Critical reflections on the blind sides of frailty in later life

Prof. dr. Liesbeth De Donder & D-SCOPE consortium

Agogische Wetenschappen
Belgian Frailty Day – 29/04/2019
Overview

1. Background – Goal
2. Conceptual reflection - discussion
3. Building blocks for future research and policy-making
1. Background - Goal
Detection
Support
Care
Older people
Prevention
Empowerment

www.d-scope.be
D-SCOPE werd gefinancierd met de steun van het agentschap voor Innovatie door Wetenschap en Technologie
• in very different theoretical contexts the same **word** can be used to denote different **concepts** (Hertogh, 2013: 95)
Possibility 1: Don’t use the word frailty anymore and use another word

- Grenier et al. (2017): “A ‘frailed’ old age risks being read and interpreted as a ‘failed’ old age”
- But: the endeavor remains the same: clearly elucidating what you mean with the term, while denouncing which interpretations you do not support

Possibility 2: A broader integrative perspective
2. Conceptual reflection/discussion
<table>
<thead>
<tr>
<th>FROM...</th>
<th>TO...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unidimensional</td>
<td>Multidimensional</td>
</tr>
<tr>
<td>Micro-level approach</td>
<td>Multilevel</td>
</tr>
<tr>
<td>Deficit-approach</td>
<td>Positive perspective on ageing</td>
</tr>
<tr>
<td>Negative outcomes</td>
<td>Positive outcomes</td>
</tr>
<tr>
<td>Risk factors</td>
<td>Balancing factors - strengths</td>
</tr>
<tr>
<td>Frailty</td>
<td>Frailty-balance</td>
</tr>
<tr>
<td>Intervention</td>
<td>Prevention</td>
</tr>
</tbody>
</table>
1) Frailty as a **multidimensional** and multilevel concept

1) Frailty as a multidimensional and **multilevel** concept

Hagestad & Dannefer: ‘**microfication**’ to denote a trend in ageing studies which concentrates on psycho-social characteristics of older adults in micro-interactions, thereby neglecting the macro-level.
1) Frailty as a multidimensional and **multilevel** concept

- Viewed from the **macro** perspective
  - Frailty is not the attribute of the individual.
  - Frailty is created by social and structural conditions. People are not frail solely by personal characteristic but are also fragilized by society.
  - (e.g. ageism, legislation)

- Viewed from the **meso** perspective
  - attempts to explain individual outcomes as a consequence of organizational dynamics such as within the family, community, neighborhoods, institutions or city infrastructure
  - (e.g. Age-friendly communities, caring communities)
2) Positive perspectives on frail older people

Focus on positive outcomes

• In the literature: Focus on adverse outcomes
  • Limited research on positive outcomes (Kojima et al., 2016)
  • Big difference between objective and subjective frailty (Grenier, 2006)
• In D-SCOPE: meaning in life, life satisfaction and mastery (as outcome variables)

"I want these last years to be qualitative. How long those last years will last, I don’t know. But I know that I will keep on declining. I will be declining. So it is important, that the now-moment is qualitative. (Woman)"
3) From frailty towards the concept of frailty-balance

- Often only registration of deficits
  - In measurement instruments: what is not working/going well?
  - Focus on problems
  - Only registration of frailty
- What with strengths? Resources?
  - Balancing factors
- Development of frailty-balance measurement instrument
Cognitive frailty – Quality of life

- No-low cognitive frailty
  - Bad QoL: 5%
  - Good QoL: 48%
  - Very good QoL: 47%

- Mild cognitive frailty
  - Bad QoL: 15%
  - Good QoL: 56%
  - Very good QoL: 29%

- High cognitive frailty
  - Bad QoL: 20%
  - Good QoL: 60%
  - Very good QoL: 20%
Social frailty – Quality of life

<table>
<thead>
<tr>
<th>Social frailty</th>
<th>Bad QoL</th>
<th>Good QoL</th>
<th>Very good QoL</th>
</tr>
</thead>
<tbody>
<tr>
<td>No-low social frailty</td>
<td>4%</td>
<td>50%</td>
<td>46%</td>
</tr>
<tr>
<td>Mild social frailty</td>
<td>12%</td>
<td>59%</td>
<td>29%</td>
</tr>
<tr>
<td>High social frailty</td>
<td>24%</td>
<td>48%</td>
<td>28%</td>
</tr>
</tbody>
</table>
4. Attention prevention
STEP 1. Accurate casefinding

STEP 2. Preventive home-visit 1

STEP 3. Home-visit (professional)

STEP 4. Warm referral

STEP 5. Intervention

STEP 6. Follow-up
PREVENTION = Accurate casefinding – Dispatching - Intervention

1. Risk profiles (target group)

2. Frailty Balance (objective – subjective – comparative)

3. Outcomes

**Frailty**

- Cognitive
- Environmental
- Physical
- Psychological
- Social

**Balancing factors**

**INDIVIDUAL**
- (e.g. personality, coping, resilience)

**ENVIRONMENT / CONTEXT**
- (e.g. informal care, Age-friendly community, Active caring community)

**MACRO**
- (e.g. care organisation, financing models, Legislation)

**Well-being**

**Life satisfaction**

**Mastery**

**Meaning in life**

DYNAMIC MODEL:
- CAN BE INFLUENCED BY LIFE EVENTS (disruptive life events – gradual changes) AND INTERVENTIONS
3. Building blocks
Cahier 1
Achtergrond en visie

Cahier 2
Het 6 stappenplan voor preventieve huisbezoeken

Cahier 3
De kwetsbaarheidsbalans-vragenlijst
Cahier 4
Resultaten van de testgemeenten
D-SCOPE methodiek getest

Cahier 5
met Linken recente beleidsevoluties en kostenschatting
D-SCOPE en beleid
Recommendations

• Adopting a multidimensional, multilevel, dynamic and positive view on frailty: frailty balance instrument
• Moving from dependency towards interdependency
• Giving voice to (the resilience of) frail older people
  • attention for silenced voices (e.g. Migration-background)
• Invest in prevention