Journal of
Ageing and Longevity

MDPI

Article

A Pilot Feasibility Study of a Group-Based Program Addressing Fear of Falling and Its Consequences on Activity Levels Among Older Adults Living in Low-Income Housing

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Abstract

Falls among older adults are a major public health concern. Older adults living in low-income housing (LIH) are at higher risk of falls due to disadvantages linked to social determinants of health, yet remain underrepresented in research. This study aimed to assess the feasibility of a program addressing fear of falling and its consequences on activity levels among older adults living in LIH in Côte-des-Neiges (Montreal, QC, Canada). A mixed-methods pilot feasibility study was conducted using Bowen et al.'s framework, drawing on data collected through questionnaires, observation grids, attendance records, and semi-structured interviews. The program consisted of six 90 min sessions designed to enhance participants' confidence in preventing falls while promoting engagement in activities. Fourteen older adults (mean age = 75.5 years) were recruited. Outcome data on fall-related psychological factors, activity engagement, and knowledge about falls were collected before and after the program. Moreover, older participants' perceived benefits were assessed following program completion. Post-program interviews with older adults, facilitators, and a community field worker were conducted to further explore program feasibility, including its acceptability, implementation, and integration. The program showed strong acceptability and a high attendance rate (95%). Although no statistically significant pre-post changes were observed in the outcome variables, older participants reported several benefits at post-test, including improved knowledge about fall prevention (100%) and greater confidence in their ability to avoid falls (85%). These findings support the feasibility of implementing this culturally adapted fall prevention program in similar

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Academic Editors: Laurie Buys and Mark A. Tully

Received: 2 February 2026
Revised: 26 April 2026
Accepted: 15 May 2026
Published: 4 June 2026

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LIH settings and provide valuable insights for its refinement and future research. Further investigation is warranted to examine the program's feasibility across other LIH settings and linguistic groups, as well as to assess its effectiveness.

Keywords: aging; older adults; low-income housing; fall prevention; fear of falling; activity engagement; feasibility study

1. Introduction

Falls among older adults represent a crucial public health issue to address, given their high prevalence, the severity of their consequences for this population and their costs to healthcare systems. According to recent data, the global prevalence of falls among older adults is estimated to be over 26% [1]. Furthermore, research indicates that slightly more than 40% of community-dwelling older adults who experience a fall will suffer two or more falls within the same year [2]. These figures are alarming, considering that falls are a leading cause of serious injuries such as hip fractures or head trauma, hospitalizations, and deaths among older adults [3,4]. In addition, fall-related physical injuries are likely to lead to a decline in independence, social participation, and quality of life in this population [5–7].

Older adults are particularly vulnerable to falls due to a combination of several biological, behavioral, and environmental risk factors. These include impaired balance and gait, reduced muscle strength, visual impairments, pain, polypharmacy, alcohol consumption, and a hazardous environment [8–11]. Fear of falling is also a risk factor for falls in older adults that has emerged as particularly important in the scientific literature over the last two decades [6,10,12]. Fear of falling is highly prevalent among older adults, including those who have never fallen [6,13,14], with reported prevalence rates ranging between one-third and two-thirds of older adults [13,15–17]. Fear of falling is particularly concerning, as several studies have shown its impact on daily activities. To reduce their perceived risk of falling, older adults may limit their participation in activities despite having the physical capacity to do so [18]. It is estimated that between 38% and 65% of older adults with a fear of falling report activity restriction related to this fear [19,20]. Moreover, higher levels of fear of falling have been associated with reduced engagement in daily activities, even among individuals with relatively high physical function [21].

This reduction in activity is problematic, as it may trigger a vicious circle of physical deconditioning and increased risk of falling, further exacerbating the fear of falling [21–24]. As such, fear of falling and activity restriction are closely interrelated and can aggravate each other. Consequently, existing evidence highlights the importance of intervening on both targets simultaneously [6] and supports their consideration in public health efforts toward fall prevention.

To this end, some fall prevention programs targeting fear of falling have been developed and evaluated over the last decades [25–28]. One of these is an American program called A Matter of Balance (AMB) [29]. AMB was one of the first programs to combine the principles of cognitive behavioral therapy with physical exercise to reduce fear of falling. It consists of 2 h group sessions offered twice a week for four weeks. In a randomized controlled trial involving 434 older adults with concerns about falling, the AMB program was shown to improve participants' fall efficacy, perceived ability to manage falls and intended activity levels, with results being more promising for older adults who demonstrated greater attendance at program sessions [29].

Over the years, the AMB program has been adapted by several research teams, notably for older adults in the Netherlands [30] and Egypt [31], for Chinese- and Spanish-speaking older adults in the United States [32], as well as for remote delivery in the context of the COVID-19 pandemic [33]. The program was also adapted for older adults in Quebec, Canada [34–36], where French is the official and predominant language. This led to the development of *Vivre en Équilibre* (Living in Balance—LiB program). Although based on a cognitive restructuring approach similar to the original American program, LiB differs from AMB in its use of more engaging and playful educational methods, its peer-led facilitation model, and the addition of a few fall-related topics, such as bladder incontinence [34]. A non-randomized trial including 135 older adults from independent living retirement homes showed that LiB had a significant positive impact on participants' perceived control over falls, perceived ability to prevent falls, level of activity restriction, level of engagement in physical and social activities, and knowledge about fall prevention [36]. Following this study, sustained efforts were made to disseminate the LiB program more widely throughout the province of Quebec, as it was recommended by the health authority as a strategy to prevent deconditioning among older adults [37].

1.1. Context of the Study

To enable broader deployment of the LiB program, it is essential to adapt and test it with older populations who are likely to experience disadvantages related to social determinants of health, and who tend to participate less in health promotion and prevention initiatives. One of these populations is older adults living in low-income housing (LIH)—also referred to as social, community, or public housing. This population often experiences a relative health disadvantage, due to lower income as well as more limited education and health literacy [38]. Although health data on this group remain rather scarce, a recent study involving 595 older adults living in public housing in Ontario (Canada) revealed a fall prevalence of 34.5% in this population, significantly higher than the national average of 19.8% among Canadian older adults [39]. In addition to common risk factors, older adults living in LIH face unique social determinants of health that may further elevate their risk of falling [39]. Moreover, this population shows a high prevalence of chronic conditions, poor mental health, and social isolation [40,41]. Given the characteristics of older adults living in LIH, including lower health literacy, reduced participation in community programs, and more limited social networks, the original LiB program may not fully meet their needs or be readily feasible in this context [41]. This underscores the need for its adaptation.

This study constitutes the second phase of a larger research project conducted in partnership with a community organization aiming to expand its fall prevention services for older adults living in LIH in the Côte-des-Neiges neighbourhood. This neighbourhood is one of the most densely populated urban districts in Montreal (Canada) and a major entry point for immigration, with approximately 47% of residents born outside the country [42]. The neighbourhood is highly ethnoculturally diverse, where 59% of the population identifies as belonging to a racialized group. In addition, nearly 43% of residents report a mother tongue other than French or English—Canada's two official languages [42]. The first phase of the larger research project focused on the co-development of an adapted version of the LiB program through a collaborative process involving fourteen older adults living in LIH, a field worker from the community organization, an occupational therapist, two physiotherapists, two service designers, six researchers with complementary expertise in rehabilitation and health promotion for older adults, as well as one doctoral student, two occupational therapy students, and two research professionals. The co-creation process aimed to ensure that the adapted program would be tailored to the social and cultural

realities of older adults living in LIH. This study was part of the Living Lab *Quartier Innovant* (Innovative Neighbourhood), a research infrastructure designed to support the development, evaluation, and implementation of innovations aimed at promoting older adults' social participation and inclusion in the Côte-des-Neiges neighbourhood [43].

1.2. Relevance of the Study for Advancing Scientific Knowledge

Compared with the broader literature on fall prevention interventions, relatively little research has focused on interventions targeting fear of falling and its consequences on activity levels. This remains an evolving field in which important gaps in knowledge persist. In fact, recent comprehensive reviews highlight the need for further research to better understand how such interventions work across diverse groups of older adults, beyond relatively healthy older populations. Such groups include individuals at higher risk of functional decline, those with lower levels of physical activity and mobility, and those living with multiple chronic conditions [25,26]—characteristics that are particularly prevalent among older adults living in LIH. Moreover, activity restriction associated with fear of falling remains insufficiently examined as an outcome of these types of interventions, despite its central role in the disabling cycle associated with fear of falling [25]. There is also a need to better integrate the perspectives and lived experiences of both older adults and stakeholders involved in fall prevention services, particularly with regard to acceptability and real-world implementation [44].

In response to these gaps, the present study aimed to assess the feasibility of the adapted LiB program in LIH in the Côte-des-Neiges neighbourhood. The study's specific objectives were to: (1) document program use (demand); (2) evaluate program acceptability; (3) assess program implementation, including the degree of execution and factors influencing implementation; (4) explore the program's potential for integration within the partner organization; and (5) examine changes in key intermediate outcome variables following program participation (limited-efficacy testing).

2. Materials and Methods

2.1. Research Design

A mixed-methods pilot feasibility study was conducted to assess the adapted LiB program in LIH from the perspectives of multiple stakeholders. According to Aschbrenner et al., "pilot feasibility studies provide an important function within intervention research by helping investigators optimize their intervention and study procedures for future trials that will determine the efficacy and effectiveness of the intervention" [45] (p. 11). They primarily aim to address the question "Can it work?" rather than "Does it work?" [45,46]. Therefore, pilot feasibility studies are not designed to test intervention effectiveness, but they are nevertheless of great value in advancing research.

Furthermore, feasibility studies are particularly warranted when an intervention has been little studied in a specific population with unique needs, or when evidence of effectiveness comes primarily from settings different from the one in which the intervention is intended to be implemented [46]. Given the underrepresentation of low-income older adults in fall prevention research and the limited literature on programs implemented in LIH settings, a feasibility study was considered an essential first step to advance research in the field.

The framework developed by Bowen et al. [46] was used to identify and define the feasibility dimensions examined in this study. This framework has been widely used in recent years in health-related research. Five of Bowen et al.'s dimensions (referred to by the authors as areas of focus) were addressed in the present work: acceptability, demand,

implementation, integration, and limited-efficacy testing. For each of these dimensions, one or more corresponding outcomes of interest were also identified and assessed.

A convergent mixed-methods approach was adopted, whereby qualitative and quantitative data were collected and analyzed simultaneously, then merged to provide a comprehensive interpretation of the overall study findings [45].

2.2. Program Under Study

The adapted version of LiB, specifically designed for older adults living in LIH, consists of six 90 min sessions, delivered in person on a weekly basis in a community room located within the LIH buildings. Like the original version of LiB, its primary goal is to support participants in building their confidence in preventing falls while encouraging continued engagement in physical and social activities.

A key component of this adapted version of the LiB program is a series of pre-recorded educational videos, each lasting 15 to 30 min, which are viewed during the sessions. The content of these videos (see Table 1) is based on the original LiB program, and addresses fear of falling and its impact on everyday life, prevalent fall risk factors (including intrinsic, behavioral, and environmental factors), as well as a range of strategies to reduce these risks and thus prevent falls. One video includes a brief demonstration of a series of simple exercises to be performed in a seated position and aimed at maintaining mobility. Participants are encouraged to practice these exercises several times a week. A brochure illustrating how to execute each exercise is provided to participants to stimulate and guide practice at home.

Table 1. Overview of session topics and educational video titles.

Session	Session Topics	Educational Video Titles
1	Program introduction; Fear of falling	Introduction to the video series Fear of falling and its impact on everyday life
2	Falls and home environment	Wall-to-wall safety
3	Falls and behaviors	Safe behaviors to prevent falls
4	Falls and physical health	Prevent falls by taking care of your physical health
5	Physical activity to prevent falls; Demonstration of a series of simple exercises	Physical activity to prevent falls Let's move together to prevent falls
6	How to get up after a fall; Program conclusion	Conclusion of the video series

During the sessions, the theoretical content of the videos is interspersed with reflective activities to actively engage participants in the learning process, such as group discussions, interactive exercises, and self-assessments. To consolidate learning, participants are provided with educational materials throughout the program, which are compiled into a participant's booklet. A facilitator's manual was also developed to guide program delivery for each session.

The sessions were co-facilitated by a dyad composed of an occupational therapy student and an older adult volunteer (peer leader), both of whom were trained to deliver the program by the principal investigator (JF) and the doctoral student (RDL). The occupational therapy student's role was to engage participants with the program's theoretical content, respond to their questions to the best of her knowledge, and support group management. The older adult facilitator contributed by sharing experiential knowledge and personal anecdotes to encourage participant engagement, distributing the necessary materials to participants and providing them with assistance when needed.

2.3. Target Population and Recruitment

The target population consisted of older adults who were afraid of falling or concerned about falls, and who lived in LIH in the Côte-des-Neiges neighbourhood. The inclusion criteria were as follows: (1) aged 60 or older; (2) able to walk independently (with or without a mobility aid); (3) afraid of falling or concerned about falls, as assessed by a single question: "Are you concerned about falls?", rated on a four-point scale (0 = never, 1 = occasionally, 2 = often, 3 = very often; participants had to answer at least "1 = occasionally" to be included in the program); and (4) able to understand and speak French. Older adults with significant cognitive impairments that could interfere with their participation in the program were excluded, as well as those who primarily used a wheelchair for mobility. Individuals who had participated in a fall prevention program or received advice from a healthcare professional about fall prevention in the past 12 months were also excluded. Older participants were recruited by means of posters and promotional leaflets distributed in the targeted LIH buildings, along with personalized outreach by the field worker from the community partner organization. Eligibility for participation was confirmed through a telephone screening interview conducted by a research professional.

The two facilitators, along with the community organization's field worker, were also included as study participants. Although she did not attend the sessions, the field worker had full access to the facilitation materials, including the educational videos. Gathering the perspectives of these three study participants served as an essential triangulation strategy to gain a more comprehensive understanding of the program's feasibility. Written informed consent was obtained from each participant prior to the start of their involvement in the study.

The program was offered to two groups of eight to nine older adults: a first group in summer 2023 and a second group in autumn 2023. Each group was held in a different LIH building in the Côte-des-Neiges neighbourhood but was led by the same two facilitators.

2.4. Data Collection

Data for this study were collected at four time points: (1) before the program; (2) during the program; (3) after the program; and (4) a few months after both groups had completed the program (after the intervention phase). Table 2 presents the study's data collection methods for each of the five feasibility dimensions and associated outcomes of interest as defined in Bowen et al.'s framework [46]. Each interview with older participants lasted between 60 and 90 min and was conducted in their homes. Interviewers received a brief standardized training session led by the principal investigator. This training included a detailed review of the interview guide (covering all questionnaires and interview questions) and instructions on standardized administration procedures. Interviewers were also provided with a booklet containing response scales for all questionnaire items and a calendar tool to support recall for time-based questions (e.g., activities performed over the past four weeks), to be used during interviews. To enhance consistency in pre- and post-program interviews, each participant was assigned to a single interviewer (with one exception due to scheduling constraints at post-test).

Facilitators (the occupational therapy student and the older adult volunteer) were interviewed twice (i.e., after the program completion for each group), and the community field worker was interviewed once. These interviews were conducted by the doctoral student (RDL) using semi-structured interview guides.

2.4.1. Demand

Demand refers to the estimated or actual use of an intervention within a defined population or implementation context [46]. The indicator chosen to assess the program's demand was actual use, which encompasses characteristics of older participants who were

recruited, participants' retention and attendance rate. Sociodemographic characteristics (e.g., age, sex, living alone or not, level of education) and health-related variables (e.g., perception of health conditions) were documented before the program, based on items from the Santé Québec questionnaire [47]. Perceived economic condition was assessed on a five-point Likert scale, ranging from very difficult (0) to very comfortable (4). The number of falls experienced in the previous year, the use of mobility aids, as well as concerns about falls (single question; see above), were also collected. Participant retention and attendance rates were documented using attendance sheets completed by facilitators at each session.

Table 2. Data collection methods by dimensions and outcomes of interest of Bowen et al.'s framework [46].

Dimensions	Outcomes of Interest	With Older Participants		Attendance Sheets and Observation Grids	With Facilitators	With Field Worker
		Before the Program	After the Program	During the Program	After the Program	After the Intervention Phase of the Study
Demand	Actual use	•		•		
Acceptability	Satisfaction		•		•	•
	Perceived appropriateness					•
Implementation	Degree of program execution			•		
	Factors affecting implementation ease or difficulty				•	
Integration	Perceived fit with infrastructure					•
	Perceived sustainability					•
Limited-efficacy testing	Intended effects of program on key intermediate outcomes	•	•			

2.4.2. Acceptability

Acceptability is defined as "how the intended individual recipients—both targeted individuals and those involved in implementing programs—react to the intervention" [46] (p. 3). Indicators used to explore the acceptability of the program included satisfaction and perceived appropriateness. A questionnaire was administered to older participants during semi-structured individual interviews at the end of the program. It included questions assessing satisfaction with various aspects of the program, such as its content and format, as well as overall satisfaction and most and least appreciated features. Individual interviews with facilitators were also conducted after the program to document their satisfaction with the content and format and their overall experience delivering the program. Finally, an individual interview was conducted with the field worker after the intervention phase of the study to document her satisfaction with the program's content and format, along with her perceptions of its appropriateness for the target population, including its strengths and limitations.

2.4.3. Implementation

Implementation is defined as "the extent, likelihood, and manner in which an intervention can be fully implemented as planned and proposed, often in an uncontrolled design" [46] (p. 3). It was assessed by examining the degree of program execution and the factors affecting implementation ease or difficulty. To evaluate the degree of program execution, an observer (RDL) attended each session and recorded whether each program activity was carried out as planned, using session-specific observation grids. In addition, individual interviews were conducted with facilitators following the final session of each group to document their perspectives on the factors that either facilitated or hindered program delivery.

2.4.4. Integration

Integration is defined as "the level of system change needed to integrate a new program or process into an existing infrastructure or program" [46] (p. 3). To explore the program's integration, two key indicators were examined: perceived fit with infrastructure and perceived sustainability. These aspects were assessed through the individual interview conducted with the field worker from the community partner organization. The interview included questions such as "To what extent is the program aligned with the mission and other interventions of the Côte-des-Neiges Seniors' Centre?" and "What factors are likely to facilitate or hinder the integration of the program in your organization?".

2.4.5. Limited-Efficacy Testing

According to Bowen et al. (2009), "many feasibility studies are designed to test an intervention in a limited way" [46] (p. 3), typically focusing on key intermediate rather than final outcomes and being conducted with limited statistical power. Accordingly, data were collected through questionnaires administered during semi-structured individual interviews with older participants at two time points: before and after the program.

The key outcomes of this study were concerns about falls and activity restriction associated with fear of falling. Additional outcomes included other fall-related psychological factors (perceived control over falls and confidence in managing fall risks), level of physical activity, level of participation in social activities, and fall-related knowledge. These outcomes were measured pre- and post-program using assessment tools commonly employed in fall prevention and fear of falling research among older adults (see Table 3).

Table 3. Outcomes and respective assessment tools.

Outcomes	Assessment Tools
Concerns about falls	A French version of the Falls Efficacy Scale-International (FES-I): 16-item scale measuring concerns about falling during various activities, on a scale from 1 to 4 [48]. A single question: "Are you concerned about falls?", on a four-point scale (0 = never, 1 = occasionally, 2 = often, 3 = very often).
Activity restriction related to fear of falling	A single question: "In the past four weeks, have you restricted any activities at home or outside of your home due to fear of falling?", on a four-point scale (0 = never, 1 = occasionally, 2 = often, and 3 = very often) [49,50]. Ten Yes/No statements, assessing whether older adults had limited their participation in specific daily activities (e.g., walking outdoors, going up and down stairs, exercising or playing sports) in the previous four weeks due to fear of falling.
Perceived control over falls	A French version of a four-item scale developed by Tennstedt et al. [29], including statements such as "I can reduce my risk of falling", rated on a four-point Likert scale (1 = strongly disagree to 4 = strongly agree).
Confidence in ability to manage fall risks	Six items inspired by a scale developed by Tennstedt et al. [29] (e.g., preventing falls, getting up after a fall), rated on a four-point Likert scale ranging from "not at all confident" to "very confident".
Participation in social activities	A modified version of a questionnaire developed by Richard et al. [51], assessing frequency of participation in nine types of social activity (e.g., visiting family or friends, attending cultural or sporting events, volunteering) over the previous four weeks (3 = almost every day, 2 = at least once a week, 1 = at least once a month, and 0 = never)

Table 3. *Cont.*

Outcomes	Assessment Tools
Physical activity (variety and frequency)	A modified version of the French CHAMPS questionnaire [52–54], measuring older adults' engagement in physical activities over the previous four weeks.
Knowledge related to falls among older adults	A six-item true-or-false questionnaire specifically developed for the study (see Table S1 in Supplementary Materials).

The perceived benefits of participating in the program were assessed using a questionnaire including 11 items, which older adults rated on a five-point Likert scale (0 = strongly disagree to 4 = strongly agree). For example, participants were asked to rate their level of agreement with the following statement: "The program helped me feel more confident during my daily activities." In addition, participants indicated whether, as a result of the program, they had made changes in any of the following areas: activity engagement, home environment safety, and fall prevention behaviors.

2.5. Data Analysis

Descriptive statistics were used to provide a profile of the study's older participants. Paired *t*-tests were conducted for all outcome variables, as sensitivity analyses revealed consistent results using the non-parametric equivalent (Wilcoxon signed-rank tests). Effect sizes were calculated using Cohen's *d* for paired samples and interpreted according to conventional thresholds (0.2 = small, 0.5 = medium, and 0.8 = large effects) [55]. In the context of this pilot feasibility study, effect sizes were used to provide an indication of the magnitude of observed changes, despite limited statistical power. Accordingly, a non-significant result does not necessarily indicate the absence of an effect [56]. Missing data were handled using a minimum response threshold of 75%, unless otherwise specified by the measurement tool. Quantitative data related to acceptability, demand, and implementation were also analyzed using descriptive statistics. All statistical analyses were performed using SPSS software, version 31.0.

For qualitative data analysis, a deductive-inductive approach was used, following cycles of coding based on the methods described by Miles et al. [57]. The interviews with the facilitators and the community field worker were first transcribed verbatim. Deductive coding was then initiated using a provisional list of overarching themes (feasibility dimensions) and subthemes (outcomes of interest) derived from Bowen et al.'s framework [46], but further codes were developed within each subtheme through inductive coding. Additionally, new subthemes were allowed to emerge from the data, enabling the identification of unexpected insights beyond the initial framework and ensuring a richer understanding of participants' unique perspectives. Initially, two interviews were coded by the first author (RDL), and the preliminary coding structure was reviewed by two co-authors (NB and JF). Based on their feedback, the coding of the first two interviews was revised by RDL, and the remaining interview transcripts, along with older participants' short-answer responses to open-ended questions, were coded. A second validation of the full coding structure was performed collaboratively with the same co-authors, leading to a few final adjustments, including clarification of certain codes. Given the convergent mixed-methods approach, a merging integration strategy was employed—meaning that qualitative and quantitative data were analyzed jointly and compared when relevant [45]. In practice, this integration was achieved through the development of a comprehensive matrix table, allowing side-by-side comparison of findings from the quantitative and qualitative analyses. This matrix was developed by RDL and validated by co-authors NB and JF (see Table S2 in Supplementary Materials). Verbatim transcription, coding, and development of the integration matrix were all conducted using Microsoft Word for Mac (Microsoft 365 version).

3. Results

3.1. Demand

3.1.1. Actual Use

As mentioned earlier, the program was offered to two groups of eight to nine older adults. Due to recruitment challenges and to account for potential absences or dropouts, three older adults who did not reside in LIH but were concerned about falls were allowed to participate in the program to ensure sufficient group interaction. Because they did not meet all the inclusion criteria, these older adults were not included in the study sample. Consequently, the final study sample consisted of 14 older adults, including six participants in the first group and eight participants in the second group.

Characteristics of Older Participants

Table 4 presents characteristics of older participants. Their age ranged from 64 to 93 years (mean age = 75.5 years). The majority were women (78.6%) and nearly all lived alone (92.9%). Most older participants rated their health as good, very good, or excellent (35.7%, 28.6%, and 7.1%, respectively). Nearly half reported using a mobility aid (42.9%), most commonly a cane. Half of the participants had experienced one or more falls in the previous year (50.0%), and over a third (35.7%) reported having restricted at least one activity over the past four weeks due to fear of falling. Finally, 78.6% of participants reported being occasionally concerned about falls, while 21.4% reported being often or very often concerned about falls.

Participant Retention and Attendance Rates

The retention and attendance for the program sessions were excellent, at rates of 100% and 95.2%, respectively.

Table 4. Characteristics of older participants (n = 14).

Variables	Mean ± s.d. or %
Age (years)	75.5 ± 8.4
Women	78.6
Living alone	92.9
Language usually spoken at home	
French	35.7
Romanian	21.4
English	14.3
Spanish	14.3
Bulgarian	7.1
Creole	7.1
Highest level of education	
Primary	14.3
Secondary	14.3
College	21.4
University	50.0
Perception of economic situation *	
Very difficult	0
Difficult	15.4
Average	69.2
Comfortable	15.4
Very comfortable	0

Table 4. *Cont.*

Variables	Mean ± s.d. or %
Perception of health condition	
Poor	0
Average	28.6
Good	35.7
Very good	28.6
Excellent	7.1
Uses a mobility aid to get around	42.9
Number of falls in the last year	
0 fall	50.0
1 fall	35.7
2 or more falls	14.3
Restricted at least one activity in the past four weeks due to fear of falling	35.7
Concerns about falls	
Occasionally	78.6
Often	14.3
Very often	7.1

* $n = 13$.

3.2. Acceptability

3.2.1. Satisfaction

At the end of the program, 92,8% of older participants reported being very or somewhat satisfied with their participation, indicating a high overall level of satisfaction (see Table 5).

Satisfaction with Program Content

In general, older participants expressed satisfaction with the program's content, including the topics covered, the information provided, the activities proposed, and the educational materials distributed. The average satisfaction level with these specific aspects was rated at 3.6 or higher on a five-point Likert scale (where 0 = strongly disagree and 4 = strongly agree) (see Table 5). These findings are supported by the field worker's feedback:

> *I think the program responds well to their needs when it comes to falls. In fact, several aspects of falls are well covered. It's not just the fact of falling, but there are many things that come into play in the context of falls. It can be not only physical, it can also be psychological... It can be auditory, visual, it can be the environmental aspect. I think it's really good, it's very instructive, very educational overall. (Field worker)*

Regarding the material presented to participants, both the facilitators and the field worker believed it was adapted to the needs and abilities of older adults. Specifically, they highlighted that it included an appropriate amount of information, featured numerous clear visuals, used a font size that was easy to read, and incorporated a video narration that supported comprehension of the program content among older adults:

> *The video capsule was adapted to be as simple to understand as possible, with visual support, images, and a way of speaking that wasn't too fast or too slow, which helped everyone understand. I think the participant's workbook was also appropriate in that there was really a lot of information so that people could have all the information they needed for the program. And the size of the text was also adapted for easy reading.* (Field worker)

Satisfaction with Program Format

Overall, study participants were satisfied with the number, duration, and frequency of the sessions. However, 21.4% of older participants felt that the number of sessions was insufficient. This view was echoed by one of the facilitators, who noted that some sessions were quite dense:

> *I would say it's not enough sessions, especially for the physical activity session. It felt like two sessions in one because you have to present all the material, the theory related to physical activity, and then experiment with the exercise program. It's hard to fit all of that into an hour and a half.* (Facilitator 1—Group 1)

Table 5. Program satisfaction.

Variables	Older Adults (n = 14)	Facilitators (n = 2)	Field Worker (n = 1)
	Mean ± s.d. or %	%	%
Overall level of satisfaction			
Not at all satisfied	0		
Slightly satisfied	7.1		
Somewhat satisfied	35.7		
Very satisfied	57.1		
Satisfaction with program content			
Clarity of information provided (0–4)	3.8 ± 0.4		
Relevance of topics covered (0–4)	3.6 ± 0.8		
Interest in the proposed activities (0–4)	3.7 ± 0.5		
Usefulness of documents provided (0–4)	3.8 ± 0.4		
Satisfaction with program format			
Session duration			
Too long	14.3	0	0
Adequate	71.4	100	100
Too short	14.3	0	0
Number of sessions			
Too many sessions	7.1	0	0
Adequate	71.4	50.0	100
Not enough sessions	21.4	50.0	0
Frequency of sessions			
Too frequent	0	0	0
Adequate	100	100	100
Not frequent enough	0	0	0
Facilitation of the program			
Not at all satisfied	0		
Slightly satisfied	0		
Somewhat satisfied	7.1		
Very satisfied	92.9		

Older participants also reported high satisfaction with the facilitation of the program (see Table 5). Two participants mentioned that they particularly appreciated the presence of the older co-facilitator, emphasizing that she understood the participants' experiences and shared similar perspectives. This perception was echoed by both facilitators and the field worker. One facilitator explained:

> *It resonates with participants, the fact that the [older] co-facilitator can talk about certain things. For example, I remember a session where we discussed hearing difficulties, and the co-facilitator shared her own experience. And then you could see it really resonated with the [program participants].* (Facilitator 1—Group 1)

The field worker pointed out that having a peer leader helps to acknowledge the contributions and potential of older adults: *I think it's a great idea to value older adults, to highlight their potential.* (Field worker) Two older participants noted that the younger co-facilitator brought valuable knowledge related to the program content. This was consistent with feedback from the older facilitator, who emphasized that having a university-level student from a health-related field contributed to a more "professional" presence and helped address questions that required an expertise in the health domain: *I felt like I was with a young person, but also a professional. There were [questions] she could answer [. . .] very well, that I couldn't have answered.* (Facilitator 2—Group 2).

Most and Least Appreciated Features of the Program

Older adult participants reported several features of the program that they particularly appreciated. These included the quality of the facilitators, who were described as clear in their explanations, patient, and kind to all participants (n = 7); the information and recommendations provided, which enabled participants to acquire new knowledge about fall prevention (n = 6); the exercise module (n = 5); the delivery format, which combined video capsules, in-person facilitation, and group activities (n = 4); the program materials (videos and printed documents) presented and handed out to participants (n = 4); and the small-group format, which fostered social interaction and sharing of experiences (n = 3).

As for the features less appreciated, some participants mentioned certain content-related elements, such as too much repetition, or a perception that some information was covered superficially or already known (n = 4). Others noted issues related to the facilitators' management of group discussions, particularly when some participants tended to dominate conversations or make comments perceived as irrelevant (n = 4). Additionally, a few participants expressed dissatisfaction with the limited time devoted to group-based physical exercises (n = 2). Four participants indicated that there was nothing they disliked about the program.

Facilitators' Experience with Program Delivery

Overall, both facilitators described their experience facilitating the program as highly positive. They reported feeling adequately prepared to deliver the program and "fairly confident" in their ability to do so. They also highlighted the good relationship they developed with one another, as well as several benefits of their involvement in the program. These included learning about fall prevention and experiencing a sense of purpose and value through the opportunity to share knowledge and witness the positive impact of the program on participants' lives (for more details on the facilitation experience and selected quotes, see Table S3 in Supplementary Materials).

Interestingly, the field worker also mentioned that her involvement in the project had enhanced her own knowledge related to fall prevention:

> *For me, it was a valuable way to learn new things and to take them into account in my own life, as well as in the lives of the people I meet every day. For example, if I see someone living in a cluttered environment, I'll talk to them a bit—just to say, 'Be careful, it can be dangerous to have things lying around on the floor.'* (Field worker)

3.2.2. Perceived Appropriateness

The field worker highlighted that one of the strengths of the program is its inclusiveness—specifically, that it can be offered to both older adults who use mobility aids and those who do not. This contrasts with a widely disseminated fall prevention program offered through the healthcare system in Quebec:

> *I find that this program is truly adapted to meet the fall prevention needs of older adults, whether or not they use a walker—so, individuals with various types of impairments. [. . .] Compared to the program I know—the PIED program—which was only available to people who didn't use a mobility aid. So it excluded a large proportion of people with disabilities or those using walkers.* (Field worker)

However, she emphasized that the availability of the program materials in only one language (French) represented a limitation, given the neighbourhood's ethnoculturally diverse population, including residents of LIH. To address this issue, she recommended developing an English version of the program, which would likely improve its reach among a larger proportion of the target population. She also suggested adding sessions dedicated exclusively to physical exercise, as these are generally well appreciated by the older adults living in LIH with whom she works.

3.3. Implementation

3.3.1. Degree of Program Execution

The degree of program execution was high (99.2%), as measured by the session-specific observation grids completed by an observer present at each session of the program.

3.3.2. Factors Affecting Implementation Ease or Difficulty

Facilitators identified six factors that, in their view, facilitated program delivery: (1) participants' interest in fall prevention, which positively impacted their level of involvement; (2) the variety of playful and interactive activities—including teamwork, competitive elements, and the use of materials—that stimulated participants' engagement and encouraged interaction; (3) the combination of video capsules and in-person facilitation, which made sessions more dynamic and fostered participants' participation; (4) the diversity of topics covered, which aligned with participants' interests and needs; (5) the accessibility of the program location; and (6) the inclusion of a 10 min break during each session, giving participants the opportunity to socialize and stretch their legs.

Facilitators also noted two factors that hindered program delivery. First, both facilitators highlighted the language barriers faced by some participants (i.e., difficulty understanding or expressing themselves in French), which may have negatively influenced their level of participation:

> *I think for one of the participants in this group, it was harder to understand everything. So maybe that made it a bit harder to participate. And maybe the fact that she wasn't comfortable expressing herself in French led her to speak less or participate less during the sessions.* (Facilitator 1—Group 1)

Second, both facilitators mentioned that inadequate room conditions for the second group—particularly poor visibility of the educational videos due to excessive natural lighting and poor acoustics—negatively impacted the audio-visual quality of the sessions (see Table S4 for specific quotes related to each factor in Supplementary Materials).

3.4. Integration

3.4.1. Perceived Fit with Infrastructure

The field worker reported that the program aligned well with the mission of the community partner organization:

> *"It fits within our collective approach—the group activities we organize to help people socialize and maintain their independence for as long as possible. It aligns with that part of our mission, to help people connect with others. It's also a form of education—educating people for their overall well-being."* (Field worker)

She further mentioned that the program was consistent with the type of activities offered by her organization, especially considering their collaboration with the healthcare system in delivering a fall prevention program prior to the pandemic. Additionally, the field worker noted that the adapted LiB program could be implemented by other organizations. This suggests a good potential for broader dissemination across the neighbourhood:

> *"I think this is a program that could be offered by other organizations as well—for educating older adults and even their loved ones about fall prevention. So I think if we could promote it broadly, and if other community partners and organizations got on board, it would help raise awareness and help people take ownership of the tools. . . to become informed."* (Field worker)

3.4.2. Perceived Sustainability

The field worker identified two key elements that could support the integration and sustainability of the program: (1) collaborating with tenant committees in LIH to secure access to community rooms and mobilize residents, and (2) maintaining the partnership with the research team for the recruitment of student facilitators. She also mentioned that one of the main challenges to program sustainability lies in recruiting and training older adults who would be interested in co-leading the sessions and have the necessary skills to facilitate such a group program:

> *"Not just anyone can do that. It would need to be someone with strong French [communication] skills, and a good level of comprehension and reasoning."* (Field worker)

3.5. Limited-Efficacy Testing

3.5.1. Program Outcomes

Table 6 presents the scores before and after the program for the outcome variables, along with the corresponding *p*-values and effect sizes (Cohen's *d*). None of the observed changes reached statistical significance. Nevertheless, mean scores for some variables reflected improvements between the two time points, with effect sizes approaching a medium magnitude ($d \approx 0.5$). Specifically, increases were observed in participation in social activities ($p = 0.091$; $d = 0.49$) and fall-related knowledge ($p = 0.139$; $d = 0.42$). A decrease was also noted in activity restriction associated with fear of falling ($p = 0.157$; $d = 0.42$). Effect sizes for concerns about falls, perceived control over falls, confidence in the ability to manage fall risks, and physical activity levels were small to negligible, suggesting limited or no observable changes in these outcomes.

Table 6. Outcome variable scores before and after the program ($n = 14$).

Variables	Before the Program	After the Program	*p*	Cohen's *d*
	Mean ± s.d. or %			
Concerns about falls (1 question)			0.366	0.27
Never	21.4	7.1		
Occasionally	35.7	78.6		
Often	35.7	14.3		
Very often	7.1	0		
Concerns about falls (FES-I)	24.86 ± 8.02	25.43 ± 9.72	0.677	0.11
Activity restriction related to fear of falling (1 question)			0.272	0.31
Never	85.7	71.4		
Occasionally	14.3	21.4		
Often	0	7.1		
Very often	0	0		

Table 6. *Cont.*

Variables	Before the Program	After the Program	*p*	Cohen's *d*
	Mean ± s.d. or %			
Activity restriction related to fear of falling (average total for a list of 10 activities of daily living)	1.15 ± 1.95 *	0.46 ± 0.97 *	0.157	0.42
Perceived control over falls (1–4)	3.30 ± 0.50 *	3.24 ± 0.50 *	0.715	0.1
Confidence in ability to manage fall risks (1–4)	3.41 ± 0.43 *	3.41 ± 0.50 *	0.985	0.15
Physical activity (CHAMPS)				
Variety of physical activities (/week)	3.50 ± 2.24	3.50 ± 1.92	1	0
Frequency of physical activities (/week)	16.16 ± 10.78	16.22 ± 8.77	0.985	0.01
Participation in social activities	7.57 ± 4.31	8.79 ± 5.24	0.091	0.49
Knowledge related to falls among older adults	4.63 ± 1.00	5.14 ± 0.53	0.139	0.42

* $n = 13$.

3.5.2. Perceived Benefits

All older participants perceived benefits from their participation in the program. Notably, they all agreed or strongly agreed that the program had helped them learn more about ways to prevent falls (100%; average score of 3.6 out of 4) and to be more aware of fall risks (100%; average score of 3.6 out of 4). A large majority also reported greater confidence in their ability to avoid falls (84.6%; average score of 3.4 out of 4) (see Table 7).

Table 7. Older adults perceived benefits regarding their participation in the program ($n = 13$).

Perceived Benefits of the Program	Mean ± s.d.
The program helped me...	
Learn more about how to prevent falls (0–4) *	3.6 ± 0.5
Be more attentive to the risk of falls (0–4)	3.6 ± 0.5
Feel more confident in my ability to avoid falls (0–4)	3.4 ± 0.8
Learn more about the fear of falling and its consequences (0–4)	3.2 ± 0.7
Learn more about how to make my home and environment safe (0–4)	3.2 ± 0.7
Modify some of my behaviors and habits to prevent falls (0–4)	3.2 ± 0.9
Feel more confident during my daily activities (0–4) *	3.1 ± 0.8
Know what to do in the event of a fall (0–4)	2.9 ± 1.1
Know some of the resources available in the community (0–4)	2.8 ± 1.0
Meet people, socialize (0–4)	2.8 ± 1.4
Do more exercises (0–4)	1.9 ± 1.6

* $n = 14$.

Furthermore, a total of 76.9% of participants reported having made changes to at least one of the three domains targeted by the fall prevention strategies addressed in the program. Specifically, 53.8% of participants reported having made changes in their behaviors and habits, 38.5% reported having made changes in their home environment, and 38.5% reported having made changes in their level of physical or social activity.

4. Discussion

Overall, the findings of this study suggest that the adapted version of the LiB program is feasible among older adults living in LIH in the Côte-des-Neiges neighbourhood, a highly ethnoculturally diverse urban setting. Despite some recruitment challenges, 14 participants

meeting the target population criteria were successfully enrolled and completed the program, yielding a perfect retention rate and a high attendance rate. The program also showed high acceptability among all study participants, including older adults living in LIH, program facilitators, and the field worker from the project's partner community organization. Nevertheless, some areas for improvement were identified to further enhance acceptability, namely the development of an English version of the program and the inclusion of more group-based physical exercises. Regarding the implementation dimension, the sessions were conducted as planned, supported by several factors identified by the facilitators, such as older participants' interest in the diversity of topics covered and the program's facilitation modalities (a combination of video capsules, in-person facilitation, and interactive activities). Findings also suggest a strong potential for program integration within the partner organization, provided that key partnerships and collaborations are established. Finally, although no statistically significant pre- to post-program changes were observed, effect sizes of small to moderate magnitude were noted in several outcome variables. In addition, older participants reported multiple perceived benefits, while most indicated having applied some of the program's key recommendations. These findings are discussed in more detail below.

Although the program was successfully delivered to two groups of older adults and reached a total sample of 14 participants living in LIH, recruitment challenges were encountered within the timeframe of the study, suggesting some limitations in program demand. These challenges were largely attributable to the fact that the program was offered exclusively in French in a highly ethnoculturally diverse neighbourhood. It is estimated that nearly 32% of residents in Côte-des-Neiges cannot sustain a conversation in French [42], a proportion that may be similar among older adults living in LIH. Language barriers may therefore have limited program participation for some older adults. This interpretation is echoed by a comment made by the field worker, who identified the program's exclusive use of French as an important weakness, as it limited its ability to reach several older adults in the neighbourhood, including those living in LIH. Broader structural and social factors related to the experiences of older adults living in LIH in Côte-des-Neiges may also have played a role [42]. These include perceived prejudices or stereotypes toward individuals from different cultural backgrounds, as well as previous experiences of exclusion or discrimination within institutions. Such factors have recently been identified as significant barriers to engagement and social participation among older immigrant populations [58,59] and may have further compounded recruitment challenges.

On the other hand, those who were recruited demonstrated an excellent engagement in the program, with retention and attendance rates of 100% and 95.2%, respectively, exceeding those reported in other studies evaluating similar interventions [30,60–62]. Several factors may help explain these positive results. First, offering the program directly in participants' housing facilities, thereby reducing the burden of travel, may have facilitated consistent attendance. Second, participants highlighted their appreciation of the facilitators and their approach to program delivery, the information and recommendations provided, and the group format of the program, which offered opportunities for social interaction. These elements have been identified as key contributors to adherence in fall prevention programs [60]. Third, all participants reported perceived benefits from the program, such as learning more about ways to prevent falls and becoming more aware of fall risks, another factor known to foster sustained participation in fall prevention initiatives [60].

Regarding program acceptability, this study highlighted that several factors contributed to the program's positive reception among participants. One of the most significant appears to be the facilitation format, which paired an older adult peer leader with an occupational therapy student. The presence of a peer leader who could connect with

participants, share experiences, and offer relatable perspectives likely played a key role in this positive response toward the program. These results are consistent with a previous effectiveness study of the original LiB program [63]. Moreover, the literature suggests that beyond being well received by participants, this approach has the potential to positively influence older adults' beliefs, knowledge, motivation, and engagement in health-promoting behaviors [64,65], including the adoption of fall prevention strategies [66–68]. The presence of the occupational therapy student also played an important role by providing content expertise and reassurance to the older co-facilitator. In recent years, facilitation by university students from health-related fields has emerged as a promising approach in fall prevention initiatives, with strong potential for acceptability [69,70]. To our knowledge, this type of co-facilitation approach has rarely been described in programs targeting fear of falling and its impact on activity engagement. In this study, the pairing proved highly complementary in terms of expertise and was particularly well received by all participants.

Another aspect that seems to have contributed significantly to the program's high level of appreciation is its content, notably the information and recommendations provided, the proposed activities, and the materials distributed. While this adapted version is based on the original LiB program, which was appreciated by older adults in terms of its core themes, information, and activities [63], it was carefully tailored to the needs and context of older adults living in LIH. This adaptation was achieved through a co-creation process grounded in human-centered design, involving members of the target population [71]. It considered both social and cultural aspects, including the characteristics and lived experiences of older adults living in LIH. The findings from this study thus support the value of using co-creation strategies to enhance the acceptability of health interventions [72–74], including among underserved or disadvantaged populations [75].

Despite the program's high acceptability and the many positive aspects highlighted by participants, a few areas for improvement also emerged. Notably, a few older participants and one facilitator mentioned that the program did not include enough sessions. Additionally, some older participants indicated that they would have appreciated the inclusion of more group-based physical exercises within the program. Such feedback from participants and facilitators should be carefully considered in future iterations of the program, particularly given the well-documented benefits of physical exercise in reducing fear of falling among older adults [76,77], as well as the strong appreciation for this type of activity reported by this population [66,78].

With regard to the program's potential effects on key outcomes, study findings showed improvements in mean scores for some outcomes following program participation, with effect sizes approaching a medium magnitude for participation in social activities, fall-related knowledge, and activity restriction associated with fear of falling. However, none of these changes reached statistical significance. Given the magnitude of the observed effect sizes, it is plausible that a larger sample would have allowed for the detection of statistically significant changes in these outcomes. This interpretation is supported by several studies on interventions targeting fear of falling and activity restriction. For example, the original LiB intervention was evaluated in a non-randomized trial conducted among a sample of 135 older adults living in senior housing and demonstrated significant positive effects on fall-related psychological factors, engagement in physical and social activities, and knowledge of fall prevention strategies [36]. Similarly, Tennstedt et al. [29] evaluated the AMB program in a randomized controlled trial involving 434 older adults. Their study revealed improvements in participants' fall efficacy, perceived ability to manage falls, and intended activity levels. Zijlstra et al. [30] also reported significant positive effects of a Dutch adaptation of the AMB program in a randomized controlled trial among

540 community-dwelling older adults, including improvements in fear of falling, activity restriction, and engagement in daily activities.

Beyond the limited sample size, other factors may help explain the absence of statistically significant changes in the outcome variables in the present study. First, substantial adaptations were made to the original LiB program during the co-creation process, resulting in a total reduction of 7 h of group activities (primarily related to physical exercise), as well as the choice of a weekly rather than biweekly session frequency to better suit the LIH context. This lower intervention intensity may have weakened the program's underlying mechanisms of action, through which participants are exposed to cognitive restructuring (e.g., reframing fear of falling), behavioral activation, and physical activity. As a result, the program's potential to produce measurable changes in psychological and behavioral variables related to falls may have been attenuated. Second, for nearly two-thirds of participants (64.3%), French was not the primary language spoken at home. This may have affected their comprehension of both the program content and the questionnaires used to assess outcomes. In fact, some participants reported during the interviews that they found it challenging to understand questions that required a certain level of abstract thinking, particularly those related to perceived control over falls and confidence in their ability to manage fall risks. Third, ceiling or floor effects may also have played a role. Several baseline scores for key outcome variables were near the extreme ends of their respective scales, which may have limited the potential for improvement. For example, baseline scores for perceived control over falls and confidence in the ability to manage fall risks were already high (ceiling effect), while those for activity restriction due to fear of falling were relatively low (floor effect). These conditions reduced the likelihood of detecting significant changes following participation in the program. These measurement choices reflect a broader limitation in the field at the time of the study, namely, the scarcity of validated and sensitive instruments specifically designed to assess these psychological and behavioral factors related to falls. Recently developed tools show promising psychometric properties, including the Updated Perceived Control over Falling Scale [79], the Multidimensional Falls Efficacy Scale [80], and the Falls Efficacy Scale–International Avoidance Behavior [81], and should be considered in future studies. Nevertheless, evidence regarding their sensitivity to change, particularly among community-dwelling, independent older adults, remains limited.

Furthermore, a discrepancy was observed between fear of falling scores obtained at the eligibility screening call and those collected at the baseline interview. Although all participants reported at least occasional concerns about falling during the eligibility screening call, three of them stated that they were never concerned about falling at the baseline interview. This raises some questions regarding the reliability of a single question to assess fear of falling. This discrepancy between fear of falling scores may reflect an actual change in participants' concerns regarding falls. However, we cannot rule out the possibility that some participants overstated their fear of falling during the screening call to be deemed eligible for the program. A similar discrepancy in participant responses was observed in a study of the original LiB program [63], where approximately 7% of participants reported no fear of falling during the first face-to-face interview, although they had previously indicated at least occasional fear of falling during the eligibility screening call. Consequently, a multiple-item measure such as the FES-I might be a more reliable instrument to assess the impact of programs like LiB on fall-related psychological outcomes. In the present study, although responses to the single screening question about fear of falling were inconsistent for three participants, they all reported being "somewhat concerned" about falling in at least one activity on the FES-I scale administered at baseline.

4.1. Strengths of the Study

To our knowledge, this is the first program targeting fear of falling and its consequences on activity engagement specifically adapted for older adults living in LIH. Intervening with this population presents a number of challenges, particularly given that older adults living in LIH may be difficult to reach, socially isolated, and less likely to engage in community-based activities [40]. This was also echoed by the community field worker early in the project, who noted that older LIH residents rarely participated in the activities offered at the community organization.

Nevertheless, offering the program directly within their building appears to be a promising strategy, as it provides an accessible opportunity for social participation. This seems especially relevant, as many opportunities for social engagement suspended during the COVID-19 pandemic had not yet resumed at the time of the study. Moreover, the small-group format of the program, which fostered social interaction and sharing of personal experiences, holds considerable potential. Unsurprisingly, this was among the most appreciated aspects of the program according to participants, a finding consistent with reports from several other studies [60,74,82].

There is a particularly strong case for implementing fall prevention initiatives among older adults living in public housing, since they experience a significantly higher prevalence of falls than the overall population of older adults, as shown in a Canadian study [39]. Implementing fall prevention programs in LIH has the potential to empower residents to live more safely and independently, while reducing their risk of falls and related injuries.

Finally, this study makes an important contribution to the scientific literature by examining the feasibility of a culturally and socially adapted, group-based program targeting fear of falling and its impact on activities engagement among a structurally disadvantaged older population. Research involving older adults living in public housing remains limited, partly because of the many barriers that affect their participation in studies. These barriers are often rooted in broader social conditions that influence health, contributing to the exclusion and marginalization of this population [41]. Conducting research with this group is essential to better understand their specific needs and challenges, and to develop more effective interventions tailored to this population [41].

4.2. Study Limitations and Future Research

This study has a few limitations. First, the use of self-reported measures to assess program-related changes, perceived benefits, and satisfaction may have introduced social desirability bias (i.e., older adults may have adjusted their responses to conform to what they perceived to be expected by the interviewer). Future studies may consider incorporating objective measurement tools, such as wearable technologies (e.g., GPS-based tracking devices), to monitor indicators of activity level, including the number of outings from the home and types of locations visited [83].

Second, the inclusion of three older adults who did not reside in LIH but participated in the program sessions may have influenced group dynamics. Although this aspect did not emerge during our data collection, it is important to acknowledge that study participants' experiences of the program may have been shaped by the presence of these individuals. While this approach was acceptable within the context of a pilot feasibility study, future large-scale studies evaluating the program's impact (e.g., randomized controlled trials) should adopt more stringent eligibility criteria.

Third, language barriers experienced by some participants may have influenced their understanding of the program content, potentially affecting the program's capacity to produce measurable changes in the variables of interest. In addition, these communication challenges may have extended to the questionnaires used to assess intervention outcomes,

thereby introducing potential measurement errors and affecting the validity of self-reported data. This limitation may have been further compounded by the fact that some of the measurement tools used were not fully validated or culturally adapted for ethnoculturally diverse LIH populations. Future studies should consider employing more culturally sensitive and linguistically adapted instruments to improve measurement accuracy.

The small sample size of this study (n = 14) is not a limitation per se, given that pilot feasibility studies are not designed to evaluate intervention effectiveness. Nevertheless, caution is warranted when interpreting the findings, as the small sample size may not adequately capture the diversity and variability of the broader target population [84], limiting the generalizability of the results. Future studies aiming to evaluate the program's effectiveness should be conducted among larger samples of older adults living in LIH, drawn from a wider range of neighbourhoods and geographic contexts, including suburban and rural settings. Based on the effect sizes observed in the present study, an estimated sample of approximately 50 participants would be required to detect medium-sized effects with 80% statistical power.

5. Conclusions

This study provides support for the feasibility of the adapted LiB program among older adults living in LIH in an urban neighbourhood characterized by high ethnocultural diversity. Although no statistically significant changes were observed in the outcome variables, the program yielded several positive results. Participants reported benefits and high levels of satisfaction, while a high degree of program execution was achieved in LIH settings. Moreover, the program's potential for integration within the partner community organization reinforces its relevance and real-world applicability. The program stands out for its original facilitation approach, which values older adults' role in promoting the health of their peers while underscoring the added value of a collaborative model that combines the respective expertise of a rehabilitation student and an older adult. Program feasibility could be further enhanced through the development of an English version of the materials, which would allow the program to reach a larger proportion of older adults living in LIH in the Côte-des-Neiges neighbourhood. Although encouraging, these findings should be interpreted with caution in light of the study conditions. Further research is needed to examine the feasibility of the program across other LIH settings and linguistic groups and, ultimately, to assess its effectiveness. In this regard, additional studies involving older adults living in public housing—and other groups at risk of marginalization—are essential to inform the development of more inclusive and culturally adapted fall prevention programs, as well as strategies to better engage underrepresented populations. Such efforts are crucial to respond more effectively to their specific needs and advance health equity in underserved communities.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/jal6020045/s1, Table S1: True-or-false questionnaire used to assess older adults' knowledge about falls; Table S2: Matrix used for mixed-methods analyses; Table S3: Sub-themes emerging from facilitators' experience; Table S4: Factors that influenced program delivery from the facilitators' perspective, with illustrative quotes.

Author Contributions: Conceptualization, R.D.B.L., N.B., J.R., S.T., D.K., T.T.D.-V., K.S., F.D., E.A.N. and J.F.; methodology, R.D.B.L., N.B. and J.F.; formal analysis, R.D.B.L., N.B. and J.F.; investigation, R.D.B.L. and J.F.; resources, N.B., E.A.N. and J.F.; data curation, R.D.B.L.; writing—original draft preparation, R.D.B.L., N.B. and J.F.; writing—review and editing, J.R., S.T., D.K., T.T.D.-V., K.S., F.D. and E.A.N.; supervision, J.F.; project administration, J.F.; funding acquisition, J.F. All authors have read and agreed to the published version of the manuscript.

Funding: This project was supported by two internal grant programs of the Institut universitaire de gériatrie de Montréal—Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal and the Fonds de recherche du Québec—Santé (grant number 279512). Roxane De Broux Leduc received doctoral scholarships from the Fonds de recherche du Québec—Santé and the Fonds de recherche du Québec—Société et culture. At the time of the study, Samuel Turcotte was a postdoctoral fellow funded through the Canadian Strategy for Patient-Oriented Research of the Canadian Institutes of Health Research (POR Award—Transition to Leadership Stream, 2020–2023), and Nathalie Bier was supported by a Research Scholar Award from the Fonds de recherche du Québec—Santé.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Research Ethics Committee on Aging and Neuroimaging of the CIUSSS du Centre-Sud-de-l'Île-de-Montréal (8 February 2022; CER VN 21-22-38).

Informed Consent Statement: Informed consent was obtained from all participants involved in the study.

Data Availability Statement: The data supporting the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy and ethical considerations.

Acknowledgments: The authors would like to thank the two facilitators, as well as the 14 older adult participants, for the time devoted to the study. They also wish to acknowledge the contribution of Mélissa St-Pierre Bolduc, Mélanie Le Berre, Sania Ouattara, and Mélanie Tremblay in the co-development of the adapted version of the program. Finally, the authors express their sincere gratitude to Miguel Chagnon for sharing his valuable expertise in the project's statistical analyses.

Conflicts of Interest: The authors declare no conflicts of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

Abbreviations

The following abbreviations are used in this manuscript:

AMB	A Matter of Balance
LIH	Low-income housing
LiB	Living in Balance

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