Do Assessment Tools Shape Policy Preferences? Analysing Policy Framing Effects on Older Adults' Conceptualisation of Autonomy

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Abstract

The concept of autonomy is essential in the practice and study of gerontology and in long-term care policies. For older adults with expanding care needs, scores from tightly specified assessment instruments, which aim to measure the autonomy of service users, usually determine access to social services. These instruments emphasise functional independence in the performance of activities of daily living. In an effort to broaden the understanding of autonomy into needs assessment practice, the province of Québec (Canada) added social and relational elements into the assessment tool. In the wake of these changes, this article studies the interaction between the use of assessment instruments and the extent to which they alter how older adults define their autonomy as service users. This matters since the conceptualisation of autonomy shapes the formulation of long-term care policy problems, influencing both the demand and supply of services and the types of services that ought to be prioritised by governments. Relying on focus groups, this study shows that the functional autonomy frame dominates problem definitions, while social/relational framings are marginal. This reflects the more authoritative weight of functional autonomy within the assessment tool and contributes to the biomedicalisation of aging.

Keywords: Policy Framing; Social Services; Aging Policy; Autonomy; Needs Assessment; Biomedicalisation of Aging

Introduction

Autonomy is a central concept in the lives of older adults. For instance, they are frequently targeted by active aging strategies (Boudiny, 2013) involving promotional campaigns seeking to enhance, or at the very least sustain, autonomy (Walker and Maltby, 2012). Autonomy is also front and centre in the scholarship on care services for older adults, especially for those being assessed for home care services or long-term care (LTC) placement (Le Bihan and

Martin, 2006). Given the centrality of this concept in the framing of social services for older adults, we assess how they subjectively frame their own autonomy as current, or potential social service recipients.

The prominence of the autonomy concept in care services dates to the mid-1980s when there was an effort to bring longstanding debates about autonomy in the discipline of medical ethics into the more practical enterprise of care services for older adults (Collopy, 1988). Autonomy has since become tightly specified through its operationalization in highly technical assessment instruments, such as the MDS-RAI (minimum data-set – resident assessment instrument), deployed to determine needs and service eligibility for older adults in many industrialised countries. Yet, it remains a contested concept, as new definitions drawing from a wide range of scholarship have challenged the individualist assumptions upon which autonomy has been traditionally ontologically grounded (Agich, 2003; Perkins et al., 2012).

This contribution studies the influence of assessment tools in framing both the understanding of autonomy for older adults and the priorities of public social services. This is all the more relevant in light of the noted gap between autonomy assessments and perceived autonomy by older adults (Hwang et al., 2006) and divergent understandings of successful aging between the medical community and older adults (Bowling, 2007). This study aims to broaden our knowledge between the conceptualisation of autonomy by both social services professionals and older adults. To achieve this, we assess how older adults understand the concept as it relates to formal and informal home care services in the province of Québec, Canada. Specifically, we conducted focus groups with older adult service users to examine their relationships with the physical and social environment, and to elicit responses that reflect their understanding of autonomy. Given the growing emphasis on incorporating more social/relational understandings of autonomy in the assessment tools, this contribution investigates whether these emergent problem definitions have influenced older adults' framings of the concept. We define informal care services broadly as those provided by friends or family, as opposed to formal home care provided by professional care workers, mostly funded by the Québec government. This distinction is important because receiving informal social supports can make care recipients feel less autonomous than receiving formal care services (Grootegoed and Van Dijk 2012). Therefore, we sought to complement the discussion of autonomy framing with a discussion of provision preferences for different home care services.

Drawing from the problem definition literature, developing concrete measures for a policy problem both increases pressure to respond to it, and significantly constrains the universe of possible solutions (Stone, 1997). At the individual level, the stability of system level effects can act to normalise information processing, resulting in uniform understandings of problem definition that are resistant to change by competing definitions (Wood and Vedlitz, 2007).

This is the essence of the policy framing process, where pervasive ideas embedded within the discourse around a policy issue shape the way it is understood (Rein and Schön, 1993). In this way, the highly technical measures of functional autonomy generated by assessment instruments should produce discernible and uniform effects on the older adults whose service usage is determined by them.

As part of the growing attention granted to social determinants of health, there has been a shift towards a broader understanding of autonomy through various programs, such as successful aging, healthy aging and active aging (Bowling, 2007; Boudiny, 2013). This coincides with the increasing popularity of relational autonomy conceptualisations, which emphasise the interdependence of human experience (Ho, 2008; Perkins et al., 2012). Proponents of relational autonomy argue that dominant social norms tend to shape ideas and attitudes in ways that limit autonomy, while generating and reinforcing systems of social support enhances it (Mackenzie and Stoljar, 2000). In the context of service provision this requires extending beyond the client or end-user with a broader view of the social support network.

These broader conceptual foundations have been reflected in newer versions of assessment instruments, which incorporate less individualised measures that privilege service users' unique social context. In Québec, health and social service practitioners utilise the SMAF (Functional Autonomy Measurement System, in English), which supplements functional autonomy measures with additional measures tapping social attributes of service recipients (Pinsonnault et al., 2009). This creates a unique opportunity for social/relational autonomy problem definitions to influence service users' understandings of both their needs and the corresponding role of social services. For instance, assessment questions measuring access to social support could eventually bring remediations of social autonomy deficits – such as social clubs and day programs – to the same privileged position held by interventions into functional autonomy, such as hydraulic lifts and attendant care. However, without an established link to specialised care practices, the more social/relational conceptualisations do not displace the more pervasive understanding of functional autonomy, buttressed by the tightly specified and replicable measures contained within the assessment tools.

This study demonstrates that functional autonomy remains the dominant policy framing of social service provision for this population. First, assessment instruments used to determine service eligibility have long prioritised notions of functional autonomy. This is reflected in the persistent use of indicators corresponding to the capacity of older adults to participate in activities of daily living (ADLs), and instrumental ADLs (IADLs), two concepts which have featured heavily in assessment instruments since the 1960s (Katz et al., 1963; Lawton and Brody, 1969). Second, the association of aging with decreasing autonomy among older adults, when constructed as a policy problem, acts to shape their personal understandings of how they fit within the social services landscape. In

particular, older adults emphasise the preservation of functional autonomy as a primary goal of health and social service provision even though they may not share the same understanding of autonomy.

We begin with a review of relevant policy framing literature, with specific attention to how framing processes constitute policy problem definition. This is followed by a description of the nature and use of assessment instruments in social service delivery. Specifically, we examine how the autonomy concept has been represented across various assessment instruments targeting older adults as social service users. This leads to the presentation of our focus group research, and an analysis of how participants differently employed functional and social/relational autonomy framings. We conclude by examining the implications of dominant functional autonomy framings on older adults' experiences as social service users.

Problem definition and framing effects

Problem definition is a central element of the policy problems literature (Peters, 2005). There has been an emphasis on how the specific framing of policy problems is reflected in the resulting discourse on the problem, and ultimately in the universe of conceivable solutions (Rein and Schön, 1993; Peters, 2005). For instance, Bacchi (1999) focuses on the framing of policy problems from a perspective that emphasises the instrumental quality of problem representations in structuring policy discourse, and the resulting implications for the lived effects of policies. She argues that the interpretation of policy problems by constituents is a fundamental aspect of understanding *what* the problem is (p.48). The focus on framing effects points to a dialogical relationship between the discursive construction of a policy problem and its interpretation by those whom it affects.

The ways that problems are communicated or interpreted plays a role in framing problem definitions. Stone (1997) examines several means of policy problem definition – through symbols, numbers, causes, interests and decisions –, which are noteworthy for triggering different types of public perception. For instance, numbers, which are more amenable to measurement, convey a certain authoritative weight that disproportionately emphasises a problem's countable effects, while distracting attention from the other non-categorical features of a problem (p.165). Hence, the way a problem is measured can reinforce dominant policy frames at the individual level (Bosso, 1994). Satisficing behaviour is also more likely when cognitive heuristics give individuals a sense of certainty when processing a given issue, which increase the tendency for individuals to consider policy problems to be serious and be confident in their judgements (Wood and Vedlitz, 2007). Dominant policy frames have far-reaching effects on individual calculations.

Frames can also be adopted or altered throughout the policy process. Rein (2006) addresses the issue of policy reframing, which occurs as different policy frames are adopted through processes such as 'creaming' and 'offloading' as a

policy is implemented. This shifts the dominant problem frame and requires a more nuanced understanding of the participation of various actors in the policy process. Drawing from this work, Van Hulst and Yanow (2016) argue that reframing can have different implications depending on 'what' is being framed, identifying three types of entities: the substance of a policy issue, the policy process, and the identities and relationships of individuals within it (p. 102). Crucially, they argue that the process of framing and reframing involves the act of sense-making, and therefore becomes extremely complicated when it is applied to entities such as personal identities, which involve emotional attachments. A consistent takeaway from this reframing literature is that, despite the singularity of dominant policy frames, there may be numerous opportunities for opposing frames to influence policy.

Frame ambiguity occurs when 'weak frames' co-exist alongside dominant frames as a way to compromise between competing aspirations among political/policy actors (Dekker, 2017). This type of ambiguity can be a bellwether of conflict between problem definitions, where a long-dominant definition faces competition from a newer one that has not yet gained legitimacy (Bosso, 1994: 199). The present contribution investigates whether frame ambiguity can manifest in tightly specified policy tools, such as service assessment instruments. The literature suggests that these instruments convey an authoritative weight that is more likely to privilege dominant policy framings.

We expect that older adult service users will consistently define their service needs within a functional autonomy problem frame. More specifically, we expect that their accounts will emphasise functional autonomy in terms of ADLs and IADLs, which are the dominant measures used by the service instruments. Explicitly, this implies that older adult service users will refer to their autonomy as it relates to specific activities that are used to determine whether they should age in place or transition to LTC. Second, we expect that needs related to preserving social autonomy will be given relatively far less emphasis by older adult service users. Insofar as these needs are acknowledged, we expect older adults to associate them with informal care from family and community groups, rather than professionalised government services.

Autonomy assessments

Autonomy instruments play a determining role in the lives of older adults requiring assistance. Once filled out by professionals, the final score triggers access to available services and supports. This can range from assistance with cleaning and meal preparation to placement in an LTC facility. In industrialised countries, the most popular form of assessment is the MDS-RAI suite. Originally commissioned by the Health Quality Bureau of the US Health Care Finance Administration, it aims to review and harmonise more than 80 assessment tools

utilised to classify behavioural and performance assessment and symptoms (Carpenter and Hirdes, 2013: 95). Advocates of the interRAI system begin with the premise that "(o)nly by using reliable data with understandable and comparable constructs can one begin to make progress in determining cost effective services that maintain quality of care" (Carpenter and Hirdes, 2013: 94).

Within this context grew the commitment to standardise needs assessment across jurisdictions. As displayed prominently on the interRAI website, the standardised tool aims to ensure that users are "speaking the same language for high quality care".[1] This allows a comparative snapshot of relative autonomy across countries and assumes a universal understanding and definition of the concept. The standardisation of autonomy measures across numerous generations of MDS-RAI instruments, in addition to the expansion of the minimum data set with increasing longitudinal data and more member countries, has led to matching standardisation in the corresponding strategies and methodologies for providing geriatric care (Bernabei et al., 2008).

The focus groups took place in Québec, which employs the unique SMAF assessment tool, rather than the interRAI-HC tool used by the other Canadian provinces for homecare assessment.[2] Although both assessments use nearly identical items to tap functional autonomy, since 1998 the SMAF has contained an additional social component designed to measure social indicators of autonomy in six unique domains: social support, social activities and leisure, social roles, social relationships, social resources, and social network and assertiveness. While the social autonomy measures have been found to be reliable through validation studies (Pinsonnault et al., 2009), no study has yet identified an influence of the social-SMAF on shaping practices of care provision, although it has been criticised for its relatively minor importance (Delli-Colli et al., 2013).

Due to the overwhelming emphasis on functional and cognitive abilities, autonomy is often thought to decrease with age, without considering fully how individuals adapt their living environments (social and physical) to address their needs. This corresponds to what Agich (2003) calls the paradoxical centrality of the autonomy concept in LTC, contrasting the theoretical foundations of autonomy in individualist notions of independence and personal capacity with its practical application in care settings where individuals are defined by dependency and loss of functionality. This has led some to critique the centrality of the ethic of autonomy in LTC practices, owing to its inherent devaluation of dependent older adults (Pullman, 1999).

This also involves a logic of access to services reminiscent of means-tested benefits, which are prominent in income security in industrialised countries. Indeed, social service provision, specifically home care, is often 'needs-tested', meaning service uptake must be determined by a state agent (Anttonen, 2002: 78). Needs testing is informed by awareness of all available services, such that the state acts as a purveyor of last resort and individuals must demonstrate

their inability to function independently with regards to ADLs. As with income, the higher the loss the greater the support. This inherent logic is reflected clearly in the deployment of the SMAF since it demonstrates the divergent positionality of older adults, caregivers and the professionals who aim to administer the assessment neutrally. Older adults, fearful of institutionalisation, will tend to claim that they are more functionally capable than caregivers or professionals would. This is compounded for older adults in Quebec whose median income is notably low, thus decreasing the demand for private care options (Marier et al., 2018). Caregivers, on the other hand, fearful of service scarcity have the tendency to emphasise the loss of functional and cognitive abilities to ensure that they will not have to accentuate their assistance (Gilbert et al., 2018).

The deployment of the assessment tools should have important consequences on how older adults define policy problems surrounding social issues related to autonomy. These are likely to be ill-defined or predominantly expressed in terms of medical interventions, as put forth in the SMAF assessment tool. As such, we expect that the assessment tool will counteract frame ambiguity and reinforce the dominant policy framing of social services for older adults as interventions targeting declines in functional autonomy.

Methodology

We conducted focus groups as our primary data collection strategy with the aim of including as many respondents as possible and to allow room for different perspectives on the framing of autonomy in social services to emerge. Focus groups are also beneficial for fostering processes of interaction both among respondents and with researchers. This interaction can be understood as an iterative process that empowers and encourages participants to think critically about discussion topics (Litosseliti, 2003). Interaction is also a product, generated by participants' freedom to engage with each other, voice consensus and disagreement, and ask for elaboration (Morgan, 1996: 139). In these ways, interaction gives depth to the discussion, which is particularly valuable when trying to gain access to shared understandings among social groups.

To capture the service perspectives of older adults, we recruited from community groups in both Greater Montréal and Québec City. Sampling from a pre-existing social group does not prevent potential limitations of the focus group methodology, particularly forms of participant bias, such as groupthink or intergroup conflict. These pitfalls are inherent to the focus group method and can only be mitigated through careful preparation and vigilant implementation. However, because group interaction is the primary product of focus group research, familiarity among group members enables stable dynamics of group consciousness, which are highly useful when exploring the resonance of contested concepts across a specific social group (Marier et al., 2020). In this way, the methodological benefits of the

sampling strategy outweighed potential limitations inherent to focus group methods. To facilitate recruitment, the principal investigator contacted the Réseau FADOQ (a federation regrouping social clubs for older adults across the province) or relied on contacts associated with the *Centre de recherche et d'expertise en gerontologies sociale* (CREGÉS) to reach other organisations involved with older adults potentially interested in participating in the study.

Between April 2016 to March 2017, we conducted eight focus groups composed of 7 to 15 older adults in the greater Montréal region (n=4) and in Québec City (n=4). Of the eight, five were conducted in French and three in English. The total sample consisted of seventy-seven older adults, ranging in age between 60 to 96 years old. Focus groups were mixed gender: however, males represented only ten percent of the total participants. While the magnitude of the gender disparity was surprising, we expected higher female participation owing to their higher rate of club membership. We did not choose to decrease the gender disparity through more purposive sampling strategies because these types of interventions may have negatively affected natural group dynamics among club members. Moreover, assessing gender differences in the framing of social services is not the primary objective of the study. Instead, we sought variation in terms of what types of social services participants used. To ensure a broad discussion of autonomy and its conceptualisation, we purposefully sought heterogeneous groups regarding their functional autonomy. As such, participants were not assessed on their levels of functional autonomy to participate. Variation in functional autonomy became apparent during focus groups discussions, where participants disclosed their impairments or fear of future impairment in relation to social service usage.

Research team members animated each focus group, obtaining consent from every participant prior to beginning the sessions. Those who wished not to participate were excluded, and their identifying information was not recorded. Each participant was provided a consent form with contact information, which extended the opportunity to withdraw following the focus groups. The eleven-item questionnaire purposefully avoided mentioning the assessment instrument or health-related services. Questions on social services did not provide specific examples of available services or their alternatives to ensure that participants provided their own indications of what these are and should be. Each session lasted one and a half to two hours and was audio recorded, with transcription occurring soon after.

Analysis and coding of the transcripts was conducted using NVivo. Using a grounded theory approach, the 8 verbatims were first coded by one research assistant and 3 of them were coded by a second research assistant. Code saturation was reached within the analyses of the 8 focus groups. Each research assistant organised open codes into themes, which were compared for consistency by the research team.

Focus group participants were asked open-ended questions corresponding to three dimensions of their interactions with policy and social service structures. The first domain corresponds to social services in a general sense and focuses on service uptake and where the onus of responsibility should be placed for service provision. The second domain covers the local environment, where we sought to elicit qualitative appraisals of both the physical and social environment from the perspectives of older adult service users. The third domain focuses on the generosity of financial support programs, with an emphasis on where funding is currently offered, who should take responsibility for this support, and what areas are deemed most important for greater investment. These dimensions were selected since they represent key areas where the capacity for autonomy can be exhibited. Members of the research team avoided directly using the term 'autonomy' during the focus groups; to observe how often participants independently employed the term.

Findings

The focus group transcripts capture the dominant framing that participants used when discussing their autonomy in relation to tasks and activities connected to social services, specifically home care. French transcripts were coded prior to translation and some of the quotations included in this section are translations conducted afterwards by the research team. All quotations in the text are represented without identifying information such as name and location to protect confidentiality.

We created two primary categories under which coded excerpts were sorted. The first contains functional framings of autonomy by service users, including discussion about ADLs and IADLs, and a focus on physical and individually bound aspects of autonomy in the social service context. The second relates to social/relational framings of autonomy, where autonomy was discussed relative to the quality and availability of social supports. The framings in this category involve autonomy in the context of care received from friends and family, or more formal forms of care targeting social support, such as day programs. Perception of social support has been shown to be a key determinant of autonomy in care contexts (Hwang et al., 2006): however, these relationships of inter-dependence and social connection have been historically undervalued in care work (Mackenzie and Stoljar, 2000).

Functional autonomy framing

As expected, participants emphasised functional autonomy in focus group discussions. Participants made frequent mention of their capacity for ADLs such as toileting or washing, IADLs such as shopping or cleaning the house, as well as communication or physical functionality, and decision-making. With a stark

preference for 'aging in place', participants framed discussions of their personal capacity in terms of functional autonomy, mirroring the criteria both for receiving home care services and for placement in LTC. Given that all participants were still living at home, it is unsurprising that the primary role of social services was often understood as the maintenance of functional autonomy. This was particularly clear in discussions of the physical environment, where participants identified a public responsibility to provide more accessible spaces and adapted transportation to facilitate autonomy in the performance of IADLs, such as grocery shopping and snow removal. The data demonstrate that participants closely linked their potential to age in place to the quality of services promoting their functional autonomy. More specifically, participants were critical of public social service provision offered by local health and community centres (CLSC in French), to which they associated the most responsibility for preserving functional autonomy.

"I am having a terrible time with transportation. I have applied for adapted transport. All of the papers came back to me that there is not sufficient information. . . . If I need a driver to take me to a medical appointment, I have to pay for it. I am living on a very, very limited income, and everything I have to pay for is a hardship."

(E9, Female, age 72)

"Me, I manage on my own at home. I am the one who does everything. I use the snow blower, and it's me who mows the lawn, but now I am nearing 70. It's come to the point where I am going to have to seek help. But how? Where is the help? So then (?) I will have to talk to CLSC (the local health community and social services centre). (hesitation) I see no other way out."

(A3, Female, age 69)

Another key finding was that participants tended to frame their discussion of services in terms that closely match the measures of the instruments. Several participants used exact measures to demonstrate the shortcomings of existing home care services, such as the means-tested cost per hour of publicly subsidised house cleaning. What is most interesting about these types of responses is that they adopted the language of service instruments to critique the quality of services themselves. For example, the measure of baths per week was introduced by a participant to criticise the indignity of enduring one weekly bath in order to continue receiving home care, while another focused on diminished assistance for house cleaning.

"I find that when it comes to services in the area, we do not have that many available to us. And I've experienced this with my husband's cancer. When you are offered one bath per week, for a person going through cancer and who already suffers from incontinence . . . err, well I can tell you that your pride takes a blow . . . we have a long way to go."

(B5, Female)

"I'm on my own . . . I have two brothers, who are here, but I've recently been operated on and I cannot carry more than 10 pounds for 2 months . . . . I wonder if I would be able to get help from someone. You can't even sweep. I like to think that housekeeping, you can neglect it a bit, but two months . . . When you are used to having a clean home, you cannot neglect it."

(A5, Female, age 73)

Participants criticised home care provision, particularly as it corresponded to lacking capacity in their own functional autonomy. If resisting LTC at all costs is a major priority, it seems counterintuitive for participants to acknowledge lacking capacity in any domain; especially those that determine home care eligibility. Indeed, hesitancy to admit functional decline has been repeatedly observed in the literature on older adults' autonomy (Söderberg et al., 2013). However, much of the criticism directed at home care in the focus groups was based on the failure of current service provision to meet a reasonable threshold of basic needs required in order to age in place. In this light, participants' lack of capacity for functional autonomy was directly attributed to the shortcomings of home care services. As such, this content supports the framing of social services within a functional autonomy problem definition.

"If you want to stay at home, well first, you will need a snow blower, you will need someone to mow your lawn . . . . If you are unable to go outside of your home, you will need to have some special stairs installed. All these things, it's you who has to pay for them. Ok, you will receive a 30% tax credit . . . Wow . . . How am I able to consider myself at home, if I am not able to mow the lawn, shovel the snow? What do you do? You go to an old people's home"

(G5, Male, age 71)

"There are no other alternatives! I don't see any. To have a man do everything (hesitation). It's difficult to find someone reliable. But this year, I even climbed the snowbank and I took off the snow from the roof. It's not easy! You know, my health that takes a hit as well. That's it. That's the way it is."

(A3, Female, age 69)

The above quotations demonstrate that older adults' relationship to their functional autonomy within the social services context contains more nuance than is typically presented in dichotomous accounts of aging in place vs. institutionalisation. While the findings confirm our core expectations regarding the influence of ADL/IADL framings on older adults' framings of their own autonomy, our expectations were confounded by persistent scepticism about aging in place as a viable strategy. Drawing from the gerontological literature, we expected that older adults would employ functional autonomy framings as a way of defending their capability to age in place (Agich, 2003; Collopy, 1988). The preference to age in place is thought to stem from the desire to control aspects of one's life (Morgan and Brazda, 2013), which is seen as a significant contributor to personal autonomy

(Simon-Rusinowitz and Hofland, 1993). However, focus group participants consistently framed this control over aspects of their functional autonomy – specifically ADLs and IADLs – as a burden. This is significant because it demonstrates that they feel able to assert control over where they receive care. As such, the desire to age in place does not affect their appraisals of personal or functional autonomy. Surprisingly, focus group participants frequently used the functional autonomy framing as a device to critique external conditions, in addition to evaluating their personal autonomy.

Social/relational autonomy framing

Social factors related to autonomy were given much less emphasis by focus group participants, particularly as they pertain to public services. Despite a questionnaire geared strongly on the social dimensions of autonomy, participants placed limited emphasis on the role of professionalised services in accounting for the loss of social dimensions of autonomy in older adulthood. Instead, informal care services such as social support from family and friends were emphasised by participants, who tended to situate these types of support outside of the role of government. In particular, family members were the preferred supports for daily activities. However, paradoxically, participants also frequently expressed concern about being burdensome to family with needs related to autonomy loss. In this way, relying on family members was often described as a last resort measure.

"The majority of people here could use a car, but when you are sick, you are no longer able to take advantage of your car. What do we have to do? Well then, you have to rely on your kids . . . "

(G5, Male, age 71)

"What happens when there isn't a lot of family with money? When you stay in a house, have you thought of that? Are there services to help these people? I ask myself these questions for once my husband is gone, or when I will no longer be here."

(A2, Female, age 79)

These expressions of hesitancy to rely on family members coincide with a study of Québec baby-boomers, who expect public social services to offer the assistance they need (Guberman et al., 2012). A negative consequence of this hesitancy is the potential for social isolation, which is compounded by decreases in, or lack altogether of, engagement with neighbours and friends. Among the focus groups participants, neighbours and friends were identified as important supports in mitigating individual loss of social elements related to autonomy. Respondents appeared more willing to accept support from friends and neighbours than family members, perhaps reflecting less stigma around accepting

care from this group. However, respondents also reported feeling more isolated from friends and neighbours than they did from family, perhaps reflecting the difficulty of intergenerational socialisation. Feelings of isolation and poor social networks decrease the advantages of aging in place and can lead prematurely to admission in a residential care facility (Bharucha et al., 2004).

"We could also say friends but also sometimes because I can say that thanks to (friend's name) I receive a lot of support ever since I was left alone, it's been 2 years now. I have a lot of support, it's important to have friends."

(A5, Female, age 73)

"Yeah my neighbourhood is ok. But you don't have people – nobody is coming to help. No neighbours knocking on your door to say 'how are ya?'. I have a neighbour and she would never knock to say 'how are you doing today?' . . . "

(F1, Female, age 70)

While focus group participants acknowledged the importance of family and friends in maintaining social autonomy, they were far less critical of these groups than of government when support was lacking. There were low expectations placed on public services; and participants' activity in community groups for older adults helped to mitigate some of the loss of social autonomy. In some cases, group involvement even helped to compensate for the lack of functional autonomy-oriented government services, as in the below example of an individual receiving transportation from a fellow club member. However, in another important way, the focus group content demonstrates the extent to which participants did not consider their social autonomy to be a pressing problem, particularly from a policy perspective. There was a consistent tendency to frame the preservation of social autonomy as the responsibility of the individual, while the preservation of functional autonomy was more the responsibility of the Ministry of Health and Social Services. The presence of community groups and social clubs represented vital social resources for participants.

"But, recently when I had to go to the hospital . . . well somebody from the seniors' club – (person's name) he drove me to the (hospital name) and he stayed there while I had whatever was done, and he took me around in the wheelchair from . . . second floor up to the nineteenth floor, wherever it was where I had to go. I don't know how in the world I would be able to manage to be able to get around myself for all of those things."

(E9, Female, age 72)

"Me, I think that a social club in a district, I think it's important because people, sometimes, when someone is left alone at some point will maybe start to visit social clubs because a wife lost her husband or a husband lost his wife. There they make friends, there they enter into contact with others, and I think that at that point they see life differently. There, they feel like they need the help they can get. I'm a firm believer of that."

(A7, Female)

The focus group discussions demonstrate that, despite the appearance of social/relational framings of autonomy on assessment instruments such as the SMAF used in Québec, these framings have not affected the way older adults understand and appraise the social services they receive. Moreover, several clear lines of demarcation appear between focus group participants' expectations regarding formal and informal care in the provision of social services. Specifically, participants appeared more willing to cede control over aspects of their care to public service providers and were much more resistant to burdening family members and friends. Proponents of a more relational approach to the autonomy of care recipients have argued that this formal/informal dichotomy benefits clinicians, who see family members as sources of potential conflict, specifically concerning assessment and decision-making (Ho, 2008).

Our findings demonstrate that the care provision dichotomy is reflected in the ways that older adults frame their autonomy as service users. Social and relational aspects of autonomy are more often framed as an individual's responsibility, while functional aspects of autonomy are more often framed within the purview of social services. While focus group participants were forthcoming with their individual strategies to promote their own social and relational autonomy, these quotations may be misleading. The pervasiveness of functional autonomy framing encourages processes of 'impression managing' among older adults, who are influenced by the stigma against impairment that this framing reinforces (Perkins et al., 2012: 223). This has important implications for this study, as we are less interested in how autonomous focus group participants presented themselves to be than in how they understand their autonomy. To this end, the persistent emphasis on functional autonomy is demonstrative of the pervasiveness of this framing.

Conclusion

This study demonstrates that the social autonomy problem framing added to the SMAF assessment instrument has not displaced the dominant functional autonomy framing in the ways older adults discuss their autonomy as service users. The most compelling support for this argument pertains to the explicit framing of participants' critiques of existing service shortfalls in terms that reflect the functional autonomy items contained within the SMAF. Specifically, we found that participants referred directly to particular tasks – ADLs and IADLs – that are identified in the measurement tools. Thus, based on the focus group interviews, it emerges clearly that measurements of functional autonomy in assessment tools impute a degree of authority to the way service users understand the problems that services aim to solve. Indicative of the strength of this connection, it emerged both in the French and English focus groups.

One limitation of this approach is that it does not deeply engage with how the assessment tool frames autonomy. While service users are implicated, they are not involved in the design of the SMAF. Therefore, greater explanatory leverage could be gained by interviewing policy designers and frontline workers who administer assessments to compare how they frame the autonomy concept. Equally, our decision to sample exclusively from pre-existing social clubs may limit the generalisability of the findings. Specifically, our sample reflected the disproportionately high female membership of the social clubs. Although distinct gender differences were not observed in the framing analysis, it would be worthwhile to test whether similar results are observable from a sample of mostly males, or from a respondent pool without prior familiarity.

Problem definition is also affected by the range of possible solutions. The systemic emphasis on biomedical services, to the detriment of those promoting social autonomy, imposes framing effects. In this way, focus group participants adopt what Rein and Schön (1993) call a frame-reflective discourse, where their responses suggest an understanding of the policy problem that is significantly shaped by the finite number of available solutions. The universe of solutions is constrained by the systemic focus on preserving functional autonomy for the performance ADLs and IADLs through the delivery of home care services for older adults in Québec. This is further supported by the lack of emphasis that participants placed on services to maintain social autonomy, particularly as a matter of government responsibility. Instead, they exhibited more individual responsibility for this domain of personal well-being.

This study also demonstrates the valuable perspectives of service users regarding the normative implications of policy instruments. Although relational scholars have long emphasised the influence of policy and institutional norms on individualised notions of autonomy (Mackenzie and Stoljar, 2000; Dobson, 2015), specifically as they pertain to the valorisation of independence among older adults (Perkins et al., 2012), less is known about how specific instruments frame service users' conceptions of autonomy. By drawing data exclusively from older adult service users, this study elucidates strong similarities between the framing of autonomy in the SMAF assessment tool and their framings of autonomy. These similarities are strongest in relation to the section of the SMAF that targets functional autonomy and employs the same questions found in the interRAI-HC tool. Therefore, similar framing effects should be found in other jurisdictions identified as interRAI member states[3], including France, the UK, Germany, Denmark, Italy, Australia and Japan. For example, a recent study in New Zealand compared the interRAI-HC with a homegrown instrument to find that the former is more likely to highlight medical and preventative care needs, while the latter identifies more social and personal care needs (Parsons et al., 2013). Comparative policy analysis of the perspectives of older adult service users in interRAI member states would allow additional leverage to establish a more robust causal connection to dominant framings in the assessment tools.

The present study's findings support the importance of the biomedicalisation of aging and its ubiquity in policy debates (Estes and Binney, 1989). In the past twenty years, government authorities have recognised the need to improve social policies in the field of aging. This includes, for example, Québec's well publicised aging policy framework launched in 2012. However, these measures continue to operate at the margins of health-based programs and, as illustrated by discussions with older adults in this study, have not altered significantly the more persistent framings of aging as a pathology, and autonomy as functional independence. These dominant problem framings not only constrain the *supply* of possible solutions but may also limit *demand* by tempering the expectations of service users about what is available and appropriate to expect from government. Efforts to incorporate alternative framings into service instruments, such as the inclusion of social/relational autonomy indicators in Quebec's SMAF, must be complemented by viable service options to legitimise their normative appeal.

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Declarations of Interest

None.

Notes

1 http://www.interrai.org/ accessed September 18, 2020.
2 For an overview of Canadian social services for older adults, see Chappell and Hollander (2013).
3 https://www.interrai.org/worldwide.html accessed, September 18, 2020

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