Quality in Ageing and Older Adults
Promoting excellence in services through research, policy and practice

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Enhancing relationships with social, physical and technological environments

As people live longer and their environments change, this may place heavier relational demands upon them to learn and manage. However, such changes also offer the possibility of co-creating new types of relationship with those environments through which to access potentially positive support.

Perhaps raised expectations and horizons in populations with increasing life spans can bring their own problems. The review by Heuser and Howe of evidence of links between social isolation, suicide and suicidal thoughts in people aged over 60 years identified nine relevant reported studies. These indicated that loneliness and isolation are increasing and experienced as increasingly problematic for older people, when linked to depression and hopelessness, but that social isolation alone is not a simple causal factor for suicidal ideas or suicide.

The potentially problematic nature of new forms of communication and connection is highlighted by the media review conducted by Vermeer et al. of the nature of online marketing for surveillance technologies in the UK, Sweden and the Netherlands. Not only could these perhaps inadvertently equate people with dementia with animals and children, but reinforce almost universally prioritised emphases on safety concerns (not necessarily shared by the people subject to surveillance) with almost no attention being paid to also ensuring their dignity or person-centred relationships.

A more personal and responsive approach may be suggested by the development of "care navigator" roles for supporting older people and their families through the complexities of modern fragmenting care systems. Funk’s study in a Western Canadian city, using interview data and discourse analysis, shows how a critical view can reveal the need for such roles to cover more than information needs. She suggests that perhaps providers can take a broader and more pre-emptive look at the issues posed, maybe working to integrate services more so that the need for navigating may be less likely to arise.

Such studies suggest that supportive relationships are not simply determined by the physical characteristics of changing environments, nor physical limitations imposed by ageing, but can be flexibly negotiated and co-produced as capabilities of people, places and localities are actively reviewed and reassessed.
The relation between social isolation and increasing suicide rates in the elderly

Christoph Heuser and Jürgen Howe

Abstract
Purpose – Suicidal attempts and thoughts are particularly relevant to the health of the elderly and can impact not only the individual, but family, friends and spouses as well. This topic is important for the gerontological research community, particularly as it relates to social isolation and the feeling of loneliness, common in this population group. The purpose of this paper is to investigate new knowledge about the relationship between an increased risk of suicide in the elderly and social isolation or loneliness.

Design/methodology/approach – An extensive search was conducted to find relevant studies to answer the research question. Database research was done in PubMed and PsycINFO for relevant studies within the last 10 years. The title and abstract of relevant articles were screened before the full-text was acquired.

Findings – In PubMed 163 studies were identified, and in PsycINFO 66 studies were identified. After a thorough screening, nine studies were found to be appropriate for this study.

Originality/value – It is not clear which risk factor leads to an increase in suicidal thoughts and attempts, however most studies contemplated loneliness and isolation as a covariant. A causal link between the concepts is not simple. Nevertheless, loneliness and isolation seem to be relevant factors for suicidal ideations.

Keywords Suicide, Loneliness, Risk factors, Social isolation, Aged, Suicidal ideations

Paper type Literature review

Introduction
Suicide is an important and grave concern in every country. The World Health Organization (WHO) considers suicide a global issue and estimates that 800,000 people die by suicide each year (WHO, 2017). In 1998, suicide “was the cause of 1.8% of the world’s 54 million deaths” (Ojagbemi et al., 2013). Across all age groups, American surveys reported over 42,000 suicide attempts per year (Steele et al., 2017). And while suicide is an issue of great importance and concern for all age groups, it is of particular concern for the elderly as the likelihood for a suicide attempt is two to three times higher for those who are 75 years or older when compared to younger demographic groups (Ojagbemi et al., 2013).

The risk factors for a suicide attempt are diverse and are often attributed to a reaction to a life-crisis. Although the data show that suicide occurs almost equally in high- and low-income groups, it has been shown that other factors, such as abuse, social isolation and violence, are related to a higher likelihood of suicide attempts amongst individuals (WHO, 2017). For the elderly, cerebrovascular diseases have been found to be a higher risk factor for women (Chan et al., 2014), but there are still few theoretical explanations for the empirical data that shows the higher risk factors for suicide attempts for the elderly (Stanley et al., 2016).

Suicide attempts, or suicidal behavior, is an important topic for the gerontological scientific community. This paper will explore the link between suicide in the elderly and feelings of solitude or loneliness, how they are connected, how strong the association between the two is, and what current research is available on the topic.
Theoretical background

Why is it important to talk about suicide and the reasons behind committing suicide?

To begin with, it is important to clarify which terms are used to describe this phenomenon, including: suicide, loneliness, social isolation and solitude. Suicide is defined as an act of self-homicide; “the act of killing oneself deliberately, initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome” (WHO, 2017). The terms loneliness, social isolation and solitude will be further discussed below.

In her paper, Schaller (2008) describes different variables in relation to suicidal behavior. In addition to personal factors, the author describes environmental determinations which burden the individual and may be high risk factors for suicide. Specifically, exclusion and solitude are factors cited that may promote suicidal behavior in the elderly (Schaller, 2008). Solitude was also looked at as a potential risk factor for suicidal thoughts in a study by Endo et al. (2017). In this study with more than 17,000 participants, researchers investigated the preference for solitude in students. Solitude was identified as a risk factor for suicidal thoughts, specifically in adolescents (Endo et al., 2017). This study found that the prevalence of solitude increased with age, and it also found that the prevalence of social isolation was greater with boys. Importantly, this study did not look at data on suicide attempts or actions, but rather looked at suicidal thoughts or ideation. It also focused on adolescents, rather than elderly participants (Endo et al., 2017).

In a systematic review conducted over a 25-year period, Mezuk et al. (2014) examined the data of suicide attempts in facilities for older people, especially long-term care units. They identified that suicidal thoughts are common amongst residents of long-term care facilities. Two notable factors for suicidal risk in this study were social isolation and loneliness. Other factors included depression, health problems and functional decline (Mezuk et al., 2014). Similarly, results from a study of Australian nursing homes by Murphy et al. (2018), identified 142 suicides committed between the years 2000 and 2013, where loneliness was identified as one of the major life stressors which led to suicide among the residents. Moreover, loneliness is said to be a predictor for suicidal ideation by Chang et al. (2017).

Generally, research on suicide distinguishes between isolation and loneliness. While loneliness is defined “as a personal and a social state with a variety of possible causes” (Victor and Sullivan, 2015), isolation refers to a more physical issue, i.e., a lack of regular contact with other people – it can also be understood as solitude. These understandings of loneliness, solitude and isolation formed the foundation of the following literature review.

Methods

To answer the question, “Do social isolation and loneliness in the elderly lead to increased suicide rates?” a literature review was conducted using PubMed and PsycINFO.

All articles were identified using their titles and abstracts. Searches were conducted for studies on the topic of committing suicide, or suicidal thoughts and ideations in the elderly, with one of the examined criteria in the study being loneliness, solitude, or social isolation. Articles which did not target people over 60 years of age were excluded, as were reports about methods and instruments to identify loneliness or suicidal ideations, suicide risk or similar keywords.

The literature review was conducted in May 2018 and began with a search for relevant keywords (see Table I). A more detailed outline of the databases, research strategies, and combined keywords can be found in Table II. The PubMed search produced 163 results, of which 27 were determined to be critical for the research question after reviewing the abstracts. The PsycINFO search also produced 163 results. Filters for article from “academic journals” and between “2010 and 2017” were applied, revealing 66 results critical for the research question.

A total of 19 studies were determined to have potential suitability for the research question. Of these 19 studies, ten were excluded because they did not make a direct contribution to answering the research question. One study was a methodology paper and another used an unclear methodology to measure the variable of loneliness. The other eight studies that were
excluded concerned either a younger population (under 60 years of age) or emphasized other variables that were not relevant to the research question. Ultimately, nine full-text results were found that could be used to help answer the research question. Figure 1 shows the complete process of the literature search. The next section will present the results of this search.

Results

The first study to be discussed is Van Wijngaaden et al.’s (2015) qualitative study on the life context of people who were nearing the end of their life and were thinking about the option of assisted suicide. In this study, researchers conducted 25 in-depth interviews with participants who were over 70 years old and described different aspects of their phenomenological perspectives (Van Wijngaarden et al., 2015). In this study five factors were found. One of these factors was “a sense of aching loneliness,” described as a feeling of loneliness, expressed by every participant, that could be consciously or involuntarily occurring (Van Wijngaarden et al., 2015).

The Ibadan Study of Aging (ISA), was a longitudinal study on the mental and physical health status of 2,152 elderly people in Nigeria, where the researchers examined predictors for suicide ideations and suicide attempts (Ojagbemi et al., 2013). To measure suicidal ideation, the authors used the 3rd Composite International Diagnostic Interview (CIDI 3.0) tool, developed by the WHO. The data analysis was completed using logistic regressions analyses. The cohort had a similar distribution between males (46.2 percent) and females (53.8 percent). The mean age was 75.06 years (SD 9.2 years). The results of this study found that 99 persons had thoughts about suicide, 20 persons talked about suicide plans in the past, and six persons had a suicide attempt in their lifetime (Ojagbemi et al., 2013). Between suicidal behavior and other variables.

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(e.g. age, sex, education and income), this study did not find any correlations. The only association that was found was between participants who had lost their spouse and suicide risk. Amongst those who had lost their spouse the risk for attempted suicide was five times higher than amongst participants who were still married or whose spouse was still living. It can be assumed that the loss of a spouse increases the likelihood of isolation and, relatedly, loneliness. This may help to explain a correlation between the higher risk for suicide attempts in the elderly compared to younger people as the elderly will be more likely to have lost a spouse and thus experience the loneliness associated with such a loss (Ojagbemi et al., 2013). A further factor identified was the issue of income. In rural communities in Nigeria, the younger population often move to other places with more opportunities, resulting in a thinner social network and a higher risk for social isolation of older people who remain in the region (Ojagbemi et al., 2013).

In the Swedish Gerontological Study of Aging, researchers looked at factors which lead to suicide attempts in the elderly. They interviewed 103 people over the age of 70 who were in hospitals after a failed suicide attempt and this group was compared with a control group (Wiktorsson et al., 2010). In this study, age and sex were balanced (age 79.7; female, 55.0 percent) Similar to the ISA, it was shown here that most suicide attempts occurred when the participant did not have a partner, or if they were living alone. Another factor that was identified was psychiatric history. More than half of the participants who made a suicide attempt had a psychiatric history and two-thirds had been diagnosed with major depression, compared to the control group where only one-tenth had a psychiatric history. Feelings of hopelessness and loneliness were also identified as factors: 58.4 percent of the patients reported feelings of hopelessness and 60 percent reported feelings of loneliness, compared with the control group, where only 17.6 percent reported feelings of either hopelessness or loneliness (Wiktorsson et al., 2010).

Though not everybody with suicidal thoughts commits or even attempts suicide, the question arises as to which factors operate to prevent suicide? This question interested Huang et al. (2017) who explored it in their study. In this qualitative study, the authors used an interview guide and structured questionnaire to understand suicide ideation in 32 participants over 65 years of age.
In 49.6 percent of cases, loss of respect, or support, of family members was one reason for suicide ideation. Feelings of loneliness were also found to occur in a stable family structure when the participant had a lack of connection within the family which led to suicidal ideations (Huang et al., 2017). For 16 participants, chronic disease was a reason for contemplating suicide. Across these 16 participants, 87.5 percent had a depressive diagnosis. The limitation of this study was the small number of participants, especially when compared to the Survey of Health, Aging, and Retirement in Europe (SHARE), a study which included 6,791 participants over 75 years of age from 12 European countries. SHARE is a multinational study with more than 45,000 participants from 15 different European countries concerning people over 50 years (Saias et al., 2012). The following studies looked at participants from different data waves of SHARE, which is the reason for the different number of participants in both studies despite data coming from the same source.

With the aid of a multi-regression analysis, Stolz et al. (2016) examined individual and social risk factors in the elderly for passive suicidal ideation using participants from data waves four and five of SHARE. An important feature of this study is that it offers a cross-national perspective which is important to inform national strategies for the prevention of suicide. Countries with a higher number of elderly people at a possibly higher risk of loneliness may need different preventative strategies than countries where there are lower risks of loneliness in elderly populations (Stolz et al., 2016). Of the participants, 12.0 percent had the desire to die. The data showed that in countries with better integration of the elderly, the likelihood and wish to die was lower than in countries without this development. Two of the countries with a high risk for passive suicidal ideation were France and Belgium (Stolz et al., 2016).

Saias et al. (2012) also used data from the European SHARE study to examine the relationship between suicidal ideation and social-environmental factors, such as loneliness and lack of participation. The researchers utilized the data of 11,440 participants over the age of 64 years from the 2006–2007 (second) data wave from SHARE. In this sample, 6.9 percent of men and 13.0 percent of women had the ideation of death. Losing a spouse was one of the significant risk factors for death ideation. In a bivariate analysis, researchers could show that the wish for death decreased when the individual participated in the community, and thus those that participated in the community had less suicidal thoughts (Saias et al., 2012). This study begins to reveal how influential participation is to avoid suicidal ideation.

Lack of participation and loneliness are not the same concept, but they are related, shown in a study from Guyana in South America. In this study, the authors examined the correlation between suicidal thoughts and risk factors in adolescent students, in contrast to the other studies which focused on the elderly. The results found that 18.4 percent of 1,197 participants had serious suicidal ideations during the last 12 months. This was not found to be the case in participants who had a solid social and family network (Rudatsikira et al., 2007). It should be noted that these results cannot simply be applied to elderly people, but it does give us an important reference for the connection between the feeling of loneliness and suicidal thoughts which is why it has been included here.

Gunzelmann et al. (2016) conducted a study with 2,527 participants in 258 different areas of Germany, that looked at suicidal thoughts in elderly people in relation to loneliness and hopelessness. The authors chose 795 participants over the age of 60 years. From these 795 participants, 371 were male (46.7 percent) and 424 were female (53.3 percent), with the mean age of participants being 69.91 years (SD 7.17) (Gunzelmann et al., 2016). The authors utilized different questionnaires for the measurements of hopelessness and loneliness. Of the entire collective group, 3.6 percent were found to have a higher risk of committing suicide. The participants with a higher risk of committing suicide were more likely to live alone and without a partner than those with a lower risk of suicide. The probability of experiencing hopelessness was higher in the group of participants over 80 years, compared to the group of 60-year-olds. Differences between women and men were not found (Gunzelmann et al., 2016).

It is well-known that people in later life stages have a higher risk of committing suicide, but is there a difference between the age groups when it comes to the correlation between suicide and loneliness? This was one of the questions looked at by Bennardi et al. (2017). In their longitudinal
study with 2,392 individuals, they showed that the feeling of loneliness is connected with a higher degree of suicidal ideation in those 60 years of age and older. This correlation was not found in participants from younger age groups.

This final study offers some perspective on men’s health specifically, and the link with social isolation and loneliness. Although there are assumptions that women have a higher risk of depression than men, this study shows how depression can make men more solitary and socially isolated (Milligan et al., 2015). Milligan et al. (2015) found that in England and Wales, over four million men are older than 65 years and 25 percent of them suffer from depression, and therefore have a higher suicidal risk. Further, according to estimates, older men who are divorced or never married have a greater risk of depression or suicide (Milligan et al., 2015). Men’s health and suicide in men may also have a high significance in other countries and the causes of suicidal behavior should be examined at different levels and according to sex in order to draw more accurate conclusions.

Conclusion

The results of these studies show that loneliness and isolation are increasing problems for the elderly and that they become more relevant the older a person becomes. Further, the results show that loneliness can be a risk factor for suicidal thoughts and attempts. Generally, risk factors for suicide attempts can be categorized in three parts: mental risk factors; biological risk factors; and social risk factors (Schaller, 2008; Linnemann and Leyhe, 2015). This literature review focused on social risk factors, specifically the connection between suicide and loneliness as a risk factor. The purpose of this study was to uncover whether loneliness leads to an increased suicide rate. After reviewing the relevant literature, the answer is unclear.

Important research articles relating to the research question were found in a literature search, which found 14 studies and contributions to the theme of suicide and loneliness or solitude. Not every study described the connection between both variables, and in most cases, loneliness, solitude or isolation were a covariant or one of a number of variables. The results showed a correlation between loneliness or solitude and depression or suicide. For example, in the ISA, loneliness was not a direct variable but the authors concluded a correlation between loneliness and suicidal ideation by using “loss of a spouse” to suggest loneliness (Ojagbemi et al., 2013). For elderly people, a partnership is important, and a significant loss can be a risk factor for suicide, which was also confirmed Wiktorsson et al. (2010). Based on these studies, loneliness seems to be an important factor for suicidal ideations. However, German researchers found no direct connection between loneliness and suicide. Rather, hopelessness was a significant factor for a higher risk for suicide in this study (Gunzelmann et al., 2016). The SHARE Study was able to find a link between the desire to die and loneliness across several countries (Saia et al., 2012; Stolz et al., 2016). The only study examined in this paper which researched adolescent students, the Guyana Study, found that a good social tie can be a preventive factor. However, this study is limited in its transferability to an older age group (Rudatsikira et al., 2007).

These results show a causal link between suicidal thoughts and loneliness which cannot be simplified. In order to better understand how solitude and isolation relate to suicide, it is necessary to conduct further variable research and data analysis.

Limitations

The present work is not without limitations. First, it cannot be said that all relevant studies on the subject have been found and reviewed. Studies in the field of gerontological research from a period between 2010 and 2018 were included in this paper. However, it is possible that relevant studies dealing with the subjects of suicide and loneliness may not all be found in gerontological research. Nevertheless, it is possible to draw conclusions based on the studies and theoretical backgrounds used.

There is still a gap between the question of whether loneliness leads to an increased suicidal risk. It is also unclear how the authors of the studies used here have interpreted the concept of
loneliness, especially as different measuring instruments were used. Also, it is unclear how or if these studies have chosen to separate the concepts of loneliness and isolation (Victor and Sullivan, 2015). Future studies should make a clearer distinction between loneliness and isolation and use instruments with a high validity to measure these constructs. Longitudinal studies are needed to avoid the bias that occurs in cross-sectional studies. A transcultural perspective will also strengthen this research as it cannot be ruled out that the results obtained are culture-dependent. Further transnational research may shed a different light on the results.

Ultimately, it can be concluded that research on suicide and loneliness is an important issue which requires further study, particularly as it pertains to the elderly.

References


Further reading


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How formal navigators interpret their roles supporting families

Laura Funk and Wanda Hounslow

Abstract

Purpose – The purpose of this paper is to examine how formal navigators interpret their roles supporting families of older adults.

Design/methodology/approach – This study was an interpretive inquiry informed by critical gerontology and discourse analytic methods. Interview data were collected and analyzed from 22 formal service providers who helped older adults and their families navigate health and social care resources in one Western Canadian city.

Findings – Although acknowledging structural barriers to service access, participants emphasized individual empowerment as their dominant strategy, interpreting their roles as providing information and education about services. In part, these interpretations may reflect the limited nature of their ability to help broker access or advocate; in part, they may also reflect the broader political and economic discourses surrounding care in Canada.

Research limitations/implications – When providers position navigation and access to care as individual problems, this can obscure structural burden as well as potential inequities among older adults. Future research should examine whether navigational role interpretations are similar or different to those of navigators in other regions. Navigators in other health and social care contexts may enact differing meanings in their work.

Practical implications – Although formal public navigators can play an important role, approaches that go beyond providing information may better meet families’ needs for support.

Originality/value – This is one of the first studies focused specifically on providers’ interpretations of the meaning of navigational work in health and social care for older adults, and to extend a critical gerontological gaze toward the issue of system navigation.

Keywords Family caregiving, Access to care, Critical gerontology, Interpretive inquiry, Structural burden, System navigation

Paper type Research paper

Introduction

The care needs and issues faced by older adults and their families vary greatly, frequently blur the boundary between health and social needs, and are often especially salient for those with multiple chronic conditions (Ploeg et al., 2017) as well as during times of transition between service settings (Manderson et al., 2012), reflecting changes over time in the health and function of the older adults. These needs are compounded by health and social care systems that, although considerably diverse and complex, are also fragmented and uncoordinated, and are thus difficult for older adults and their families to navigate (Bookman and Harrington, 2007). For instance, typically home care and nursing home settings are organized and delivered in different ways, generating confusion for older adults and families during transition.

Support with system navigation is thus an often-unmet need among family carers (Farran et al., 2004; Funk et al., 2015; Martinez-Donate et al., 2013). Navigational work is particularly salient in the context of formal services that are fragmented, as well as, in more recent years, more difficult to access (Bookman and Harrington, 2007; Koehn, 2009). Although publicly funded, non-medical care resources have never been universally guaranteed in Canada, policy shifts since the 1980s have eroded access to both medically necessary services as well as formal
social and preventive supports, such as home care (Segall and Chappell, 2000). Accompanied by
the diffusion of market-based, individualizing ideologies across sectors involved in caring for older
adults, such shifts are also aimed at moving care delivery for older adults out of institutions into
home and community, where families take up increasing proportions of costs and responsibilities
(Aronson, 2006; Chappell, 1993; Williams et al., 2001).

These shifts provide important context in which to understand the work that older adults and their
families do to access and coordinate various services and resources. There is emerging concern
in this regard about how the work required to navigate services can contribute to carer burden
(Funk et al., 2017; Taylor and Quesnel-Vallée, 2017) as well as hinder access, generating
inequities among older adults (Dixon-Woods et al., 2005). Challenges are faced by ethnocultural
minority and low-income older adults and their families, for instance, in navigating and accessing
care services (e.g. Koehn, 2009); these challenges, such as language and literacy, are mediated
by the context in which services are delivered (Rootman and Gordon El-Bihbety, 2008).

A need has emerged for health and social care providers to provide navigational support to older
adults and their families. For this reason, professionalized, formal navigator positions are being
developed in North America, designed as system innovations to reduce barriers to accessing
care and promote care equity (Dohan and Schrag, 2005; Manderson et al., 2012). Primarily,
these positions are targeted to specific disease categories (predominantly cancer), with a focus
on navigating medical care and sometimes accessing other formal services. More recently in
Canada, these positions have been implemented in other sectors such as home care and
long-term care for older adults, with a focus on ensuring smooth transitions between settings and
improving consumer access to information about resources and services. Private consultants
have also been entering the field to perform this work for well-resourced families, and non-profit
agencies across several sectors continue to play an important role.

Extant literature generally defines patient navigators as providing information, brokering access to
health services and alleviating barriers in marginalized populations (Egan et al., 2010; Health
Council of Canada, 2013; Manderson et al., 2012). Emerging evidence suggests that these
positions can be beneficial, yet as the concept diffuses through various sectors, there is little
consensus about the contemporary scope of the navigator role, ranging from advocacy to
support (Bradford et al., 2007; Colombo et al., 2011; Corrigan et al., 2014; Manderson et al.,
2012; Robinson-White et al., 2010). Moreover, we know little about how formal navigators in
other sectors help older adults and carers access non-medical, social resources and supports.

It is imperative to understand how health and social care professionals interpret the meaning of
system navigation, as these interpretations inform the work they do with older adults and their
families. To date, there has been little in-depth and detailed investigation into how formal
navigators understand the meaning and purpose of their work and role. This is important, since
there may be increasing emphasis on navigational supports in the future, and navigators’ role
interpretations can inform their practice; moreover, from a critical gerontological perspective,
these role interpretations can provide insights into broader circulating discourses about care
responsibility. The purpose of this study was to explore role interpretations in a diverse range of
service providers who assist older adults and their families with accessing services and supports
(i.e. formal service navigators).

Methods

In keeping with a focus on meanings constructed in social interaction (in this case, the research
interview), qualitative, interpretive inquiry (Gubrium and Holstein, 2000) informed by critical
gerontology (Grenier, 2012) guided study design. Interpretive inquiry draws on social
phenomenology and discourse analytic traditions to examine how individuals make sense of
everyday practices by drawing on broader socio-cultural frameworks of meaning (Atkinson et al.,
2003). With formal system navigation, these frameworks of meaning could include, for example,
organizational discourses prevalent in health and social care fields. A critical gerontological
approach (Grenier, 2012) promotes empirically informed critical analyses and interpretations that
in this study involved considering the broader sources and potential implications of particular
social and cultural constructions of system navigation that emerged in the interviews.
Following institutional REB approval (from the university and regional health agency), three general types of formal service navigators from one large Western Canadian city were recruited to participate in in-person, semi-structured qualitative interviews (April–August 2016). This included regional public employees (e.g. long-term care navigators, clinical social workers, home care case coordinators and community resource coordinators), referred to herein as “public navigators”; employees of local non-profit organizations serving older adults and/or carers (e.g. executive directors, client support coordinators); and private consultants. Our operational definition of navigators was broad, so as to recruit a range of navigators, including traditional “patient” navigators as well as professionals helping older adults access social care resources. Participants were recruited through invitation letters distributed by managers and supervisors of various public agency and non-profit departments and organizations, and cold calls to private consultants identified through internet searches. Managers and supervisors were asked to forward the letter to employees in positions involving a substantial focus on system navigation with older adults and their families. Potential participants contacted the first author directly.

Qualitative interviews with 22 participants, preceded by a written informed consent process, were guided by broad questions about participants’ role and position, families experiences with navigation and common navigational barriers. Generally, participants chose to be interviewed either in a research office or other private, quiet locations close to but not directly within their usual workspaces (a few opted for their homes). All interviews except two were with just one individual; in three interviews, multiple participants (two and three) from the same organization participated. The second author was one of the interviewers; the other interviewer was a research assistant.

Interviews (averaging roughly an hour in length) were audio-recorded, transcribed and analyzed by the first and second authors using discourse analytic techniques (Cheek, 2004; Powers, 1996; Smith, 2007). The data contained participant descriptions of how they interpreted their roles and defined system navigation; perceived barriers to, and sources of, disadvantage for families who are trying to navigate systems; and perspectives about improving families’ system navigation experiences.

Through close, multiple readings of interview transcripts and, where needed, listening to audio for clarification, we examined these data through an iterative process that involved collaborative discussion and developing and reviewing visual tables. Through this process we first identified codes representing descriptive, inductive themes, and after applying these codes to the data, we further explored the coded data to refine the analysis as well as identify broader discursive themes, including those that threaded across descriptive topics. This discursive analysis of the stated meanings (as well as what was “not” said) was informed throughout by our critical theoretical standpoints and our knowledge of the broader context of health and social care service delivery for older adults in Canada. We then examined and discussed comparisons and contradictions in discursive meanings expressed within and across interviews and sought to identify variation. The final set of themes reflected our consensus regarding explicit and implicit meanings we identified in participants’ talk about system navigation work. We had no significant analytic disagreements during this evolving process, in which we continually refined our understanding of the data. Rigorous, worthy and credible analysis was promoted through attention to complex contextualized meanings in the data, thereby, moving beyond describing, to unfolding abundant, relevant and concrete detail (i.e. thick description, as per Tracy, 2010).

Findings

Interpreting the core problem of navigation: families’ lack of information, skills and the right dispositions

Provider role interpretations draw on and reinforce particular interpretations of the problem of formal navigational work. Throughout their interviews, all three types of participants spoke about several closely related individual-level barriers faced by families navigating formal systems: a lack of accurate knowledge (e.g. about available resources and how to access these, what questions to ask, system literacy, being an “educated consumer”), skills (e.g. interpersonal, making needs visible to providers) and personal dispositions (e.g. being persistent, not afraid to advocate, comfortable asking for help, prepared, having reasonable expectations).
Conversely, with the right information and encouragement, access was generally believed to be easier. Here, navigators position their role in supporting families; in other words, participants’ role characterizations aligned with this dominant definition of the problem. Participants similarly tended to position their roles as empowering families through educating and providing information about how to access services and resources (publicly funded, in some cases private or non-profit) and interact with formal providers. For instance, one private consultant characterized her work as “[giving] people an opportunity to be empowered and how to look after themselves and get care for themselves.” A representative from a non-profit organization further stated that they hope “we have empowered [families] to know where to go to get the information that they need and then as a backup plan they can always call us.”

To a lesser extent, insufficient community services and resources were identified as creating challenges for families trying to access help for an older adult. This generated feelings of powerlessness or moral distress in some participants. As an example, one participant referred to the shortage of nursing home beds:

Families will bargain with, barter with me. They’ll plead with me. They’ll threaten me because they want so badly for their loved one to go [to the nursing home] they want to go to. But I always say, I can’t create a bed where there is not one […] It’s out of my control. I don’t have the resources to give everybody what they want all the time. (Public navigator)

An alternative interpretation was expressed by three public navigators who framed the problem as rooted in families’ high expectations of systems. For instance, one public navigator characterized the public as having a sense of entitlement and expectation for services and in some cases not appreciating what is available; in these cases, she interpreted her role as providing a “clarification” or a “tune-up” to address this disjuncture. Another public navigator likewise communicates to families: “this is what we have to offer. It’s great that we have it at all, so be thankful.”

Interpreting navigation as guidance or coaching toward particular options

As an exception to the dominant emphasis on information, in some cases, providers characterized their role as assessing the needs of the older adult and providing targeted recommendations or suggestions reflecting that assessment. In particular, public navigators employed by the health agency spoke about “hooking people up to the appropriate resources,” “getting them to the right direction,” providing information in a way so as to “match needs with services” or “figure out what makes a good fit.” Moreover, at times navigational guidance was characterized as supporting organizational goals, such as quick and seamless flow through systems, avoiding or shortening hospital stays and even mobilizing family responsibility. For instance, one public navigator explained how, after talking about the limits of formal services with families, she prompts them to consider more personal involvement: “opening up the conversation to say ‘what can we do for you to help you help your mom or dad.’” Other participants spoke about how their work alleviated the burden of calls to family doctors from anxious and confused families, and one consultant described when she tells families not to bother the health care team with unnecessary questions: “I call them off the team in that way.”

Participants tended to posit their specialized knowledge as making them well suited to guide older adults and their caregivers through complex systems, as in: “we’re the ones that have the knowhow and can’t possibly expect them to know the intricacies of all these problems” (public navigator). One non-profit representative further suggested that “being outside the health system helps us to objectively give information.” She believed that some health care system gatekeepers may be more inclined than others to withhold certain information about the available scope and depth of services “because of pressure to make the best use of health resources.” In contrast, as an independent organization, for instance:

[…] what we can do is say really you can have up to 55 hours [of home care] if you’re an employed person caring for someone. Be aware that even if they only say you can have 10 or 15 hours of assistance that the parameters are such that you can go to this level […] we can have very factually just put it on the table and say it’s there – feel good about asking.
Interpreting navigation as involving advocacy and direct support

Participants varied widely in the extent to which they believed they could initiate or activate resources for families. There was less evidence in the interviews of role interpretations reflecting active involvement in coordinative or administrative work involved in accessing services, or advocacy, with a few exceptions that may in part reflect participants’ differing formal positions. Private consultants, for instance, tended to express more involvement in helping to coordinate care between multiple services. Other navigators spoke of becoming involved in communicating with professionals on behalf of families, or other forms of advocacy in “exceptional” cases.

As examples, one public navigator spoke about how she tried to convince a home care nurse to conduct an assessment that was needed to obtain a specialized therapeutic mattress: "I had to do a lot of advocating in this particular situation, for the client’s best interest I nag, and harp, and email a few different people." Another public navigator spoke of how she tries, where possible, to help older adults access their preferred choice of nursing home, adding:

> Sometimes the client may have a little bit of a quirk or whatever [...] and I’ll phone the [nursing home] and say "You’re going to get an application soon" [...] and they’ll often say "we already got it but this person doesn’t look to be maybe a good fit." So I’ll advocate on the client’s behalf and offer to come down and meet with the [nursing home] to discuss it a little bit more.

A private consultant also referred to encouraging health care providers to provide flexible or creative solutions to meet client needs, describing this as “pushing” the system to be more flexible and less “patronizing to some of the families about knowing what’s best, when they don’t know necessarily what it means to this family or individual.”

As the needs of older adults can sometimes conflict with those of their families, participants also spoke of examples in which they intervened on behalf of carers to convince older adults to accept home-based formal services; they also provided examples in which they convinced family carers to help keep older adults at home who do not wish to move into a nursing home (or convince them to let this transition happen, if this is their wish).

The representative of a non-profit agency described herself as particularly well positioned to help families with advocacy, referring indirectly to the power of her status and social capital, derived from years of experience in the field. She believed this helped alert health care providers to particular client issues and needs: “They pay attention when I call. But I always think it’s a shame when they didn’t pay attention when Mr Smith called because he called them too and they didn’t do anything."

In telling these stories about their work, some participants conveyed role interpretations that included these more active forms of navigational support. However, more commonly participants described less direct approaches such as equipping families with self-advocacy tips, telling them what questions to ask or how to advocate to have their concerns and needs for services addressed. This can include prompting them to ask for specific services they may not have known were available. Other participants encouraged families “not to be afraid” to advocate, or showed them how to write a letter of complaint.

Several participants expressed that they wanted to do more to help more families navigate systems, including advocacy (i.e. it was part of their role interpretation), but believed they did not have enough time to do this in the way they would like (due to resource limitations). One non-profit representative explained how this meant: “we have to be very careful and diligent on picking and choosing who we’re really going to ‘go to war’ for because we can’t possibly do it for everybody.”

As another example, a public navigator noted:

> Big caseloads do not allow us the time to help people as much as we would like to. We don’t want to do everything for people but you want to be able to support them and give them the tools and help advocate when it’s appropriate and navigate.

Interpreting structural barriers as individual deficits

As noted above, carers’ lack of knowledge about available services (and how to access them) was an almost ubiquitous thread throughout interviews, in many ways positioned as the
raison d’être for formal navigational support. In most cases, to elicit conversation on other types of barriers faced by families, the interviewer had to ask a targeted, specific question.

Moreover, participants rarely if ever spoke unprompted about disadvantaged groups of carers and families who face barriers to accessing formal services. Furthermore, none defined their role as directly addressing the issue of inequities in service access for older adults. A few participants, drawing on frameworks that position the problem as rooted in individual qualities (e.g. lack of knowledge; emotional responses), denied the existence of group inequities directly, as in the following example:

I think you see struggles right across the board. I wouldn’t want to pinpoint and say that these families seem to struggle more. The lack of knowledge, that happens wherever or whoever you talk to.  
(Public navigator)

Overall, structural barriers tended to be framed as individual problems or deficits, even if related in some cases to culture or language, or to poverty or access to transportation. For instance, although population groups of immigrant or newcomer families were mentioned by participants as facing more barriers, these tended to be framed as a group-specific problem attributed to language and communication challenges, as well as cultural norms of family responsibility (that can make it difficult for carers to reveal their needs to formal providers). In a few cases, broader structural roots of these problems were alluded to, as with one non-profit representative who described the delays involved in accessing an interpreter through the public health authority for families that struggle with English language.

Barriers to access related to poverty and educational level, acknowledged by many participants, also tended to be framed as individual deficits. Participants described persons with lower education and socio-economic status as less knowledgeable about services, less skillful in speaking to professionals about service issues or concerns, less resourceful and more passive or fearful in interactions with professionals. Again, structural frameworks were sometimes invoked, as when one public navigator explained the complex reasons why some patients miss their medical appointments:

[They] got an opportunity to go look at an apartment on that day. Or [they] got a call from [Housing agency] and there was something available and [they] had to go meet with them right there and then […] And unfortunately the medical system right is not always very forgiving […] If you don’t show up twice, sometimes that’s it […].

She added that although these patients recognize the importance of their medical appointments, they “ultimately also have to have a place to stay.”

Moreover, some participants expressed that carers may not have the means to provide transportation or hire private transportation when publicly subsidized services, such as Handi-Transit, are unavailable due to long waitlists or service restrictions.

Notably, one public navigator invoked the rhetoric of individual responsibility in part to mitigate potential feelings of guilt when she could not address the complex structural socio-economic and social factors limiting one particular client’s access to care. She described one of her low-income clients who lived alone with addiction and without community supports, transportation or a phone. His medical needs were substantial, yet he was not eligible for home care. She did her best to get him a phone, ensure he got to an appointment and notify his daughter who lived out of town: “and he goes ‘Who’s gonna check up on me now? What happens if I can’t get out of bed? What happens if I die?’ I didn’t have an answer for that […] What am I supposed to do?” She expressed relief in knowing now that he eventually got into an apartment and had access to post-surgical nursing care, but added:

There’s lots of things that I can’t solve and […] personally there’s some choice, I have to remember. There’s some choice that he had to make to get there. There’s also family responsibility that I have to remember and then there’s system because I can’t solve all his problems.

Interpreting navigation as a systemic, structural problem

To a much lesser extent, and most often in response to targeted questions from the interviewer, some participants characterized system fragmentation as a barrier and the root of the problem of system navigation. This included the existence of silos lacking in lateral communication, a lack of
centralization and standardization or continuity of procedures, and system inflexibility to complex, individualized needs. Two excerpts are illustrative:

Hospital [providers] tell you about nursing home placement from their perspective. Meaning […] we don’t have time to talk about criteria for selection. Community [providers] say we don’t know a lot about the nursing homes anymore because we’re too far removed from that. So we can’t help you but here’s the list. (Private consultant)

[System] can be quite fragmented, they all have different criteria, and often we’ve designed the systems such that […] you can’t pass go until you’ve spoken to [someone in an authority role], we’ve made them with these checks and balances which turn out to be a little less user friendly. So I think that’s a reason why we need navigators (laughs) is we’ve just made it so that it tends to be that you need to speak to a few people in order to get things in place. (Public navigator)

Some participants believed that systemic or structural features of health and social care systems generated and complicated navigational work by families, who were also often simultaneously going through difficult emotional times in their lives. Adding to this complexity, a few participants suggested that older adults’ needs and circumstances were becoming more diverse and complex, and that caregiving and health trajectories were quite complex, variable and unpredictable.

Moreover, in a silo-based system, as one public navigator stated, such complexity makes it more difficult for providers to deal with older adults’ needs effectively, resulting in the client being “shuffled” between multiple organizations or agencies (complicating navigation). System complexity, a lack of clear information (about patients and/or services) and system fragmentation were also described as limiting participant’s abilities to provide effective navigational support in other ways. As one public navigator stated: “I’m in the system and I’m confused about what I’m supposed to be doing […] so I can see how it can be SO confusing for people who aren’t in the system.”

Discussion and conclusions

Future research should examine how these navigational role interpretations compare to navigators in other geographic regions and health and social care contexts (including settings outside of Canada), since formal navigators in these contexts may understand and approach their work differently. Another limitation of this study is the primary focus on language rather than practice. Observational and case study approaches should ascertain whether providers’ stated role interpretations align with or contradict their everyday approaches to working with families. Moreover, it should not be assumed that these findings reflect the experiences of older people themselves, or their families. Future research needs to examine how older adults and their families experience their interactions with formal navigators, including their satisfaction with various kinds of navigational supports.

Existing literature on system navigation by older adults and their carers has documented the struggles they face in this work (Funk et al., 2017; Meyer, 2017; Peel and Harding, 2014; Ploeg et al., 2017; Williams et al., 2018). The present study is novel as its focus was on providers’ interpretations of the meaning of navigational work in health and social care for older adults and their families, examined from a critical gerontological perspective. These findings contribute to existing scholarship in several important ways. First, we found that the main problem of navigation tended to be interpreted by formal navigators as an individual-level problem of insufficient knowledge and skills. From this perspective, the navigational support role was framed as individual empowerment and educating older adults and their families about how to access services. The far lesser emphasis on more substantial, direct forms of navigational support (including advocacy) may partly reflect limitations in participants’ job descriptions, and time and workload constraints. In this way, material conditions shape role definitions; these in turn reinforce broader circulating meanings of system navigation and access to care.

A second, notable finding from this research was that formal navigators did not directly interpret their roles as helping to alleviate inequities among older adults in access to services, tending instead to frame their roles in terms of more general support for all families, and in some cases,
on alleviating pressures on formal services (e.g. home care) or providers (e.g. physicians). Such patterns may be understood in relation to the broader social context in which families and patient consumers are increasingly responsibilized by professionals, equipped with the skills necessary to self-navigate complex systems on their own. Service providers themselves, who are strongly committed to helping families navigate systems, can inadvertently recycle this interpretation of the problem as a private trouble of individuals, particularly in situations where they are themselves constrained to help effectively (Ceci and Purkis, 2009; Funk et al., 2011; Woolford and Curran, 2012).

A third important finding from this research was that the public and private navigators focused on navigational support during key transitions or crises (e.g. after diagnosis, significant health status change), or when asked directly by families. In contrast, MacCourt and Krawczyk (2012) have indicated that carer-friendly approaches may involve informing families about services “proactively and prior to crises” (p. 27), although time and workload constraints may act as constraints in this regard. Finally, these findings also contribute to an understanding of how a lack of time and power among some formal navigators can restrict their abilities to become engaged more intensively or actively, in ways that can help reduce inequities between older adults in accessing formal services. The abilities of formal navigators to provide support effectively needs to be considered when developing and resourcing such positions. Although private consultants can offer tailored and immediate in-depth advocacy and navigational supports to those with the ability to pay, this may exacerbate inequities that navigational supports were originally intended to address.

This research raises other issues that remain to be discussed further by those developing system navigation supports. For instance, operationalizing navigational support positions within formal public care systems may be a promising practice, since these employees may better poised (e.g. than non-profit employees) to take action to help families of older adults overcome access barriers, depending on their authority, internal knowledge and system connections. However, when relying on system staff as navigators, ongoing critical reflection is needed, to ensure that broader equity goals are not subordinated to organizational goals of reducing reliance on formal services (e.g. quick hospital discharge). For some public navigators in this study with considerably more control in brokering families’ access to formal services, navigation was closer to gatekeeping. However, prioritizing the input and perspective of older adults and their families is key to successful formal navigational support precisely because older adults’ needs are not always clear or discernable to those working within fragmented systems.

Public and non-profit navigational positions can be an important step in rectifying problems with system navigation among older adults and their families, although more rigorous outcome evaluation is needed, and existing evidence is mixed (Egan et al., 2010; Manderson et al., 2012; Verhagen et al., 2014). Indeed, these approaches alone may be insufficient, in light of some participant comments regarding the roots of the problem in system fragmentation. Integrated care approaches may be best able to address problems with navigation and access to care, and we need to be careful to avoid developing a reliance on system navigator positions, at the expense of thinking more “upstream.” We cannot, in other words, avoid “the bigger and more involved issue of integration” of the broad range of services and supports for older adults (Manderson et al., 2012, p. 114).

References


Atkinson, A., Coffey, P. and Delamont, S. (2003), Key Themes in Qualitative Research: Continuities and Changes, Altamira, Walnut Creek, CA.


Peel, E. and Harding, R. (2014), “It’s a huge maze, the system, it’s a terrible maze’: dementia carers’ constructions of navigating health and social care services”, Dementia, Vol. 13 No. 5, pp. 642-61.


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Marketing of surveillance technology in three ageing countries

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Abstract

Purpose – The purpose of this paper is to review marketing materials of surveillance products for people with dementia and their carers in three ageing countries, as part of a dementia-technology media analysis.

Design/methodology/approach – An online environmental scan was conducted using search terms for surveillance technologies (STs) and dementia through a Google search focussed on the UK, Sweden and the Netherlands. Data were extracted on the products’ and websites’ marketing messages from consumer and marketer perspectives.

Findings – Information was gathered for 382 product websites, of which 242 met eligibility criteria. The majority of products come from the UK. In the UK and Sweden, the companies behind the websites appeared to be mainly “cottage industries” which focus on selling ST. In contrast, sellers in the Netherlands included a more balanced mixture of small, medium and large companies. In all three countries, the website messaging focussed on the need to manage safety concerns, without considering privacy or consent.

Social implications – Contrary to the perception of future dependence on technology, the ST sector seems to be a niche market. The media messages, equating people with dementia with animals and children, are at odds with initiatives that strive for dignity and dementia friendliness.

Originality/value – No previous study is known to have explored media messages from websites that market ST for people with dementia.

Keywords Safety, Carers, Dementia, Surveillance, Marketing, Technology, Review, Environmental scan, Cottage industries

Paper type Research paper

Introduction

The use of technology designed to help ageing populations, especially those with dementia, is rising in social importance. The EU identifies dementia as a societal challenge and highlights the necessity for research on technology-related care (European Commission, 2015; European Parliament, 2011). Technology is perceived as promising, and significant investments have been made to advance older people’s access to, and uptake of, technological products (European Commission, 2007; European Commission, 2015). On a national level, social policies and market priorities seek to facilitate “ageing in place” through the use of technology (Kubitschke et al., 2010; van Hoof et al., 2010) which delays institutionalisation; encourages people to remain in their own home in later life (Brittain et al., 2010); saves costs (Duff and Dolphin, 2007) and reduces caregiver burden (McHugh et al., 2012). Accordingly, technology, as part of healthcare delivery for people living with dementia, is expected to grow in Europe (Kubitschke et al., 2010; Dutta et al., 2015; World Health Organization, 2012; van Hoof et al., 2010; European Parliamentary Research Service, 2016).

Surveillance technology

Surveillance technologies (STs) are devices which monitor movements with the intention to cost-effectively support health and independence (Woolrych et al., 2013). ST has particular relevance for family carers of people with dementia (Bennidge et al., 2014). ST can be generally described as comprising “monitoring systems that can allow for 24-hour supervision by carers”
(Kenner, 2008), with specific technologies including, but not limited to: monitoring devices, personal and social alarms, telecare, electric tagging and tracking, and global positioning system (Landau and Werner, 2012; Percival and Hanson, 2006; Robinson et al., 2007; Niemeijer, 2015; Mental Welfare Commission for Scotland, 2005). ST can be used to monitor people with dementia so that a carer can intervene as appropriate to increase safety (Niemeijer, 2015).

“Ageing in place” in the UK, Sweden and the Netherlands

In common with many other nations, the UK (UK), Sweden (SWE) and the Netherlands (NL) all have ageing populations. Projections show that life expectancy for 65-year olds is similar in each of these countries (UK 17.9, NL 18.2, SWE 19.8), and the proportion of older adults who live alone is also similar (UK 32 per cent, NL 32.2 per cent, SWE 39 per cent) (Eurostat, 2015; Office for National Statistics, 2017). As these societies age, the number of vulnerable people requiring long-term care also increases (Berridge et al., 2014; Niemeijer, 2015). A European study found a variety of reasons for family carers seeking to place the person living with dementia whom they care for in a care home, with common reasons including care dependency and caregiver burden (Afram et al., 2014). The use of technology has been identified as a potential solution to help carers and people with dementia to remain living in their own home, lighten the care burden and to support caregiving (Berridge et al., 2014; Kubitschke et al., 2010; Bharucha et al., 2009; Cahill et al., 2007; Kenner, 2008; Pollack, 2005; Topo, 2009).

In the UK, the government ageing agenda has an eye to cost (Duijnstee, 1992; Goins et al., 2002; Kodner, 2003; Walker, 2008). The UK National Health Service and Community Care Act (1990) highlighted the need to incorporate market forces in the delivery of services that facilitate “ageing in place” as opposed to more institutionalised care settings (Welsh Assembly Government & Alzheimer Society, 2011; Department of Health, 2006, 2009; Department of Health Social Services and Public Safety, 2011; Phillipson, 1998; The Scottish Government, 2010). Despite the differences in healthcare systems, the Netherlands and Sweden also have national health and social policies that promote the move from institutional care to “ageing in place” (Kümpers, 2005; Wimo et al., 1999). The capacity to leverage technology for increased well-being is measured by the “Networked Readiness Index”, which is similar to those in the UK, Sweden and the Netherlands (Dutta et al., 2015).

Marketing ST

Marketers have begun to recognise the importance of ST as a market and, accordingly, there has been an increase in numbers of such technological products being sold, particularly through online platforms (Rialle et al., 2008; Robinson, et al., 2009; Wan, et al., 2016). The knowledge base on how ST products for dementia are marketed is very limited, with little beyond the work of Kenner (2008) who describes an “aging enterprise” which constitutes technologies as part of a privatised consumer healthcare trend (p. 262); a trend which might not be influenced by older adults, but rather by other external pressures. These pressures include discourses that influence our understanding about diseases, as well as those affected by them, and which are often framed and negotiated through media messages (Clarke, 2006; Collin and Hughes, 2011; Lyons, 2000; Seale, 2003; Williamson and Skinner, 2011). Clarke (2006) described the importance of recognising the relations between media, disease representations and the interests of powerful organisations who play on underlying fears to market products that offer a solution (Fuller, 1998). Clarke (2006) called for a “dementia media analysis” (Miller et al., 2012; Kleebpung, 2010) to identify and assess what cultural stereotypes and values underlie the media messages that describe and portray people with dementia.

Aim

The aims of this paper are to: investigate the online market for surveillance products for people with dementia in three comparable, ageing countries (UK, SWE and NL), and to describe the marketers’ characteristics; and to respond to the call for dementia media analysis by exploring the marketing messages in online advertisements for STs for people with dementia.
Method

Environmental scan

To identify surveillance products used in dementia care, and explore media messaging used by marketers, an environmental scan methodology was used, adapted from a procedure of Choo and colleagues (Choo and Auster, 1993; Choo, 1999, 2001). Environmental scanning is an information viewing, seeking and organisational learning strategy (Aguilar, 1967; Choo and Auster, 1993; Choo, 2001) through which companies get to “know” the market in which they are situated and are able to effectively respond (Choo and Auster, 1993). Originating in a company context, healthcare researchers have started using environmental scans (Graham et al., 2008); however, there is not, as yet, a standardised approach to environmental scanning (Choo and Auster, 1993; Choo, 1999, 2001). A common approach is to seek answers to a set of pre-defined questions regarding the product of interest (Graham et al., 2008).

To provide information on the ST market for people with dementia and their carers, the environmental scan detailed in this paper entailed: an online product search; selection of eligible products through application of pre-defined eligibility criteria; extraction of product data and marketing messages through answering a set of questions for each eligible product; and data synthesis through both qualitative and quantitative means.

Search strategy

An internet search for surveillance products was carried out using the Google search engine. Search terms and their synonyms are shown in English in Table I. Each search term was translated into Dutch and Swedish for product searches in the Netherlands and Sweden, respectively (translated search terms available on request).

Eligibility criteria

The product web descriptions identified in the online search were assessed for eligibility using pre-defined eligibility criteria.

The inclusion criteria were:

- technological device that tracks and/or alerts;
- marketing makes reference to dementia, Alzheimer’s or similar;
- product can be used by a person with dementia or a carer;
- marketing website based in the Netherlands, UK or Sweden; and
- marketing of the product targets care homes, institutions, people with dementia or carers.

Exclusion criteria were:

- “non-technical” products;
- manufacturer not involved in retail;
- traders between the manufacturer and marketing website;

<table>
<thead>
<tr>
<th>Search word</th>
<th>Synonyms</th>
</tr>
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<tbody>
<tr>
<td>Surveillance technology</td>
<td>Surveillance technologies, devices, products, assistive, GPS, tracking, tagging, tracker, track, monitor, locate, locator</td>
</tr>
<tr>
<td>Dementia</td>
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<tr>
<td>Carer</td>
<td>informal caregiver, caregiver, Family caregiver, family carer</td>
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<tr>
<td>UK</td>
<td>UK, England, Great Britain</td>
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<tr>
<td>AND [...]OR</td>
<td>Safety, independence, empowerment, risk, danger, alert, peace of mind, consent, informed consent</td>
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website designers; and

webpages marketing second-hand, previously used, or previously owned goods.

Three researchers (English, Dutch and Swedish) were involved in developing the search criteria and screening the websites for information. Every website with at least two of the keywords was selected for further analysis. The researchers placed field notes in the data set, and provided descriptions of what was portrayed on websites. When a product was entered, the reviewer would screen for duplicates by the excel search function in the data set. If a duplicate was found, the new product would not be entered. However, there was a possibility that similar products were displayed by alternative websites under different circumstances. Therefore, the reviewer screened again the data set to remove repetition and irrelevant products (e.g. non-technological products sold on Amazon). This removal was carried out twice after the exclusion criteria. Duplicates of products were included only if they were provided by alternative websites using different marketing techniques.

Data extraction

A draft data extraction tool was devised, based on domains relevant to characteristics of products and marketers, and the anticipated information needs of potential users. The draft tool was validated through discussion with researchers from a “dementia and technology network” (INDUCT) and piloted by the first author after which additional subcategories (market share and growth) were added. The final data extraction tool covered nine domains, extracting information on: identification, marketer characteristics, product functional availability, target market, sales, safety, privacy and portrayals (Table II).

The extracted data were entered into an excel spreadsheet, in formats suitable for the nature of the data. Data types included nominal, categorical, numerical and qualitative formats (Table II). Qualitative data included quotations from websites. Data were collected over a period of one year, between October 2016 and October 2017, with data regarding product prices gathered on the same day in August 2017.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Item</th>
<th>Data type</th>
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<td>1 Identifiers</td>
<td>Product name</td>
<td>Nominal</td>
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<tr>
<td></td>
<td>Company/organisation name</td>
<td>Nominal</td>
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<tr>
<td>2 Marketer</td>
<td>Organisation size</td>
<td>Categorical (cottage industry, small, small-medium, medium, large)</td>
</tr>
<tr>
<td>characteristics</td>
<td></td>
<td></td>
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<tr>
<td>3 Product function</td>
<td>Main function</td>
<td>Numerical</td>
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<tr>
<td></td>
<td>Additional information</td>
<td>Categorical (track, alarm, track and alarm)</td>
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<tr>
<td>4 Availability</td>
<td>Availability in Sweden, UK, the Netherlands?</td>
<td>Categorical (yes/no)</td>
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<td></td>
<td>Country of product origin</td>
<td>Categorical (Sweden, UK, the Netherlands, Other)</td>
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<td>Categorical (online, in store, both, other)</td>
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<td>Presence of portrayals</td>
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<td></td>
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Notes: \[^a\]If the origin of a product was unclear, it was classified according to the country in which it could be purchased; \[^b\]purchase price excluded monthly fees or shipping costs
When websites did not provide information about the marketer that provided the product (e.g. size of marketer, country origin, number of employees), additional public-domain information was gathered online, for example, from LinkedIn. Classification of the size of the marketing organisation was based on the number of employees within that organisation, with “cottage industry” defined as “a small-scale informally organized industry run from home” (Investopedia, 2017) and operationalised as “online web shop indicative of; its location being a private house, a private phone number communicated, or listed with one employee usually described as the owner”. Small-scale companies were defined as having a maximum of 10 employees; small-medium between 10 and 50, medium-large between 50 and 200; and large more than 200 employees.

Data analysis
Price conversions were made into pounds and the Excel “AVERAGE” function was used for calculating the mean purchase prices. The “COUNTIF” function was used to summarise the frequency of specific words in nominal data (e.g. “safety”). For categorical items, the SUM function was used.

Findings
In total, 382 products were identified online. After the application of the eligibility criteria and removal of duplicates, 242 products remained. Reasons for exclusion included: being “non-technical” products, e.g. identification bracelets without tracking facility; and networking facility without detection monitors (e.g. for temperature, light or fire[1]). In a descending order of frequency, the identified products originated from: the UK, Australia, the USA, Sweden and the Netherlands.

Price
The purchase price of ST displayed ranges from £0 to £654 in the three countries, with similar products priced differently by different providers. Thirteen products were under £10. The headline price displayed often included extras (i.e. shipping costs, monthly fees). However, the mean price is unknown because many websites neither displayed prices, nor included extras.

Marketers
Figure 1 displays the response to the question “what is the size of the marketer”. The “cottage industry” category was the largest single category in all three countries, marketing through single-handed online web shops or companies with up to ten employees. Whereas the majority of ST marketers in the UK and Sweden were cottage industries, there was a different pattern in the Netherlands where there was more balance across the size of a company. Many marketers in the data set made unsubstantiated claims to be the market leader.

Safety
In scanning the web descriptions for “what is mainly communicated about what the product does for safety”, two main types of products were elicited; products that “detect” and those that “alert”. The latter required that the person with dementia should push an alert button in case of emergency, or that somehow the carer was made aware of an emergency, although there was generally scant detail on how, when, where or to whom alerts would be raised. Most of the detectors did not send notifications. However, some products both detected and alerted, for example, a tracker watch that could notify the carer with information about the recipients’ location and health status:

The [...] can act as both a locator for keys and bags or a tracking device for a loved one, to help keep them safe if they wander. Location tracker – cottage industry 1.
Location finding may require the carer to access real-time monitoring on a computer or phone (Kenner, 2008; Mulvenna et al., 2017):

Ideal for monitoring: pets (e.g. dogs/cats/horses etc.), children/teenagers of all ages & abilities, vulnerable adults or frail elderly who may misuse the SOS & on/off buttons e.g. autism, Alzheimer’s/ dementia sufferers. SOS button – cottage industry 2.

A minority of products were described as “preventing risk”; however, little or no explanation was provided on the mechanism for this.

Marketing by keywords and portrayals

Figure 2 illustrates the key descriptors used on websites. The greatest emphasis was on safety and security. The target problems were wandering, being lost and falls. There were differences in the diversity of keywords used in each of the three countries. In Sweden, keywords were descriptive of “spy” and “camera”. In the Netherlands, “sensor” was a common keyword. In the UK, words such as “ethics” and “consent” were used, which remarkably were not used in Sweden and the Netherlands. However, the word “consent” was not used in relation to having
approval to use ST on a person with dementia. Instead, words such as “hidden”, “discreet” and “secret” were used, indicating covert surveillance.

Keywords were often accompanied by striking visuals of people with dementia, pets, children and possessions, either kept safe through ST use, or portrayals of being lost and harmed through non-use of ST. No major between-country differences were identified in visual portrayals.

Marketing target
There were no examples of marketing messages being targeted at people living with dementia. Instead, messages were aimed at families and carers, researchers or organisations involved in social care provision:

[...] provides an ideal way for families and caregivers to keep track of the people they love. Ideal for children [...] and seniors who value their independence. It’s all about having peace of mind when you’re not there with them. Location tracker – cottage industry 3.

Our customers include: dementia & Alzheimer’s patients, stroke patients, local councils, care homes, schools, rehabilitation centers, dementia research groups, universities, cautious parents, travelers/employers. Location tracker- cottage industry 4.

Privacy
Most products identified through the environmental scan required data sharing. The majority reported that carers would receive data, such as the location of the person with dementia. However, the second largest group involved data sharing with third parties (e.g. online cloud storage, alarm centre):

GPS personal alarm and its 24/7 response service lets you to carry on with your life knowing that there is help available at the press of a button. Location tracker with SOS button – Cottage industry 5.

Few STs reported that they provided the person with dementia with the data of their location or gave them instructions to guide them home, although this is an expressed need of people with dementia (Robinson et al., 2009).

Discussion
This paper represents the first media analysis of online marketing of surveillance products for use with people with dementia. The key finding about marketers was that they were predominantly “cottage industries”, especially in the UK. In all three countries, the products being marketed were generally unsophisticated, able to either detect or alert, rather than both. Product descriptions emphasised safety and security, referencing risk situations such as wandering, falling or being lost, even where the product had no function that would prevent such risk. Advertising was targeted at carers or service providers, and not people with dementia. People with dementia were commonly portrayed as a “problem to be managed”, and the consideration of ethical issues (such as freedom to choose, consent and covert surveillance), whilst varying by country, was largely absent.

Niche market?
Huge investments have been made in the research and development of telehealth and telecare (Department of Health, 2008; Woolnchy et al., 2013), including the Whole System Demonstrator randomised controlled trial (Steventon et al., 2013) and NHS testbeds such as “Technology Integrated Health Management for dementia” (Galea et al., 2017). Yet, counter-intuitively, the majority of marketers identified in the environmental scan were “cottage industries” suggesting a “niche market”. This finding may be due to data collection being by product rather than by market share. The UK has a large home-care social alarms market, and is a significant adopter of telecare (Taylor, 2012; Goodwin, 2010; Kamalasekar, 2010; Gibson et al., 2016). People who meet the eligibility standards for social care can access pendant alarms commissioned by local authorities (Berridge et al., 2014). In Sweden, municipalities pay for alarm installation, and users contribute to this monthly service. There is a mix of public and private sector provision, with private
manufacturers financing much of the research and development into advanced telecare (Berridge et al., 2014). In the Netherlands, the social security system, municipalities, well-being organisations and other home-care organisations provide alarms but payments are not standardised but vary according to who is using the technology, and for what purpose (Kubitschke et al., 2010).

Not “fit for purpose”?
The number of websites claiming to be “market leader” suggests that a certain amount of creative licence was employed in advertising, and it was clear that many products had been re-purposed for the dementia market having originally been designed for a different use.

People living with dementia have expressed the need for technologies to have a simple user interface that can be tailored to individual needs and skills that allows people with dementia to engage in everyday activity and allows carers to have a break knowing that they will receive an alert if risk situations arise (Dixon, 2016), such as personalised notifications when the person with dementia leaves an area of safety (Phillips and Zhao, 1993; Schulz et al., 2012; Seelman, 2012). However, the majority of identified products could either detect or alert, or required real-time monitoring.

Carers have concerns over false alarms (Dixon, 2016; Niemeijer, 2015; Hall et al., 2017), privacy (Dixon, 2016), and data sharing with other parties (Robinson et al., 2007; Fisk, 2015; Niemeijer, 2015) yet most products involved third parties such as call centres. Product descriptions included only limited information on functionality, and focussed instead on risks such as falling, wandering and getting lost. Whilst the promotion of ST products emphasises independence and safety (Kenner, 2008), this outcome has not necessarily been established through research (Futrell and Mellilo, 2002; Hughes, 2008a, b; Marr, 1989; MWCS, 2005; Moffat, 2008; Nelson et al., 2004; Niemeijer, 2015; Plastow, 2006; Robinson et al., 2007; Sävenstedt et al., 2006; Welsh et al., 2003). Alerts from ST devices can signal when a fall happens, but do not avert the fall. The question posed by Niemeijer et al. (2015, p. 124) therefore remains unanswered: “[…] does ST actually offer more security?”

Throughout the EU, there is an expectation that businesses to not misrepresent their products when advertising to consumers (Collins, 2005; Van Boom, 2015). The “Unfair Commercial Practices” directive underpins the national advertising authorities in the UK, the Netherlands and Sweden (Advertising Standards Authority, 2018; Netherlands Enterprise Agency, 2018; Reklamombudsmannen, 2017). Consumers in the three countries can submit complaints about misleading advertisements, and companies are penalised where complaints are upheld. However, problematic practices are not always addressed (Van Boom, 2015), and in a media-rich online environment, consumers may not be aware of being misled (Van Boom, 2015; Mitra et al., 2008).

Portrayals of dementia
The portrayal of people with dementia as a “problem to be managed” has been highlighted in previous research (Rozanova et al., 2016). Placing people with dementia in the same class as wallets, keys, young children, dogs and/or prisoners is reminiscent of the “objectification” described in healthcare prior to the person-centred care movement, and is concordant with “abjection”, a defining feature of the social imaginary of the fourth age (Higgs and Gilleard, 2014). Marketers may have simply adapted existing advertising materials when dementia care was identified as a potential new market, assuming a lack of autonomy and decision-making capacity in line with the “empty shell” portrayal of dementia (Alzheimer Europe, 2013).

No marketing was directed at the person with dementia themselves, even though people in early stages of dementia may choose to engage with ST, for example, actively seeking out devices such as ST bracelets (Niemeijer, 2015), safe in the knowledge that they can be monitored by a “supportive other”. In these circumstances, ST can indeed help to maintain independence (Essén, 2008) and freedom (Dorrestijn and Verbeek, 2013), reflecting Foucault’s (1997) notion of freedom incorporating an individual’s conscious choice to use technology.

There was between-country discrepancy in use of terms such as “ethics” and “consent”, but none of the marketers considered personal choice of the person with dementia. Little information was provided on the acceptability of surveillance devices from the perspective of people with dementia.
Whilst most products are solely designed for, and used by, carers (Topo 2009; Demers et al., 2009), this should not mean that the perspective of the person with dementia should be ignored. Some people may not like having an unfamiliar device attached to them (McShane et al., 1998; Wan et al., 2016) and may take off items such as pendants or bracelets. As Niemeijer et al. (2015) observed, when an ST bracelet is taken off, it no longer does its job. This may explain the emphasis on “hidden” devices for covert monitoring.

Media representations of dementia can influence interactions with people with dementia and make a difference to the utilisation of healthcare resources (Kessler and Schwender, 2012). Bodies now exist that review and counteract media messages. For example, the Glasgow Media Group (GMG) reviewed various claims used in the media (e.g. issues of war, representations of AIDS, communications of risk), and how this impacts negatively on certain groups (e.g. refugees, disabled people) (Briant et al., 2011; Eldridge, 2000). Whilst members of the GMG have worked, and continue to work, to publicise their critiques (Eldridge, 2000), the unhelpful media coverage of dementia keeps on growing (Kessler and Schwender, 2012).

Implications for stakeholders

There are important implications from this study for a range of stakeholders including manufacturers, marketers, the media and researchers, in addition to all those living with dementia. Families, and people living with dementia themselves, should consider the power of media messaging which may present out-of-date and inappropriate technology as “tried and tested” or “market leading”, or may emphasise safety enhancement or risk reduction for products that provide only “after the event” alerts. Organisations that support people with dementia and their families could play a role in highlighting some of the decisions that need to be made, such as whether a product has the appropriate combination of detection and alerting functions to suit an individual’s particular circumstances. In addition, support organisations could also highlight ethical considerations of surveillance, for example, whether a person with dementia themselves is choosing to use technology, or whether carers are making choices in circumstances that do not yet require “best interests” decision making (for an illustration of carer fears over safety leading to autonomy restriction, see Graneheim et al., 2001). Manufacturers and marketers should pay closer attention to the potential market of people in the early stages of dementia who can express their own needs and preferences. Furthermore, marketers and the media should be made aware of the potential for stigma exacerbation from media messages that objectify people with dementia.

Conclusion

This paper draws attention to an emerging issue of ST for people with dementia. The marketing of ST does not take into consideration the needs of people with dementia themselves. The marketing of STs raises issues of rights, autonomy, dignity, privacy and consent but all too often the marketers’ messages run counter to the maintenance of dignity in later life.

Note

1. Detection monitors that raise alerts are used to manage potential risk situations, for example, when a person with dementia continues to use their own kitchen but is at risk of causing a fire by forgetting to turn off the gas to the stove.

References


Kamalasekar, S. (2010), “European remote patient monitoring market”, available at: www.frost.com/sublib/display-report.do?bdata=aHR0cDovL3d3dy5mcm9zdC5jb20vYXJzdC9tZXRyaWJscy9zaG9yaWJscy9zaG9yaWJscy5wYWci%2FaWQ9TTE9EQ0-wMS0wMC0wMC0wMC0wMEB%2BQ1JhY2tAfhAxMTAxOzYyODY1NjixZzg2&icid=M5DB-01-00-00 (accessed 24 October 2017).


Mental Welfare Commission for Scotland (2005), Safe to Wander? Principles and Guidance on Good Practice in Care for Residents with Dementia and Related Disorders Where Consideration is being given to the Use of Wandering Technologies in Care Homes and Hospitals, Mental welfare commission for Scotland, Edinburgh.


National Health Service and Community Care Act (1990), National Health Service and Community Care Act, HMSO, London, 74, pp. 165-244.


Further reading


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**How to Handle Later Life**

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Amaranth Books Ltd
Dorking
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10.1108/QAOA-03-2019-060

How to Handle Later Life aims to provide comprehensive, relevant and accessible information to enable those approaching later life, and interested others, to successfully navigate the experiences and challenges that may be encountered. The book is intended to do the legwork for readers, simplifying access to key information on numerous issues. Following on from Shoard’s (2004) previous publication *A Survival Guide to Later Life*, this longer, more substantial, self-help book makes available an impressive 1,143 pages of material. Designed as a reference book to dip in and out of, the scope and length need not worry you.

The content is both extensive and diverse with 12 sections comprising 41 chapters. Part 1, “growing older”, is intended for all to peruse; this section sets the foundation for the rest of the book and includes chapters on the ageing body; food, drink and temperature; physical activity; and psychological well-being. Following this opening section, the subsequent 11 parts focus on topics that Shoard invites you to “hop, skip and jump [...] around” (p. 3) – to be examined as and when required.

Early sections deliver an abundance of information. The housing part covers the decision to move or not and the role of sheltered or retirement housing or villages. Advice is varied, including to try a stair-lift out before you buy one and to use worn alarm pendants rather than fixed versions. A section on connections examines closely relationships and communication in later life, exploring group activities, use of computers and the internet and the role of animals.

The following two sections cover the world of healthcare and healthcare provision. The National Health Service and provision for strokes, anxiety/depression, falls, continence and dementia are all explored. Shoard goes on to consider practical help such as, equipment, telecare, human help and live-in care and help from the council encompassing social care, assessments, support for carers and organising and paying for care and support. Turning her attention to maintaining the ability to go out and about, Shoard provides content on the legal requirements of organisations and offers multiple tips to maximise independence in later life. Later sections offer material on the roles of representatives and advisors such as, powers of attorney, deputies, guardians, advisors and advocates. Money matters are examined including universal state benefits, means tested benefits, earning, investing and bestowing. Final chapters make explicit aspects to be considered when staying in and leaving hospitals and at the end of life. Cross-referencing is prevalent throughout the book and a convenient glossary is provided. A list of “useful contacts” is present as a last hurrah for readers to obtain information from other sources.

This ambitious, large-scale book is the culmination of many years of dedicated work, starting as a result of Shoard herself traversing the complex arena of eldercare for her mother. It offers a wealth of information to guide older people and their relatives. While this work is a desirable, detailed, practical and common sense addition to the self-help literature focussed on older age, it will have limited applicability for those outside of the UK context. Additionally, much of the content, rather than standing the test of time, is likely to require regular updates as systems, organisations and policies change.

Despite these limits to wider relevance, Shoard appears to have largely met her brief, delivering a comprehensive, accomplished resource, a plethora of knowledge, which is likely to allow those approaching, or in, later life and their loved ones to deal with the complex systems of care, housing, hospitals and finances, as well as maximising the
positive aspects of life and well-being at this stage of their lives. The sizeable book is accessible, due to its clear writing style and easy navigation, with sections and chapters complemented with useful summaries and all locatable via blue page markers. Readers of this work are likely to develop an increased understanding and awareness of issues of later life, which as Shoard writes is “a world of endless inter-connections” (p. xiii).

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