but who had not been involved in the falls-related TRIL ethnography and who, thus, had not explored in depth their understanding of living with falls with one of the research team. This group would be invited to come together on two occasions: first to further refine and develop the audio-visual contents and, second, to offer final evaluative feedback. From the TRIL cohort, seven individuals were invited to take part in this nonethnography TRIL group. Six participants had histories of falling or expressed fear of falling, and the seventh was the husband of one of these participants. A member of the research team had a telephone conversation with each participant and written information was shared and consent obtained.

THE EXPLORATORY FOCUS GROUP WITH THE EXPERT PANEL

We invited the expert panel to come together to share their experiences, knowledge, and understanding of falls-prevention intervention strategies. Our venue was within the hospital where participants had

undergone the clinical component of the TRIL research program, and transport was arranged. The room was bright and airy; we opened with refreshments and small talk. The three facilitators, the ethnographer, the designer and the research assistant introduced themselves and the group agreed to a code of conduct that included trying not to talk over each other, respecting each others' views, and politely asking for points of clarification. While facilitators encouraged the panel to lead, direct, and generally shape the session, the reality was that—for this group of older adults—they were more used to being "taught" and being given information.

A combination of small and whole group interaction followed. Small group work opened with the question: "Following a fall what advice was most helpful?" or "If you had a trip or stumble, or have balance problems that led to a fear of falling, what advice was most helpful?" General discussion focused on key topics highlighted from within falls-prevention information strategies: health and pills/medication; removing home hazards; assistive devices; keeping moving: strength and balance training; footwear; social reasons for being afraid of falling.

There was animated discussion about the reactions of other people to falling: "They're just all waiting for me to fall: 'Mam we'll get the messages,' when I want to do it meself." This led to some reflection on the difficulty of "speaking out" and "being able to share your concerns, without everyone jumping in and taking over." Mixed views in terms of confiding in the family were expressed: "They worry all the time and it gets me low." "Ah they're very good and they can help you out." There was also some quiet probing about breaking the silence about either having had a fall, trip, or stumble, or feeling nervous about falling:

> *You don't want to worry them so you don't tell them.* **(Participant 1)**
> *But why should it be a worry?* **(Participant 2)**
> *Well that's just it, like everything else, the kids, you've been the one to make the decisions and then they start wondering if you still can, that's it.* **(Participant 3)**
> *We should make a program about that....*
> *[pause]* **(Participant 2)**

That said, one participant wanted to know "what all the fuss is about, you fall, you stay on the ground to get over it, somebody might help you up, you tell the family and you get on with it."

Indignation was expressed that external factors that may cause a fall were not always taken into account: "It's the curbs; it's the

Corporation's fault for not sorting the pavements." Others did relate personal reasons: "I have a nervousness." "It's poor balance."

As part of falls-prevention strategies in the home, all spoke of needing reliable, affordable, and trustworthy care as well as repair and home maintenance services: "... someone you can trust." "They should ring in advance of coming." Most of the maintenance work required is small: "... banging in that loose tile." "I need new door handles." Also it was acknowledged that family and friends do help, but the group wanted the independence of "... paying for a good job." But payment needs to be "reasonable, affordable." All seemed to have some knowledge of grants for home modifications, from small assistive devices to extensions: "Social services, they'll sort you." "When I came to the Day Hospital, the person there (social worker), she sorted me."

The group spontaneously offered advice to others dealing with falls or a fear of falling. Some of the group had scorned some aspects of this advice when offered to them, particularly by professionals: "Slow down, lift your feet." "Take advice from/listen to your family." "Tell people what you are doing in advance." However, this contradiction was not discussed. Four out of the seven participants had within the last two years been involved in a postfalls, physiotherapy-led, balance and strength exercise program in a local day hospital which they suggested "... was good at the time," and "I liked being part of a group but didn't take anything home with me." Although another commented: "Oh, I learned loads, so many good tips."

As all group members had been involved in the ethnography phase, there was familiarity with two of the facilitators, and there had been previous one-to-one discussions about falls. One participant suggested that although nervous to begin with, he was not surprised that the group came together so well:

> ***I'm a great reader but when it comes to something like this*** **[falls]**, ***I'm not so interested in the leaflets and the information. I'd talk with people but it's actually better if its people you don't know so well but they've had similar problems.***

At the end of the session participants were invited to write down anonymously one comment about taking part in the group: "I got a lot from the meeting because I felt I can cope well with the problem." "Great to hear other people's opinions." "Enjoyed sharing ideas." "Great interaction" (in the group). "Definitely want to come back, let me know."

The expert panel had agreed on four topics they felt would provide useful discussion points for thinking through strategies to deal with falls and fear of falling: falling and ageism (intergenerational aspects of falls); home modifications and maintenance; keeping physically active; and coping strategies. As a research team, we agreed to take these away and over a four-week period gather information, write scripts, and either through animation, film or stills, illustrate the expert panels' stories, tips, challenges, and strategies about falls. With the expert panel, we reiterated that our goal was not to produce a falls-prevention strategy. We did not have the expertise for this. Rather, our goal was to work together to produce points of discussion that might enable others to begin to realistically explore their falls' experiences.

DESIGN WORKSHOP

Following the focus group, a multidisciplinary design workshop was held with the research team to agree on broadcast contents, based on the material gathered from the focus group and the extensive ethnographic data. The research team discussed this material at length, and a broad range of ideas and potential features for content emerged. Scripts were written up on each of the topics, and these were used as a framework for adding the visual content. It was also agreed that the content of each broadcast should have points of discussion. From within the telephone technology pilot research, and following a broadcast, participants had the opportunity to join an audio group discussion. As detailed below, the contents were refined within the next round of participant focus group meetings.

REVIEWING AND FURTHER REFINING BROADCAST CONTENTS

Within four weeks of the exploratory focus group, the research team organized the meetings with the expert panel and the nonethnography TRIL groups to review and refine the initial broadcast contents. The sessions were planned to take place on the same day, the expert panel meeting in the morning and the nonethnography TRIL group in the afternoon. We organized the two groups to share a sandwich lunch. Within this informal gathering, there was much bantering from the expert panel, extolling the other group and how they had sworn "not to give away secrets" and "we've been asked not to share

with you what we've come up with'' and ''ah no we can take criticism, we think it's very good.''

During the morning session with the expert panel, members behaved as a group of friends, picking up ''threads'' from the previous focus group. During discussions, they reminded each other of particular stories/illustrative events they had previously shared. There was some repetition from the earlier focus group: ''Didn't we do this last time?'' ''Yes, but we are now asking you if you think others would welcome this information.''

The afternoon session with the nonethnography TRIL group seemed very relaxed and informal. One member, unfortunately, was unable to join us due to illness. This was the first time they met; they didn't know each other, but all had a common interest in falls. The group presented wide falls and fear of falling experiences in terms of daily challenges and coping strategies. These ranged from dealing with poor mobility to being relatively active. Both meetings were structured around presenting the broadcasts that lasted between 4 and 10 minutes. At the end of the main content of each broadcast, there was a series of questions for discussion. These provided a useful framework for the groups to both consider the key messages and how these were presented.

Both groups concluded that it had been useful to be given ''permission'' to talk about their falls. The second group, and this was their first meeting, suggested that sharing was important and it was good to know that others were also 'getting on with it.' The expert panel, for whom this was the second meeting, suggested that familiarity with the group was very important, and it had been good to not feel that others might think they were ''moaning.'' One panel member said, ''being part of a group is something to look forward to.''

FINAL EVALUATION MEETINGS

In response to the refinement focus groups, the research team spent a further three weeks developing the broadcast contents. As with the refinement focus groups, the expert panel and the nonethnography TRIL group met on the same day to participate in the final evaluative sessions. Feedback on each of the four contents noted both overall messages and specific detail. For example, the falling and ageism broadcast content had a strong message: ''It's not just older people who fall, but it is more common in older people and can have more serious consequences.'' Both groups liked a cartoon scene of two

characters, young and older, sitting in a church and both worrying about getting up to receive Holy Communion because of their fear of falling.

The falling and ageism broadcast also emphasized that it's not just older adults who need to take care when out and about. Using the expert panel's own stories about the difficulty of moving about in busy streets, or having the time to cross the roads, or generally feeling uneasy in crowds, the research team had taken film footage of local busy streets. The film incorporated an animation of a group of people crossing a street and using pedestrian controlled traffic lights. Earlier TRIL research had suggested that for some people—perhaps those with a small child, or a person using a walking stick—the traffic light sequences did not give enough time to safely reach the other curb (Romero-Ortuno, Cogan, Cunningham, & Kenny, 2009). Both groups related to this content: "It's very true because with traffic lights there's no chance to cross in time." "I like the balance of older people and younger people having the same problem."

The nonethnography TRIL group wanted more practical advice: "Something about what to do when you fall would be helpful." "You need to give more information about the fear, I'd like to see the statistics." "How do you motivate yourself against the fear of falling?"

Home modifications and keeping active broadcast contents were well received by both groups. In terms of the former, the nonethnography TRIL group concurred with the finding from the exploratory focus group with the expert panel. They, too, expressed a need to have safe, reliable nonfamily support for care and repair jobs and that they would be willing to pay a "reasonable fee." In terms of keeping active, members from both groups suggested that it was important to also emphasise the need to stay "mentally active." They felt it could help those that suffered a "life change, such as the death of someone close." There was also discussion about how group exercise activities, such as joining a walking group, may have a positive impact on both physical and mental health: "Being sociable and sharing getting out, even when you don't feel like it, that's good." "Going there [a keep fit class] with the other oldies, we have a laugh, you know, and M [the instructor] well, she's getting on too."

The most controversial broadcast content had to do with coping strategies. The expert panel had given us so much information on their personal experiences and what had helped that we had agreed to produce short scenarios of falls' events with potential coping strategies. Four vignettes were produced, two in animation form

and two using younger actors to act out scenes like a fall in the bathroom. Both groups had issues with this: "I would prefer older actors, but it did get the message over." "I like that in each instance [scenarios] you get the faller to go to the doctor, but I'm not sure if you should be having the young'uns acting out the older ones." "I liked having the young actors, gets you thinking more about what happened and what to do." "I think the voices, if you at least had older people's voices, that might be more believable."

Both groups emphasised positive aspects of being part of a small group. The nonethnography focus group expressed, "we feel we know each other" and exchanged contact details and some very personal, emotional details even though this was only their second time meeting. In general, they gave constructive feedback although, initially, as discussed earlier, both groups seemed more used to being led rather than facilitated. Over time, opinions, likes and dislikes, and suggested changes were shared. Indeed, participants suggested that a group problemsolving approach highlighted both common experiences and pooled coping strategies.

The expert panel related particularly to the intergenerational material (falling and ageism) and coping strategies, more so than the nonethnography TRIL group who focused more on the technology. It may be that the expert panel members, having had several months with an ethnographer regularly visiting them and talking about falling beyond a physical event, might have been more comfortable with exploring the social and cultural aspects of falling.

Both groups wanted to know more, what next, and when they might be invited again: "Coming together with similar people, that's great." "When are we coming back?" "Glad I came, wasn't sure originally." There were also comments about constructively developing a falls peer strategy: "We think what we've produced is good." "Should get people talking." "I want to know how it goes with the technology group, what they say about our falls' topics." There were pragmatic requests from both groups: "Please invest in more comfortable chairs." "Bit of a walk to the venue." And there were more substantial, conceptual comments.

DISCUSSION

Peel and Warburton (2009, p. 7) suggest that peer education "... occurs between people who share common characteristics and similar experiences; and that it relies on influential members of a social group or category (Johns, 2007)." In our case, the meaning

of peer emphasised a group of older adults coming together to share their experiences of falls, or fear of falls, their challenges and coping strategies. The focus was on working with a research team to translate such shared experiences into audio-visual contents. In turn and from within peer settings, such contents may encourage others to share falls experiences and coping strategies without worrying about being labelled as a "moaner." Such settings also tend to avoid concern about well-meaning family and professionals taking control, reducing risks, and unwittingly, negatively impacting on autonomy and, ultimately, positive identity. Such openness may encourage receptivity to more practical falls education.

As this was group learning and sharing, we did not designate an influential member to teach or motivate the group. Indeed, it was clear across the two groups that there was already practical knowledge about current falls-prevention intervention strategies and—through word of mouth networking—about home modification grants and some services.

Participants enjoyed a shared problem solving strategy. In particular, there was a sense of placing falls within the wider context of every day life. Multiple meetings occurring over a five-month period may have facilitated this. There was time for personal reflection and also—from with the group gatherings,—opportunities to revisit and reconsider previous points of view.

While across the two groups some participants had undergone balance and exercise training within a physiotherapy setting and had found this helpful, there was also the suggestion that, for others, the training stayed within the physiotherapy setting: "I liked being part of a group but didn't take anything home with me." Yet, we would argue that participants did retain a lot of the advice and spontaneously drew on this to give advice to others who were dealing with falls or a fear of falling: "Slow down, lift your feet." As already noted in the literature, perhaps this suggests that for these older adults, while they are willing to engage with professional training and advice within a professional setting, they nevertheless feel that such learning is not applicable to them within their everyday lives. Rather, it is knowledge that can be passed on to those who need it.

Relatedly, and during the life time of both groups, group dynamics seemed to be supportive with a suggestion that "...it's actually better if it's people you don't know so well but they've had similar problems." In this case, a community of interest was formed. Participants come together to reflect upon falls and fear of falling experiences. There were no prior relationships invested in familial or professional ties or, indeed, a need to perform a side stepping

dance in order to avoid negative and ageist labeling: "You are falling because you are old." "As someone who falls, it is likely that you cannot cope with other aspects of your life." Rather there was a sense of common purpose and with the research team. Coproducing the falls broadcast contents seemed to lead to a satisfying outcome: "We think what we've produced is good." "Should get people talking."

There are limitations to our strategy. Our groups were contrived in that they were part of a large research program and had already been exposed to professional assessment or guidance about falls. In the case of the expert panel, they had also formed research relationships with some of the research team and explored subjective understanding of falls. While we presented the final contents to a non-TRIL group of older adults, findings of which are beyond the scope of this paper, we did not engage this group in the process of peer learning and sharing to produce the contents.

With hindsight, we should have invited at least some members of both groups to share in, and become involved with, the design and production process. Our rationale was that our participants gave an abundance of rich information. It was our job to give this back in innovative, multimedia ways. However, members could have acted as advisors and interpreters throughout the process. Each group could have democratically designated members who were willing to take on this role.

CONCLUSION

ProFaNe's recommendations for best practice in research aimed at reducing the physical, social, and psychological negative impacts of falls on older adults include promoting benefits that fit with a positive self-identity and utilizing a variety of forms of social encouragement to engage older people. We suggest that, withstanding our limitations expressed above, our peer learning strategy set out to do just that. Certainly in terms of the latter, our strategy engaged older adults in falls related discussions over a period of time and from within a community of interest group that was free of familial and professional ties. In terms of the former, for the majority, peer group sharing seemed to be a way of opening up the silence surrounding falls incidences. Our strategy also helped the older adults to consider falls as incidences that can occur across the life course and place them within the wider context of every day life. We suggest that such peer learning and sharing are valuable and complimentary to falls and fear of falling support strategies.

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