Food Security in Older Adults: Community Service Provider Perceptions of Their Roles*

Heather H. Keller,[1] John J.M. Dwyer,[1,2] Vicki Edwards,[2] Christine Senson[2], and H. Gayle Edward[1]

RÉSUMÉ

L'insécurité alimentaire chez les adultes plus âgés est influencée par les contraintes financières, l'incapacité fonctionnelle, et l'isolation. Vingt-huit fournisseurs de services sociaux et communautaires ont participé à quatre groupes de discussion ayant porté sur: a) les perceptions et les expériences en matière d'insécurité alimentaire chez leurs clients plus âgés; b) leur perception quant à leur rôle visant à promouvoir la sécurité alimentaire; et c) leur opinion quant aux contraintes ayant eu une influence sur ces rôles. Une analyse par comparaison continue a permis d'identifier les principaux thèmes. Les fournisseurs de soins formels ont fait état de six rôles visant à améliorer la sécurité alimentaire: a) surveillance, b) coordination et c) promotion des services, d) éducation, e) défense des intérêts, et f) fourniture d'un environnement social. Le thème final résume ces rôles comme « le besoin de personnaliser les services ». Les fournisseurs de services sociaux et communautaires jouent un rôle qui peut promouvoir la santé des adultes plus âgés par le truchement de leur insécurité alimentaire. Les fournisseurs de services sociaux doivent être reconnus et soutenus dans leur rôle de promoteurs de la santé.

ABSTRACT

Food insecurity in older adults is influenced by financial constraints, functional disability, and isolation. Twenty-eight social- and community-service providers participated in four focus groups to report (a) perceptions and experiences with food insecurity in their older clients, (b) beliefs about their potential role(s) in promoting food security, and (c) opinions about constraints that influenced these roles. A constant comparison analysis identified key themes. The formal caregivers reported six roles for improving food security: (a) monitoring, (b) coordination, and (c) promoting services, (d) education, (e) advocacy, and (f) providing a social environment. The final theme summarizes these roles as ''the need for personalization of service''. Social and community service providers are involved in roles that can promote the health of older adults by addressing their food insecurity. Social service providers need to be acknowledged and supported in this health promotion role.

[1] Department of Family Relations and Applied Nutrition, University of Guelph

[2] Hamilton Public Health Services

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Requests for offprints should be sent to: / Les demandes de tirés-à-part doivent être adressées à :
Dr. Heather H. Keller
Department of Family Relations and Applied Human Nutrition
Macdonald Institute
University of Guelph
Guelph, ON N1G 2W1
(hkeller@uoguelph.ca)

Introduction

Older adults are living longer than ever before (Public Health Agency of Canada, 2005). The quality of these additional years and the financial independence of older adults are important considerations in the later stages of life (National Advisory Council on Aging, n.d.; Public Health Agency of Canada, 2005). Some older adults may limit their spending where possible due to concerns with ''outliving their money'', and food may be viewed as a flexible expense (Lee, Frongillo, & Olson, 2005). The oldest age group (85 plus years) is growing most rapidly in Canada (National Advisory Council on Aging, 1990; National Advisory Council on Aging, n.d.). Many of

these seniors have a disability and several health problems that affect their quality of life. This can result in health-related expenses and purchasing of services, further limiting money spent on food.

There is recent interest in ensuring that there is sufficient food to meet our population needs (Dietitians of Canada, 2005). Anderson (1990) defines food security as the timely availability of food that is safe and nutritious, acquired in ways that are socially acceptable to the individual, without resorting to emergency food supplies, scavenging, or stealing. Thus, food insecurity occurs when an individual or household does not have safe, nutrient-dense, acceptable foods. Under this definition, food insecurity can result from many factors in addition to insufficient funds to purchase food.

Frongillo and Horan (2004) have expanded the definition of food insecurity to include having problems acquiring, accessing, and utilizing food. Many older adults, regardless of finances, have these difficulties with obtaining food and being able to prepare meals in their own homes. Some of these seniors may have formal social- and community-service assistance to stay in their homes for as long as possible. The provision of these formal services provides an opportunity to influence food insecurity in older adults (Keller, 2005; Lee et al., 2005). The current study was based on the premise that social- and community-service providers have opportunities to promote food security among their low-income program participants (Lee et al., 2005). Although low income may be only one predictor of food insecurity in older adults, this vulnerable group provides a starting point for investigation. The purpose of this study was to describe service providers' (a) perceptions of and experiences with food insecurity in their older clients, (b) beliefs on their potential role(s) in promoting food security, and (c) opinions about constraints that influenced these roles.

Review of Relevant Literature

Food, Nutrition Risk, and Older Adults

The recent interest in the food insecurity of older adults has arisen partly out of the knowledge that the food intake of some older adults is inadequate for maintenance of health (DeWolfe & Millen, 2003; Johnson & Garcia, 2003; Keller, Østbye, Bright-See, & Campbell, 1999). Poor food intake has been identified specifically in older adults with disabilities (Bartali et al., 2003; Sharkey, 2002), the isolated (Donkin et al., 1998; Sharkey, 2003), and those requiring formal or informal care to remain at home (Keller & Hedley, 2002; Keller, McKenzie, & Goy, 2001).

More recently, nutrition risk has been widely investigated in community-living older adults. *Risk* is defined as the occurrence of characteristics or factors that have the potential to lead toward poor food intake and under-nutrition (Council on Practice Quality Management Committee, 1994; Reuben, Greendale, & Harrison, 1995). Risk factors on a variety of nutrition indices specific to this age group include intake of food groups, limitations on basic and instrumental activities of daily living, and insufficient funds for food purchase (Keller, Hedley, & Wong Brownlee, 2000; White, Ham, Lipschitz, Dwyer, & Wellman, 1991). These indices in a variety of samples tend to indicate that food intake is affected by many factors, including physical disability (Keller, 2005; Margetts, Thompson, Elia, & Jackson, 2003; Sharkey, 2002). Nutrition risk parallels health, physical, and mental status. Older adults with difficulty in activities of daily living have a higher prevalence of risk than do independent seniors (Keller et al., 2001; Sharkey, 2002). Approximately 20 per cent of the general senior population is typically found to be at risk, as compared to 60 per cent of seniors who require formal services to remain in their homes (Coulston, Craig, & Voss, 1996; Davidson & Getz, 2004; Keller, 2005; Keller & Hedley, 2002; Keller & McKenzie, 2003; Payette & Gray-Donald, 1994).

Food Insecurity and Older Adults

Older adults are often considered to be at low risk for food insecurity since they appear to receive adequate funds from government and work-related pensions or lifetime savings and assets (Dietitians of Canada, 2005). In Canada, approximately 10 per cent of households report food insecurity (Rainville & Brink, 2001). Older adults receiving benefits have a lower prevalence of food insecurity as compared to younger households (Dietitians of Canada, 2005). Similarly, in the United States, a relatively low 6.3 per cent of senior households were identified as food insecure (Nord, Andrews, & Carlson, 2003). This reported low prevalence as compared to other vulnerable groups may be attributed to the way *food insecurity* is defined and measured (Wolfe, Frongillo, & Valois, 2003).

In the past decade, a conceptual framework for food insecurity, specific to older adults, has been developed (Wolfe, Olson, Kendall, & Frongillo, 1996). This framework includes factors that can help predict or may lead to food insecurity. These factors include poor physical health, restricted mobility, limited family contact/assistance, inadequate health insurance, unavailability of disposable income or savings, and unexpected expenses. This framework indicates

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that *food insecurity* in its broadest sense can be a problem for older adults. New questions to include when measuring food insecurity in older adults have been developed (Wolfe et al., 2003). Specifically, questions address access to adequate nutrition regardless of income, ability to prepare food, motivation to cook, and availability of financial resources for specialized foods that promote health (Wolfe et al., 2003). Some of these questions are already included on nutrition risk indices. Using a valid nutrition-screening index, 20–40 per cent of seniors report difficulty with food-related activities of daily living, such as grocery shopping and cooking (Keller, Goy, & Kane, 2005; Keller & McKenzie, 2003). It is anticipated that, as this conceptual framework is used in research and practice, figures for the prevalence of food insecurity in adults over the age of 65 will rise and become reflective of the true nature of this problem.

Social and Community Service Providers and Food Insecurity

Social and community services provide assistance with basic and instrumental activities of daily living, allowing older adults to remain independent in the community for as long as possible. These services include Meals-on-Wheels programs, seniors' centres, congregate dining programs, home nursing, home-making support (e.g., meal preparation, housekeeping), transportation for those with disabilities, food banks, and many others. The expansion of potential predictors of food security for older adults leads to the question of how well these social and community agencies can support food security for their clients.

Previous work has elicited providers' perspectives on food security for their clients (Kempson, Palmer Keenan, Sadani, & Adler, 2002). These nutrition educators shared stories on the coping strategies used by their program participants to maintain food sufficiency. Two types of food management practices were described: managing the food supply (e.g., preserving food), and regulating eating patterns (e.g., restricting personal food intake). The strategies formal providers identified closely mirrored those mentioned by low-income participants of focus groups ($n = 62$). Data collected from social service staff reflected the key issues for this vulnerable group (Kempson, Palmer Keenan, Sadani, Rindler, & Scotto Rosato, 2003). Other researchers have relied on community experts, such as health providers and clergy, to identify barriers to nutritional well-being in rural areas (Arcury, Quandt, Bell, McDonald, & Vitolins, 1998).

In addition to corroborating client perspectives and experiences, there is a need to investigate how social service providers' can influence food security. If used, this *upstream approach* suggested by Frongillo and Horan (2004) could assist providers in identifying the steps they need to take to ensure that their older clients do not become food insecure. In a recent study, researchers started to address this question (Lee et al., 2005). This qualitative study investigated how formal providers with the Older Americans Act Nutrition Program determine need for services (Lee et al., 2005). Through their data analysis, the researchers found support for including additional predictors of food insecurity in older adults. As well, they showed that current eligibility assessments create gaps in service provision for vulnerable seniors (Lee et al., 2005). Still missing from the literature, however, are providers' perceptions of and experiences with client food security and their views as to how they can influence food insecurity in their older clients.

The upstream approach to prevention is consistent with Canada's Framework for Health Promotion (Health Canada, 1986). Three major challenges to Canadians' health can be found within the framework: (a) disadvantaged groups, including older adults, experience more health disparities than the does general population, (b) preventable diseases influence health and quality of life, and (c) many individuals suffer chronic disease and disability with inadequate community support (Health Canada, 1986, Introduction para. 1). An expanded understanding of what *health promotion* is and a wider application of this approach is needed (Health Canada, 1986, Health promotion, para. 3). Community and social service providers have the potential to be health promoters, encouraging older adults to self-care and make healthy choices (Health Canada, 1986, Strategy II, para. 1). As these providers are frequently in the homes of their older clients, they have the potential to play significant roles in promoting food security. However, it is currently unknown what roles these care workers would view as feasible. The purpose of this qualitative study is to explore and report how providers view their potential roles in promoting food security in older adults with low incomes. Through this study, our intent is to provide important information that fills a current knowledge gap. Recommendations based on this work will help us move forward towards improving food security for older adults.

Methodology

For this study, we used a qualitative design. For several reasons, focus groups were chosen as the means of gathering data on service providers' opinions about and experiences of food insecurity

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among their older adult clients. First, groups are efficient for collecting a large amount of data on a specific topic in a relatively short timeframe (Madriz, 2000). This study had minimal funding and focus groups provided a means of hearing diverse perspectives in an effective way. Second, focus groups are useful for collecting qualitative data when members have similar skills and characteristics (Krueger & Casey, 2000). This study included paid and volunteer community-service-agency workers who had had common experience in a single city. Third, much of the information provided in this study was not of a personal nature; thus a group format was appropriate (Morgan, 1988). Most importantly, interaction occurred among group members, promoting disclosure that might not have occurred in individual interviews. Hearing about others' experiences and opinions can result in spontaneous responses (Madriz, 2000). Consequently, there is less facilitator involvement and thus less facilitator influence, and the quality of the information provided is improved (Madriz, 2000). The group setting also helps participants feel comfortable. They often enjoy the interaction, become enthusiastic about the topic, and feel empowered by the process (Madriz, 2000). As the study focused on providers' opinions as to the potential roles they could perform to advance food security for their clients, this potential for empowerment and for moving their practice forward was an important product of the focus groups.

Focus-Group Participants

The City of Hamilton was chosen for the study for two reasons. First of all, this large urban city was close geographically to the research team. Second, within the confines of the city, a diverse array of service agencies is available. Hamilton is a city of over 490,000 (City of Hamilton, n.d.). It is located in south-western Ontario. It is ethnically diverse. Furthermore, low-income seniors are vulnerable, and their numbers are increasing within the community (City of Hamilton, 2005). Community agencies ($n = 42$) servicing low-income seniors were contacted. They were asked to seek participants for the project among their staff and volunteers. Focus-group dates were set in consultation with providers. During a 4-week period, four 1-hour long focus groups were held over lunch at various locations around the city. A light lunch was provided to individuals volunteering their time. Of the four groups, only group 3 was paid for taking the time required to attend (they were paid for their lunch-break by their employer). As some employees could not attend a group discussion, for staffing and schedule reasons, agencies were provided with the interview questions prior to the focus group. Representatives then brought forward the collective ideas and comments from their agencies.

In total, there were 28 participants, divided among the four focus groups. Focus group 1 consisted of 9 employees or volunteers primarily involved in meal delivery or congregate dining programs. This session was held at a community centre. Agencies represented included a community nursing service, Meals on Wheels, home care, a culture-specific community group, and individuals from a seniors' recreation centre. Focus group 2 included 7 participants from support agencies and one seniors' cultural group. This meeting was held at a large grocery chain that provided meeting space for community groups. Group 3 was held at the service agency offices. These 6 participants were case coordinators, counsellors, and two gerontology students from the local university, placed with this faith-based provider. Focus group 4 consisted of 6 participants and was conducted at a community centre. Participants were representatives of seniors' centres, food banks, meal programs, and immigrant groups. Demographic information from participants was not collected, although 2 males and 5 volunteers attended sessions. Also, diverse levels of experience were represented in group membership. Participants joined the focus groups because they believed that the research might lead to a change in policy and help their senior clients.

Focus-Group Procedure and Analysis

The researchers used a previously tested semi-structured interview guide that focused on topics pertaining to food insecurity (Brown & Raphael, 2002; Hayward & Rootman, 2001). Through the discussions with participants, the team sought to elicit perceptions and opinions about food insecurity in older adult clients. Another goal was to try to understand how service providers promoted food security for clients. Key questions included, How can services and programs support older adults at-risk for food insecurity? What additional services and programs are needed to promote food security? What changes in policy are needed to promote food security in older adults? What limits service providers' ability to promote food security in their older clients?

An experienced moderator facilitated the sessions and a member of the research team assisted with note taking. Each focus group was transcribed verbatim, and a member of the research team checked all transcripts with the tape-recorded versions for accuracy. For data analysis, each research team member systematically reviewed all transcripts and inductively generated a list of codes describing themes.

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This coding template included keywords representing themes. The team met to discuss and define the codes, pinpoint examples of data that reflected these codes, and resolve any inconsistencies in interpretation. This discussion resulted in a master list of thematic codes. One team member used these codes for hand-coding of the four focus-group transcripts. Another reviewed the coded text to ensure consistency. All coded transcripts were imported into Ethnograph (Version 5.0; Qualis Research Associates, 1998). Data supporting these themes were collated using Ethnograph. The entire research team met to review collated data and formulate initial interpretations. The research team used a constant comparison approach to interpret the data. This involved reviewing coded data that supported themes and continually referring to previously coded sections for comparison (Flick, 1998; Morse & Richards, 1998). The team recognized that the health promotion principles identified in the 1986 Ottawa Charter for Health Promotion could be a template for organizing themes specific to potential roles that participants might take on to promote food security (World Health Organisation [WHO], n.d.). The goal of this charter was to promote health for all by the year 2000 (WHO, n.d.). This charter lists several principles for the health promotion process. These include advocate, enable, mediate, build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services (WHO, n.d.). This charter provided a strong theoretical framework for reflection on the key themes identified in this study.

Findings

Focus-group participants corroborated that food insecurity was a concern for their low-income clients. Providers also reported six roles that they did or could perform as part of their service provision for these older adults. These roles included (a) monitoring, (b) coordinating, (c) promoting services, (d) educating, (e) advocating, and (f) creating supportive social environments. Agency representatives also reported constraints on their fulfilling these roles. A final key theme encapsulated these roles: the ''need for personalization of care''.

Recognition of Client Food Insecurity

Providers were acutely aware of the food insecurity of their clients. They commented that fixed and low incomes played a significant role in food access. Agency staff and volunteers described the lack of ''luxury'' in their senior clienteles' lifestyles. For example, ''take-out'' foods were considered a ''treat''; clients did not buy new clothes. Fee-based services, such as grocery-shopping assistance, were used as rarely as possible by older adults budgeting carefully to make the most of their meagre incomes.

> [T]hey [older adult] can only shop once a month. . . . trying to make that food last a month . . . There's lettuce in there that could walk out the door. There is sour milk, there's green meat, there's things that they [older adult] try to stretch to last over a month. . . . So what you'll have is you'll have them eating very well maybe the first couple of weeks and not eating hardly anything at all the last two weeks. Or the food that they're eating the last two weeks isn't the safest or the freshest. (Focus group 2, Participant 10)

In addition to income, participants also stated that mental illness and confusion, physical disability, and fatigue or weakness were barriers to food access. These conditions influenced the older adults' ability to manage money, navigate public transportation services, negotiate large stores, or prepare meals. One focus-group member stated,

> [S]ome of the seniors in our community that are the most vulnerable in terms of food, I find that their lives are so chaotic . . . that comes with mental illness, I think [food safety] is a real factor . . . and also what they'll do is they'll go down to the corner store and pick up a bowl of soup or something or the doughnut shop . . . and I think it has a lot to do with social isolation but these people also are the ones that don't have family members . . . [they] don't have that contact with people who help them to access things and to keep some order in their lives. (Focus group 4, Participant 27)

Although these agencies typically assisted low-income clients, this mix of determinants of food access could influence the food security of older adults with adequate incomes. Providers noted that rarely did a ''single cause'' of food insecurity occur with their clients. Rather, older adults had a complex mix of problems that interacted and affected food availability.

The Monitoring Role of Providers

Focus-group participants described many senior clients as having mental health or money problems, and disconnected families. Isolation was also a problem, due to changes in health and living situations. In these cases, providers perceived their key role to be monitoring the food intake of these clients. As many families were absent, there was no one going into the home on a frequent basis to check-up on the older adult. This role was perceived as foundational to the service, although the form of activity depended on the mandate of the agency. Staff and volunteers described this role as an aspect of their assistance and explained

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that this responsibility differentiated them from commercial community services (e.g., grocery stores, taxis, etc.). Monitoring is a natural role for these formal providers, as they are frequently in the home environment:

> [I]t's one thing for a doctor to suggest proper foods and nutrition or for a clinic to make a suggestion, but you really need to lay eyes on what is in that [older adult's] fridge and how that client is managing with food (Focus group 3, Participant 17).

Additionally, senior clients trusted these agencies with their concerns: ''[A] couple of people recently confided that they [older client] are scared to use their oven. They [older client] want to be able to stay in their homes but they're afraid of not turning it off'' (Focus group 4, Participant 25).

Focus-group members described various monitoring activities including checking the fridge for spoiled food, identifying when an older adult needed further services or supports, and encouraging food consumption. As one provider explained: ''[I]t's the foreseeing of the risk, as opposed to waiting until it happens'' (Focus group 2, Participant 11). Monitoring was essentially taking the ''extra step'' through a formalized security check or an informal identification of a need for monitoring. For example, ''As a server, I tend to watch. Do they have yesterday's soup still on the counter? And also there's the frozen meals. I make sure it is put in the freezer while I am there. Otherwise, it could sit in the fridge'' (Focus group 1, Participant 3). Agency staff and volunteers reported that, with the change in government policies around home-making support, and specifically the discontinuation of help with food preparation, their role of monitoring had expanded and had become a necessary part of their service.

Roles of Coordination and Promotion of Services

Participants discussed the lack of formal coordination of services and suggested that, as a result, the community social support system was difficult to negotiate for older adults and their families. This was especially a challenge for those with mental health problems or for whom English was a second language. As one home care case manager pointed out, ''You walk out the door, and they've [older adult or family] got this list of phone numbers [to contact], and they're just in a muddle. And they don't make the call'' (Focus group 1, Participant 9). Despite this lack of formal coordination, these ''social'' service providers felt accountable for helping seniors negotiate the system: ''[W]hen the rubber hits the road, we are all connected in this service'' (Focus group 4, Participant 23). Employees of social service agencies reported making referrals to other services, even when it was not part of their job description. Participants also encouraged older adults to use community services that would support staying at home:

> [T]hey've [older client] now gone to insulin and now they've been told by their family doctor how to use it, when to eat, but they [older client] don't retain that information. So we're finding a lot of them are coming out with the slip [of paper] and we're saying, ''When did you take your insulin? How often? Did you eat?'' [They say] ''Well, no I haven't.'' We're just now getting in contact with the Diabetes Association so that we can get someone in to him . . . (Focus group 1, Participant 6)

Hospital discharge was identified as a potential crisis point for senior clients. Participants reported that seniors would not request or indicate a need for services before leaving hospital. However, once they had been discharged home, community providers described identifying needs and following through with referrals on their behalf.

Knowledge of other services and partnering within the community were described as essential for coordinating the community social system. One participant recalled that community providers would get together on a yearly basis to talk about what they were offering and the changing needs of clients. Although this opportunity was reported to be no longer available, the networking that such activities provided was perceived to be directly beneficial to clients. Participants discussed other means of making the community at large, and particularly physicians, aware of their services. Common suggestions were mass media, such as posters and flyers. The families of seniors were also discussed as potential targets of service promotion. Providers described how they worked hard to negotiate services and encouraged their clients to use these services. The participants acknowledged that this was a frequent struggle. They stated that older clients did not perceive a need for the service, wanted to remain independent, and/or pointed to stigmas associated with a service. Ultimately, the autonomy of clients was reported as being respected: ''[S]ay 'You [older client] need our service.' Well it's their [older client] choice, and if they don't feel that they [older client] do or they don't want to accept it, [there is] nothing we can really do about it'' (Focus group 2, Participant 12).

Constraints to coordination were policies that limited involvement or eligibility for services. For example, a provider described a scenario where the home of a senior was considered unsafe for the worker coming

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in to provide care. Consequently, the service was withdrawn: "...the most vulnerable tend to be ignored because well, 'if you're not willing to comply with exactly what we want you to do, then fine, you can't have our services'" (Focus group 4, Participant 27). Additionally, the limited funding to food-based services was reported as a major constraint. Participants would gladly support and promote these services for their clients, but a perceived deficit existed in these services in the local community. Some individuals described trying to fill gaps (e.g., starting up an informal congregate dining in an apartment building with no funding), but identified that time and effort beyond current provider mandates was a constraint. Support agency participants discussed the restriction of time on home-maker services: "We were laughing and saying, "You know, that we have to bathe them [older client] and feed them and do all this other stuff, so it's okay, let's feed them while they're in the bath" (Focus group 2, Participant 11). Despite these constraints, providers reported attempting to coordinate and promote their services to enhance food access of their clients.

The Education Role

Educating seniors and peers on the food-related needs of older adults was described as a role that these providers undertook. Education meant helping older adults select more nutritious foods through a grocery service, choosing to have a new service start, or increasing a service. Grocery-shopping providers talked about how they attempted to educate their low-income seniors about buying lower-cost brands to help stretch their food dollars; they described providing an extensive booklet to their clients to assist with these food choices. In one case, a focus-group member described organizing a diabetes education program for tenants of an apartment complex. This program showcased low-cost foods and new recipes that could stimulate interest in food. As one participant reported, the education they provided involved not simply relaying information but also encouragement and counselling:

> But a lot of times when people call us for service, they're crying. Because I think women have always done this job [grocery shopping]... But you try to say to them, we always say to them, "You know what? If your toilet broke, you'd have to call a plumber. Right? You know? So now your shopping [legs] are broke, you have to call someone." And you try to work it out so that it's just another service. They're still being independent. Right? And you're rather than relying on people to do it for free, or asking your next-door neighbour, you've chosen to be independent and pick up the phone and call someone else. (Focus group 2, Participant 10)

For other providers, examples of education involved not only the service promotion discussed above but also education on the specialized needs of older adults. For example, food bank staff and volunteers were described as being unaware of the needs of vulnerable older clients. These staff and volunteers tended to be unaware of the difficulty frail seniors had in accessing their local sites or of their inability to carry several grocery bags on the city bus. Participants also talked about the inappropriate food products at food banks. For example, the specific diet and health needs of older adults were not taken into account when publicized food drives were held by local food banks.

The Advocacy Role

Advocacy in relation to food security was described in terms of accessing additional financial resources and food for older adults. Examples of reported advocacy efforts included dietitians' completing paper work so clients could get additional funds for specialized food products; social workers' helping seniors complete forms for additional assistance or even going to the food bank themselves or driving the client to the food bank; meal programs' providing free meals or meals at a reduced cost; service providers' going to medical appointments with the senior to help interpret treatment plans and intervening when a senior's alcohol intake was excessive. Advocacy was necessary, as "clients tend to be very isolated and a lot of them have no support whatsoever, no family, no friends, no neighbours. They are alone. And they have been rattling on undetected" (Focus group 3, Participant 21).

A great deal of frustration was expressed around the disconnect between what had been observed and researched in terms of the needs of these older adults and the actual policies and services in place to support food security for seniors: "[U]nfortunately meal preparation isn't recognized as a basic need. It is a basic need right now that you have personal care so you have to be clean, right? But you don't have to eat" (Focus group 3, Participant 21). Despite being involved in formal advocacy efforts, such as applications for congregate dining programs, these providers reported seeing little change in policies that would benefit their clients.

The Social Support Role

Agency staff and volunteers were very aware that their services provided a socially supportive role.

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Many of the clients were socially isolated, and this was seen as a vital component of the older adults' food insecurity: ''We go to these homes, and you think doesn't anybody care about these people'' (Focus group 1, Participant 5)? ''Yeah it is, like one lady says, if it wasn't for meals coming in, she'd never see anybody'' (Focus group 1, Participant 9). Without social stimulation, participants described older clients losing interest in eating. Agency staff and volunteers reported that minimal social interaction was a necessary component of the service to promote food intake of some clients. As one agency participant pointed out:

> [H]e was very socially isolated and depressed . . . [W]e put in home-making and that was food preparation and grocery shopping and he would eat a little bit if somebody was there with him . . . the meal just coming to the door just wasn't enough to stimulate him to eat (Focus group 3, Participant 18).

The social stimulus was reported by some participants to allow older clients to interact with the ''outside world'' and maintain an interest in life: ''I stop and take two, three minutes time for conversation with that woman or that gentleman. They want to know what happened, 'Did you go to the races, did you see this?''' (Focus group 1, Participant 1). Participants said that the best option for ambulatory clients was to leave their homes and interact socially with their peers: ''They [older clients] need to socialize. They need to form friendships and that needs to be encouraged, any way we can, in any setting that we can. I think that they need socialization'' (Focus group 4, Participant 27). A meal outside of the home provides such an opportunity. However, these participants perceived that funding congregate dining programs was not a priority for local and provincial governments. These individuals believed that the social aspects of care were neglected in current funding schemes.

The Need for Personalization of Service

Focus-group participants reported that success in promoting food security depended on the personalization of their services. Unlike commercial community services, these social service providers described understanding the need for individuality and for being accountable to their vulnerable clients. They explained that they would do things that commercial providers would find unreasonable to do. Specifically, staff and volunteers of meal programs said that they catered to the needs of the individual senior and a personalized meal was the norm. They described adjusting individual meals based on extensive likes and dislikes, the need for different consistencies, and the requirement for special foods, including high fibre, diabetes, renal, and low-sodium diets.

Participants also described their feelings of social responsibility to their clients. They asserted that they would not leave their older clients in the ''lurch'' if the senior was in desperate need and on a waiting list. For example, one volunteer meal delivery driver told the story of providing a client in a desperate financial situation with some used clothing. As well, this passage encapsulates the personalization of service by a senior-focused grocery shopping provider:

> [H]e [grocery store manager] called me and told me that they [grocery store] couldn't do it [deliver groceries] anymore. Because he [grocery store] didn't understand how, how we could provide that kind of service when they [older adults] called the store 15 times a day. They [older clients] wanted to know when they [grocery store] were coming. They [older clients] wanted to know why the milk wasn't good, why the bananas weren't yellow . . . [S]ometimes we will refer a client to a store. Now we'll check back with the client six weeks later to see how it's working out. (Focus group 2, Participant 10)

In the context of the senior client, personalization means attention to detail, individualization, and understanding the special needs of older clients. In essence, personalization of service is the carrying out of the six roles: (a) monitoring, (b) coordinating, (c) promoting services, (d) educating, (e) advocating, and (f) creating supportive social environments. However, some providers indicated that not all staff and volunteers were capable of this extensive personalization and left the community health organizations where they had been working.

Discussion

Social and community service agencies report having roles that promoted food security for older clients, and, thus, in support of clients' health. Providers such as Meals-on-Wheels drivers, senior-specialized transit, and grocery-shopping services are not typically considered as health promoters (Health Canada, 1986). However, based on the data, we found that these agencies are in an appropriate and unique position to monitor, coordinate and promote, provide education, advocate, and socially support older adults so that food security can be attained. These roles are possible within the context of a philosophy that promotes personalization of service.

Food insecurity, regardless of an individual's age, has the potential to influence health (Dietitians of Canada, 2005). In the United States, six per cent

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of adults with diabetes were identified as having food insufficiency (Nelson, Cunningham, Andersen, Harrison, & Gelberg, 2001). These individuals were also more likely to report fair or poor health status than were adults with diabetes and food security. Further, food insufficiency has been found to be independently associated with increased physician visits (Nelson et al., 2001). Others have shown that food insecurity is linked with being overweight in women (Townsend, Peerson, Love, Achterberg, & Murphy, 2001) and with multi-morbidity in older clients of meal programs (Sharkey, 2003). In Canada, food insecurity is connected to heart disease, diabetes, high blood pressure, and food allergies (Vozoris & Tarasuk, 2003). The association between food security and health (Raphael, 2004) warrants considering food security a determinant of population health. Food security is a mechanism for promoting health for older adults.

Achieving Health for All: A Framework for Health Promotion (Health Canada, 1986) is a well-known policy document. Principles of this framework include shifting the emphasis towards prevention of disease and helping those with chronic disease or disability to cope in their local environments. This framework expands the scope of public health beyond the dissemination of educational materials and focuses broadly on the diverse ways health can be improved. Community service providers are identified as one resource to support health, specifically for the chronically ill and disabled (Health Canada, 1986, Strategy II section, para. 6). Encouraging food security for older adults is consistent with this framework.

To be successful, health promotion needs to occur across multiple sectors. In this study, social service and community providers reported operating at three levels: the community (e.g., advocacy), family (e.g., education), and individual (e.g., personalization of service). This multi-sector work requires good communication and close affiliation. The Assistant Secretary of Aging (qtd. in Torres-Gil, 1996) stated that inter-agency communication was necessary to combat food insecurity in older adults: ''Nutrition services [Meals on Wheels, congregate dining] do not operate in isolation but are part of a broader, more balanced, integrated approach to a comprehensive and coordinated system of services that include social and supportive services as well as health and medical services'' (p. S7). Consequently, it is important that the health community consider these providers as partners in health promotion. Older adults are likely to be better served through integration and communication among diverse services, as food insecurity appears to have social, physical, mental health, and poverty roots (Wolfe et al., 1996; Wolfe et al., 2003).

The health promotion framework (Health Canada, 1986) can be used to develop multi-sector partnerships and strategies. Specifically, coordination and flexibility are identified as being necessary for success. The principles of the framework reflect those in the 1986 Ottawa Charter for Health Promotion (WHO, n.d.). Charter principles of ''reorienting health services'', ''advocating'', and ''mediating'' were comparable to the themes of advocating and coordinating services and the general concern that current policy limited preventive efforts like the congregate dining and home-making identified in this research. Participants reported ''creating supportive environments'' through monitoring, providing social support related to food intake, and personalizing the service for older clients. Some of the roles identified by providers were enabling. For example, participants described the key role of educating the senior client, family, and other community partners. Coordination and education across sectors could lead to high-quality, seamless service (without overlap) that addresses food insecurity through diverse services. The roles reported by participants in this research demonstrate that they see themselves as health promoters, consistent with the Health Canada (1986) framework.

Previous work has outlined some of these health promotion roles for social service and community providers in the area of food security. Kempson et al. (2002), in interviews with 51 nutrition educators, showed that many of the strategies used by persons in food insecure households were risky and unsafe. The role of community providers educating clients about safe eating practices and food purchasing was noted as a strategy to counteract food insecurity. Advocating for food-insecure people is not a new concept, especially at a public policy level (Dietitians of Canada, 2005; Kempson et al., 2002). Previous qualitative work on the food security of older adults has recommended that service providers, and especially personal support aids, take on personal advocacy roles for their clients by assisting seniors with registering at food banks, filling out forms, and obtaining access to food (McDonald, Quandt, Arcury, Bell, & Vitolins, 2000). This role is essential for seniors without family supports and is consistent with our current work. Dietitians are being encouraged to take up an advocacy role (Dietitians of Canada, 2005), especially at the policy development level, to promote the food security of all Canadians. Advocacy needs to occur at a professional as well as at the personal or ''concerned citizen'' level. Likewise, other community providers need to undertake and maintain efforts advocating for older adults, especially since there is no coordinated plan for food security monitoring in Canada.

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The notion of *coordination and promotion of services* has been described previously in the context of food security and older adults. Older adults may be especially reluctant to participate in food-based assistance programs and are unaware of their food insecurity (Frongillo & Horan, 2004). Only 1 of the 28 participants in our focus groups was from an agency (home care) that has a specific mandate to coordinate services. The roles of coordination and monitoring of clients demonstrate that these participants feel accountable to their clients beyond what is mandated and set social service providers apart from commercial services (e.g., grocery stores, taxis). Many sectors do not see health as part of their mandate or as a priority for their service (Health Canada, 1986, Strategy III section, para. 3). If community social services are to adopt the mandate of health promotion, they need to be provided with the resources to do so (Health Canada, 1986, Strategy II, para. 1).

Finally, the role of *social support* has been identified as important for the food intake of older adults (Brunt, Schafer, & Oakland, 2000; McDonald et al., 2000; Vitolins et al., 2000). In addition to promoting the participation of vulnerable seniors in socially interactive programs (e.g., congregate dining), the providers in the current study described a personal social role when interacting with clients. Although time-limited, these brief contacts can moderate seniors' isolation and may improve mood and well-being. Personal contact is also an important part of these food-based services and should be acknowledged as an essential component of providing care to older clients. Funding agencies and governments need to understand the vital role of social support and personalization of service and the time that is required to assist older adults in the community.

Recommendations

The following advice to improve food security in older adults is based on participants' suggestions and on analysis of the focus-group data. First and foremost, social- and community-service providers should be considered as health promoters and partners in the health care of older adults. Physicians and other health care practitioners need to be cognizant of the contribution that these agencies can make to improving or maintaining the health of older adults. Communication within and among the diverse community partners is necessary to maintain seamless, non-overlapping service. Regular face-to-face contact, such as a yearly meeting or ''fair'', may promote communication among client service agencies and groups. Government and other funding bodies need to value the time required to personalize services for older adults. Additionally, they need to recognize that a visit by a community agency can be a social opportunity and allocate funds to reflect this time commitment. Coordination and promotion of the various assistance available in the community is every employee's job and needs to be funded and included in service mandates. Home-making support in the form of food provision either through grocery shopping or meal preparation needs to be recognized as an essential service for vulnerable older adults. Like bathing, eating is a basic quality-of-life issue. Eligibility for services needs to be carefully reviewed and to be seen as a barrier to food security. This is critical when considering the multi-faceted causation of older adult food insecurity. Innovative programs, like apartment buildings' organizing diabetes education sessions, need to be supported. Food banks and food security advocates need to be cognizant of the potential food insecurity of older adults. A guaranteed income does not necessarily mean sufficient and appropriate food. Food bank staff also need to address policies that act as barriers to access for older adults. The food products donated to food banks should include those appropriate for older adults (e.g., low sugar and fat, high fibre, easy to chew, etc.). Further research needs to be completed on overcoming the consumer stigma attached to some home-based services, specifically meal programs. Finally, food-based services particular to older adults, such as Meals on Wheels and congregate dining, need increased funding and support to continue their vital work in ensuring food security for older, vulnerable adults.

Conclusion

Social and community service providers take on health promotion roles outside of their single-service mandate. Thus, these agencies need to be regarded and treated as health promotion services within health care systems. Their support specifically of food security for older adults needs to be recognized and acknowledged. Gerontologists, social service, and health care workers need to be cognizant of the complexity of the food insecurity issue for older adults. We all have a part to play in promoting food consumption by older adults, as many factors outside of finances influence safe and acceptable food access for older adults.

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