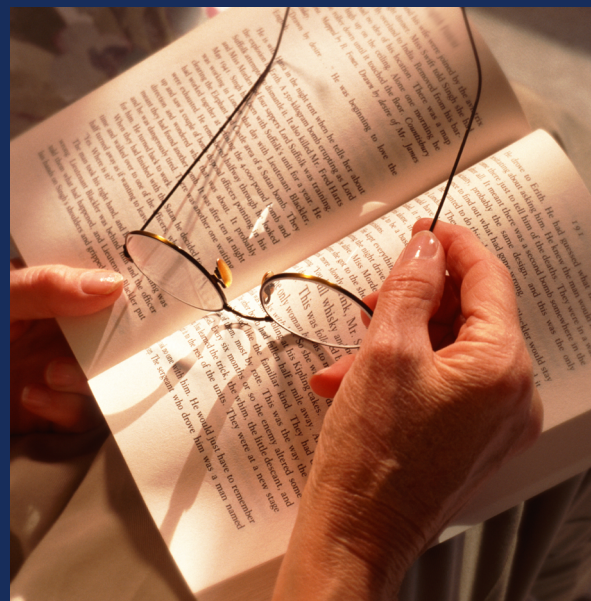# Living well in old age

The value of UK housing interventions in supporting mental health and wellbeing in later life

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About GENTOO

Gentoo is a large North East housing association. Our work is focused around three key areas to maximise our impact: people, planet and property. We invest the income from our property activities along with the talent and energy of our team into finding solutions for some of society's most pressing concerns. Ultimately we aim to enable people to realise their true potential and achieve their aspirations. Nationally, we campaign and influence strategies that may affect our colleagues and customers. Locally, we are one of the biggest employers and landlords in Sunderland. www.gentoogroup.com

About ISOS

The Isos Group is one of the North East's leading landlords – between Isos Housing as the parent company and Cestria as the wholly-owned subsidiary, the group manages more than 17,000 homes across the region, from Berwick in the north down to Stockton in the south and Cumbria in the west. Isos has a housing team dedicated to their older customers, we provide self-contained flats, sheltered schemes with communal facilities, bungalows and extra care schemes with help at hand 24/7, we offer a range of accommodation to suit all needs. www.isoshousing.co.uk.

About housing and health

housing and health is a collaboration between HACT and Common Cause Consulting, working to forge links between providers of social housing and health care services. We help housing and health providers to identify current and future opportunities in the healthcare market; develop business cases for transformation and NHS investment; reach the right people in the NHS and housing; create new partnerships between Housing Associations and NHS Providers and improve evidence and demonstrate value. housing and health offers a set of services such as consultancy; innovation and business development programmes; strategy development; masterclasses, workshops and training; good practice briefings and resources published on www.housingandhealth.org as well as research.

Contents

Background

Overview

This report presents the findings of a literature review which explored what is known about UK housing interventions that are aimed at promoting mental health and wellbeing among older people. The review was carried out by researchers at the Social Care Workforce Research Unit, King's College London, between May and October 2015. The review was commissioned by HACT and six housing associations as the first stage in an emerging programme of work that is designed to:

* Improve the evidence base through robust research and credible academic evaluation (including health economics evaluation) so that housing associations will be in a stronger position to design interventions that work and to present their offer and a persuasive business case to commissioners of health and wellbeing services.

* Raise the national profile of the sector as a credible provider of early intervention and prevention services.

* Enable the sector to implement a set of interventions that produce better health and wellbeing outcomes for older people and their families.

Aims

The aims of the review are two-fold. In part one we systematically identify research which has evaluated interventions in UK housing associations that target mental health and wellbeing among older people (their tenants or leaseholders). More specifically, we address the following research questions:

1. What are the nature and extent of literature on housing interventions for older people with mental health problems?

2. What are the typical components, content and organisational structure of the housing interventions (ie what works)?

3. What are the outcomes of the housing interventions on older people's mental health and wellbeing?

In part two, we revisit this same literature to explore questions around integration and how health, housing and social care agencies are working together to support older people's mental wellbeing and ability to live well at home. This section identifies some of the barriers to effective collaboration and how these might be overcome. We also outline, from an integrated care perspective, what is distinctive about the 'housing offer'.

Rationale

Today 30 per cent of all UK households include someone aged 60 or older – and this is set to increase. Numbers of people aged 65 and over are expected to reach 16.9 million by 2035, and to account for 23 per cent of the population (Rutherford 2012). This demographic shift is cause for celebration but also challenges existing housing, health and social care services, most of which were designed for other population profiles. While many older people live active and happy lives, contributing to society and their families, some face physical and mental health challenges that need to be addressed.

The usual problems associated with growing older are musculoskeletal problems such as arthritis, and greater risks of heart attacks, strokes and cancer. Less often mentioned is that about 15 per cent of people aged 60 and over have a mental health problem. The numbers of older people with mental health problems may increase by a third over the next 15 years (Mental Health Foundation, 2009). A recent analysis of statistics reporting client records of those recieving Supporting People funding found mental health problems were increasingly reported among tenants (Stewart, 2015). Another report commissioned by the Joseph Rowntree Foundation (JRF) also found a slight (and statistically significant) increase in the

numbers of sheltered housing tenants receiving support with their mental health problems over a four year period (Pannell and Blood 2012).

The most common mental health problems among older people are depression and dementia. Depression alone affects an estimated two million people over the age of 65 in the UK (Tucker, Darley et al. 2001). In terms of older people, about 22 per cent of men and 28 per cent of women aged over 65 years are probably affected (Mitchell, 2011). While depression and anxiety often go hand in hand, anxiety is thought to affect 3.8 per cent of older people.

One in fourteen people over the age of 65 in the UK lives with dementia and this increases to one in six over the age of 80 (Alzheimer's Society, 2012). By 2021, it is estimated that that there will be one million people in the UK with dementia (Alzheimer's Society, 2013) although the numbers may be stabilising and predictions less dramatic than thought previously (Matthews, Arthur et al. 2013). In 2002 the first wave of the longitudinal Cognitive Function and Ageing study (CFAS1) predicted that the prevalence of dementia among people aged 65 years and over would reach 8.3 per cent by 2011. The second wave of CFAS2 in 2011 found a prevalence rate of 6.5 per cent. Not all countries – for example Sweden and the Netherlands - show a statistically significant decline in incidence and prevalence (Wu, Fratiglioni et al. 2016), but nevertheless the trend appears widespread in the UK, US and Germany, and has been accompanied by greater interest in factors that might protect against, or modify, the development of dementia (ADI, 2014).

There is increasing concern about the number of older problem drinkers (Wadd et al. 2011) and the number of older people addicted to prescribed and over the counter medication but we lack reliable estimates about the numbers of people affected.

However, in addition to these statistics, many older people have undiagnosed and untreated mental health problems, some of which are severely disabling (Mental Health Foundation, 2009).

Older people are at an increased risk of developing mental health problems for several reasons. They are more likely to experience stressful life events such as bereavement, a drop in status with retirement, or a disability that affects how they get out and about and what they can do. Mental and physical health also affect each another. For example, people with a heart condition have higher rates of depression and vice versa. All of these factors can result in isolation, loss of independence, loneliness and psychological distress in older people – but these are not inevitable.

A particularly important factor is the tripartite relationship between heath, ageing and inequality (Draper and Fenton, 2014). This means that the experiences of older people from different groups in terms of age, gender, socio-economic status, will impact differently on their mental health. Several authors (Guasp, 2011, Manthorpe et al, 2010, 2012, Moriarty & Manthorpe, 2012) have highlighted the limited evidence base in terms of our knowledge about the mental health of older lesbian, gay, bisexual and transgender people and older people from minority ethnic groups.

Recovery from some forms of mental illness may be possible when a person is included and engaged in meaningful activities with others (Ryan, Ramon, & Greacen, 2012). However, social supports are typically located where a person lives which places limitations on people with limited mobility or living in places without public transport or that are not safe to access. While economic resources are important, social capital and participation may offer some protection for people living in deprived neighbourhoods (Cattell, 2012). It has been government policy for several decades that older people should to be able to achieve and sustain good mental health and wellbeing – whether this is put in terms of A Happier Old Age (DHSS, 1978) from as far back as 1978, or the current emphasis on wellbeing (as expressed in the *Care Act 2014*). Good standard, accessible, and acceptable housing - and the creation of a built environment (the villages, towns and cities) that meets the needs of an ageing population - will help everyone achieve this aim.

Housing either helps promote quality of life of older people (Evandrou et al. 2015) or it makes things worse. For many older people housing is more than bricks and mortar given the meaning (emotional and symbolic) that is attached to 'home' in later life (Robertson 2015). The charity Age Concern (now Age UK) (Age Concern 2006) identified five key areas that it considered as particularly influential on mental health and wellbeing in later life: discrimination, participation in meaningful activity, physical health, poverty and relationships (family, friends, belief). In addition,

unwanted social isolation (absence of meaningful relationships, lack of social contacts) is identified as a strong risk factor for poor mental health, which is claimed to affect a million older people in the UK (Evans and Vallelly 2007). Importantly, much depends on the definition of loneliness and isolation and whether the figures only consist of the 10 per cent of older people who report feeling lonely almost all the time or include the 30 per cent who sometimes feel lonely (Victor and Bowling, 2012).

Older people's views on housing, health and social care are often overlooked or simply not sought. The UK inquiry on mental health in later life (Age Concern 2006) argued this point, saying that the views and experiences of older people on accessing services by and actions proposed for housing, health and care sectors are neglected (Hurst and Minter 2007). When asked, the most important basic needs identified by older people, beyond health and long term care, are personal and financial security and suitable housing (Blazer, Sachs-Ericsson et al. 2005).

During times of austerity, including the financial constraints ushered in by the July 2015 Budget, it is important to know what works in supporting older people with mental health problems, so as to wisely invest increasingly limited resources. The focus on establishing what works best but is also most cost effective will help UK housing associations. Within the housing sector, providers are good at developing services for residents but capturing the outcomes of these services and evaluating their impact are less well evidenced (Mouland 2015). A multi-agency and outcomes-based approach to the wellbeing of older people could address the main challenges related to population ageing, nationally and, importantly, locally (McKinley 2010, Tickell and Connor 2015).

Defining mental health and wellbeing

The Joint Commissioning Panel for Mental Health (2013) identified some misconceptions about what constitutes 'mental health' such that it is often assumed to be mental ill health and, in particular, with older people, just dementia. It declared 'Mental health is not just about the absence of ill health but the promotion of positive health and wellbeing' (p5). For the purposes of this review we focus on mental health and wellbeing broadly so as to encompass the risks to wellbeing of older people in experiencing bereavement, social isolation and loneliness, and the impact of physical disability,

dementia and other long-term disabilities and diseases on mental health. This allows for reporting on the extent to which housing associations promote mental health and wellbeing in later life, while going beyond the absence of ill-health to incorporate feelings of satisfaction, achievement and inclusion. The promotion of mental wellbeing is not confined to one particular area of service or profession and so may be more inclusive of housing interventions (Age Concern, 2006) than other areas of practice.

There is growing international recognition of the benefits of addressing mental wellbeing as a comprehensive (and sometimes preventative) approach to mental health (Henwood 2001, Allen 2008, Nyqvist, Forsman et al. 2012). The World Health Organization (WHO) defines mental health as 'a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO, 2001). We use this definition in this present report unless otherwise indicated.

A national survey of older people's perceptions of quality of life found a close association between key themes of quality of life and mental wellbeing such as social relationships and emotional support (Bowling and Gabriel 2007). This reflects the diverse and interrelated nature of the factors that are believed to impact on mental wellbeing (Age UK, 2015). Mental wellbeing generally includes indicators related to: purpose and meaning in life; life satisfaction; a sense of belonging and support; building relationships with others, and participation in meaningful activity. While our focus is on old age, such a definition of mental wellbeing is probably applicable to most people.

Methods

Focus group consultation

To explore current housing practices related to the mental health and wellbeing of older people, information was first collected through a consultation focus group of UK social housing providers in July 2015. Representatives from seven UK social housing providers were invited to join this discussion following expressions of interest and support for the review (see inside front cover). Guided by a semi-structured discussion guide, the focus group format enabled participants to share information about their current services and evaluations. Participants were also asked to identify known gaps in services, prevalence of mental health problems and trends in demographic changes, knowledge of what works, and valued publications from housing associations and the wider sector.

Participants prioritised the following questions as the ones they thought they would elicit the most useful information for them in thinking about adapting or developing their services:

- Do scheme managers have an impact on tenants (and how)?

- Are people living healthier lives as a result of housing interventions?

- What measurable outcomes should be considered when designing and evaluating services (e.g. living well with dementia, sustained tenancies, length of stay in living space)?

- What information should be routinely collected in evaluations?

- How do we enhance the visibility of services provided among commissioners and other agencies and professionals?

Search strategy

There is considerable variability in the terms and meanings relating to housing with services for older people, leading to the retrieval of many unnecessary citations in searches and confounding any systematic analysis of the interventions and models of care provided (Wallace, Croucher et al. 2006, Howe et al. 2012). For example, terms such as 'very sheltered housing', 'supported housing', 'integrated care', 'extra care', and 'retirement village' – are all used to refer to housing schemes for older people and yet they encompass very different services.

The search terms were grouped into five categories covering:

- population/target group (using terms such as older adults, senior, elderly, ageing, aging, older people, old age)

- mental health condition problem area (mental health problems, dementia, Alzheimer's, memory, depression, hoarding, drug/alcohol/substance misuse)

- prevention/maintenance topic (mental/social/emotional/psychological wellbeing or health, quality of life, life satisfaction, meaning of life)

- intervention/method/location/service model (extra care, sheltered, general housing, specialised care)

- type of article or source (peer reviewed, published reports or grey literature).

We searched CINAHL, NHR CRN portfolio, PsycINFO, the Social Sciences Citation Index, Social Policy and Practice, EMBASE, Social Care Online, AgeINFO, Pubmed and MEDLINE databases and the Cochrane Library.

Alongside searches of electronic databases we also trawled websites of key organisations such as the Housing LIN, Mental Health Foundation, Alzheimer's Society, Centre for Sheltered Housing Studies, Community Care, Housing LIN, PSSRU, Joseph Rowntree Foundation (JRF), the Social Care Workforce Research Unit (SCWRU) and The King's Fund. Additionally we hand-searched key journals related to ageing, mental health and housing and integration. These included, for example, *Ageing and Society*, *Aging & Mental Health*, *Health & Social Care in the Community*, *Housing Care and Support*, *International Journal of Geriatric Psychiatry*, *Journal of Housing for the Elderly*, *Journal of Integrated Care* and the *Journal of Interprofessional Care*. Bibliographies of literature and scoping reviews were checked to ensure that all references were included. Where publications were difficult to obtain online, authors were contacted via email and we are grateful to those who responded.

Study selection

An 'intervention' was defined as the process or model used within housing associations (this term is used as an 'umbrella' term to cover specialist housing mainly in the social housing sector) to improve the mental health or wellbeing of older people. Therefore, in addition to experimental studies, quasi-experimental studies and before-and-after studies, we also included evaluations of different models in the form of enquiries, surveys, and case studies, so long as they reported outcomes related to mental health and wellbeing.

The search was restricted to publications in the English language that had been published since the year 2000. Studies that included older people, as defined in the included studies and where the majority were over age 65, were eligible for inclusion.

The majority of the literature reviewed here comes from peer reviewed journals, research reports from large housing associations, and UK government policy documents or that of devolved adminstrations. The review is based largely on qualitative studies. This reflects increasing recognition that concepts such as quality of life and wellbeing should be viewed in terms of the 'lived experience', which is best captured through in-depth methodologies (Evans and Vallelly, 2007) but it also reflects the limited number of larger studies that address housing-related interventions in depth.

Data extraction and analysis

Due to the heterogeneity (wide range) of research methods in the studies we included in this review, particularly the broad range of qualitative designs and inclusion of grey literature, we reviewed and synthesised the findings using a modified narrative synthesis approach (Popay et al., 2006). Relying primarily on the use of words and text to summarise and explain the findings, our narrative synthesis did not involve the putting together statistical data; instead we identified the underlying themes that contribute to outcomes across the included studies.

Data were extracted from eligible studies using an adapted version of the standardised NICE-SCIE Data Extraction Tool for intervention evaluation (SCIE 2010). The tool was adapted to include the following categories: bibliographic identification and source of study; intervention characteristics; description of study; type of study; study population; methods of evaluation and outcome measures; analysis; outcomes/findings including cost effectiveness data. Emerging themes related to intervention strategies for mental health and wellbeing were categorised across the sample for the narrative synthesis.

Gaps in the evidence base were identified by:

- extracting those highlighted in research papers and reports

- an analysis of the evidence collated during the process of the literature review.

The effectiveness of housing interventions designed to support older people's mental wellbeing and ability to live well at home

Introduction

Drawing on both the experience of housing association providers from the focus group discussions and on our review of recently reported empirical research, in this section we present and consider what is known about UK housing interventions that aim to promote mental health and wellbeing among older people. Much of this covers a broad range of overlapping themes, but for the purpose of providing a cohesive structure we explore the findings under each of the following. We then include a description of the evidence and discussion of the implications for practice and commissioning.

- Identification, diagnosis, management of symptoms.

- Environments.

- Reducing social isolation and loneliness

    A - Interpersonal relationships and social support.

    B - Activities and participation.

    C - Interaction with the wider community.

- Promoting agency, autonomy and decision making

The evidence base

A major challenge of uncovering 'what works' in UK housing interventions is related to the lack of evidence in reports that describe a housing service. This makes the process of working out how studies were conducted and whether or not they measured any desired outcome especially difficult.

Promoting mental health and wellbeing is often reported to be embedded into schemes but is not well evidenced or evaluated. There is much that needs to be done before research takes place to consider what are the outcomes that are likely to be affected in any housing intervention. Is it for example, to decrease tenants' loneliness? How can this be measured and what does 'good' look like? How to work with people who are not lonely? It is easy to say that robust studies are needed to fully evaluate outcomes for older people with mental health problems but the groundwork has to be there. In order to improve the usefulness and generalisability of research findings, well-designed studies are needed involving: developmental work, feasibility work, clarity of measures and outcomes, pilot studies, larger sample sizes, multiple sites, longitudinal studies and so on. The MRC Guidelines for the Evaluation of Complex Interventions[1] stress:

> 'Developing, piloting, evaluating, reporting and implementing a complex intervention can be a lengthy process. All of the stages are important, and too strong a focus on the main evaluation, to the neglect of adequate development and piloting work, or proper consideration of the practical issues of implementation, will result in weaker interventions, that are harder to evaluate, less likely to be implemented and less likely to be worth implementing'.

Despite these limitations 985 papers were identified through peer-reviewed literature database searching, trawling of the grey literature and hand searching references of key texts (see Figure 1). Studies were excluded by title/abstract if they did not meet our inclusion criteria, then the full text was obtained for the remaining 152 studies. Reading the full texts it became apparent that while housing associations provide case studies and surveys of resident satisfaction, most studies do not measure the impact of strategies or interventions aimed at improving the mental health and wellbeing of older people. Thus, most of these reports were excluded from the review of housing interventions when it became apparent they did not meet this review's specific inclusion criteria. Nonetheless 17 intervention studies were identified. As a reflection of the paucity of

1   https://www.mrc.ac.uk/documents/pdf/complex-interventions-guidance

literature measuring cost-effectiveness but with an understanding that housing associations are aiming to improve their services, we highlight some case studies, enquiries and references that may help to better understand what works in this area. These are identified by the key themes: identification, diagnosis, management of symptoms; environments; reducing social isolation and loneliness; promoting agency, autonomy and decision making.
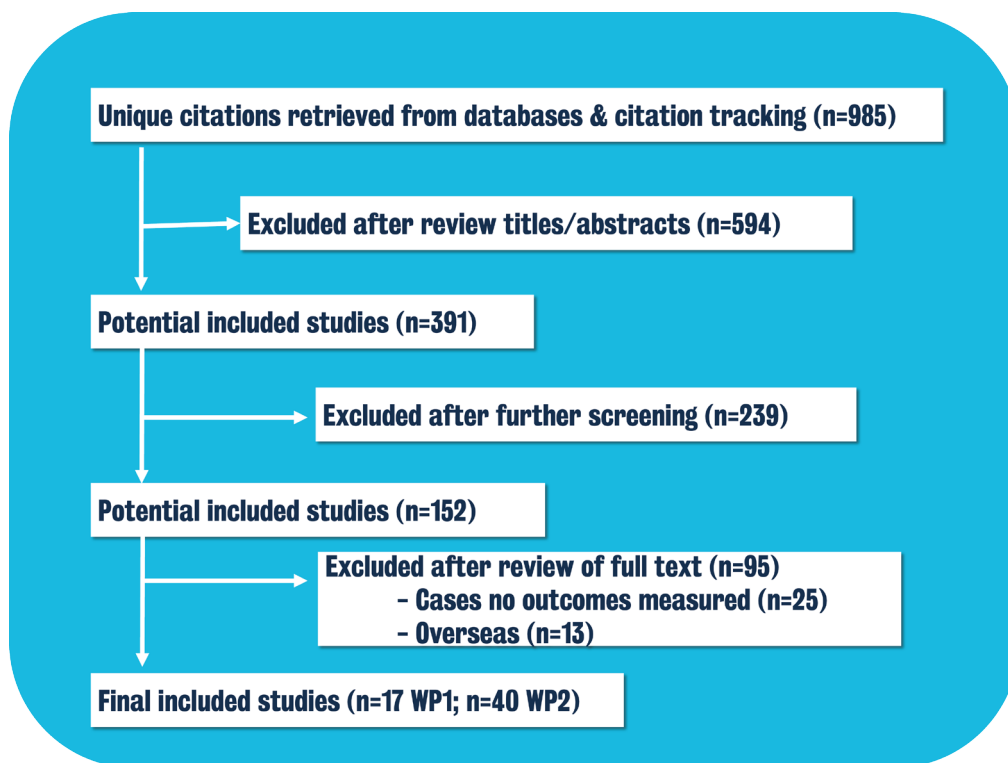
One of the fundamental comments to come from the focus group discussion with housing providers was, 'we're doing this; we need to evidence what works'. There was consensus that housing providers are developing services to promote mental wellbeing for older residents and are using empirical evidence to the best of their ability, but that commissioners of health and social care services may not fully understand what is distinctive about the 'housing offer'. We return to discuss this subject further in Chapter 4.

Recognising the limitations of the housing literature, the focus group participants also acknowledged that lessons from social care interventions for older people may be applied from health and social care sectors.

Appendix 1 outlines six key reviews in the field of housing for older people. Most were evaluations of extra care housing schemes and two focused on dementia care. Whilst most reviews report on factors to improve quality of life in residents, no comprehensive review on mental health and wellbeing interventions was identified.

Appendix 2: Interventions in UK housing associations. Each included study had a slightly different focus, adopted different methodologies, and presented different outcomes. This makes synthesis across the studies especially challenging and therefore we have identified the key themes from the literature to explore in more detail.

Figure 1: Application of selection criteria and search results

Unique citations retrieved from databases & citation tracking (n=985)

Excluded after review titles/abstracts (n=594)

Potential included studies (n=391)

Excluded after further screening (n=239)

Potential included studies (n=152)

Excluded after review of full text (n=95)
 – Cases no outcomes measured (n=25)
 – Overseas (n=13)

Final included studies (n=17 WP1; n=40 WP2)

Key themes from the literature

Identification, diagnosis, management of symptoms

Participants in the focus group discussed ways in which their housing associations identified signs and symptoms of mental health problems among tenants. They acknowledged that tenanats sometimes come into their services with long-term conditions such as dementia or depression but are not required to share such information, thus possibly delaying access to existing services.

In a study of 10 extra care housing schemes, the incidence of dementia and depression among tenants was difficult to ascertain from staff reports. The authors argued that a more proactive approach to maintaining good mental health and wellbeing was needed with systems in place to identify and then provide suitable support to people with mental health problems in order to help them maintain a good quality of life (Brooker, Argyle et al. 2011). The Enriched Opportunities Programme (EOP) intervention included specialist staff leadership and training, individualised care-work, community liaison and the provision of activities. Chief of these was the appointment of an 'EOP Locksmith'. This was a senior member of staff who could work with individuals to help them achieve their goals and to liaise with other scheme staff to help ensure people can access services within the scheme. The intervention was found to have a positive impact on the quality of life of people with dementia.

Another study by Anchor Housing Group (Anchor Housing 2008) concluded that people with dementia could live effectively in sheltered housing, but this would require greater clarity in the role of scheme managers who are often left to fill gaps in services thus masking the potential need for additional support such as befriending and advocacy programmes.

At Gentoo housing association some staff are trained to National Vocational Qualification (NVQ) (now Qualification Credit Framework) to identify tenants with possible problems, suggestive of dementia and promote better understanding of their customers' needs. The housing scheme managers may then help residents to manage symptoms and 'signpost' their tenants to other services.

In addition, several housing association staff have developed relationships with local GPs to encourage early referrals and reduce hospital admissions by providing training to housing practitioners. Locally these seem to be working well but these small collaborations are not running at a higher level and have not been evaluated nor implemented system wide.

Several housing providers have described the use of technology (very broadly defined) which is thought to help people manage the symptoms of their mental health problems. Participants in the focus group expressed concern that they have been using the same technology for 30 years (although this may have overlooked the internet revolution in terms of access to broadband and the rise of developments such as Facebook or Skype which may help maintain wellbeing) and may not be maximising the progress of technology development in the care and support provided to older people with mental health problems. This may be an area for scoping out what is known about this subject.

Promoted recently in the UK, are innovative (and not so innovative) technologies that may enable older people to improve their health and wellbeing. Telecare may help increase older people's ability to stay in their homes including people with dementia, and there is growing interest in its potential for helping people manage long term conditions such as depression (Chan, Campo et al. 2009, Matlabi, Parker et al. 2011). A recent survey was conducted by the Association of Directors of Adult Social Services (ADASS, 2014), which analysed of the current state of telecare and its potential application in meeting individual improved outcomes. The survey found that 70 per cent of respondents believe older people will be the greatest beneficiaries of technology, especially those with learning disabilities, and in 32 per cent of councils personal budgets were being used to fund such technology.

One systematic review of 'smart home technology' found that older people were open to having these in their homes if the benefits were tangible, for example: benefited physical activity, capacity, independence and if privacy concerns were addressed (Morris et al. 2013).

Another study included in this review evaluated the introduction of telecare with social (not for profit) landlords and housing associations.

It reported mixed satisfaction among those involved in the pilot (Pleace and Quilgars 2002). In particular, policy makers tended to see more potential in the technology than others, but the vast majority of older people expressed a preference for more personal forms of interaction with service providers; they generally wanted to communicate with a person directly, rather than 'talk to a machine'.

Whilst telecare solutions are seen as a potential means of addressing the future care needs of ageing societies, running in parallel with policies aimed at ageing in place, results of their utility with older people are mixed. From this review we found telecare may be beneficial for housing providers as they integrate services with health and social care, and make adequate plans based on care needs of residents. However, it is important that their development and implementation are not accepted without critical examination. This is in-line with wider telecare evidence (outside the housing sector) which has found that monitoring systems for people with chronic or long-term conditions can be effective but there is insufficient evidence about the use of telecare for older people with dementia or mental health problems and its cost effectiveness is less certain (Barlow et al 2007; Milligan, Roberts & Mort, 2011).

Environments

Older people want housing that enables them to be safe and comfortable regardless of age, income or level of capacity. As a reflection of this, and perhaps as a reflection of the poor housing and environments in many parts of the UK, age-friendly communities and age-specific housing have gained some momentum, fostering healthy ageing, self-fulfilment and participation. They are not large in terms of their proportion of older people's housing generally.

A review of international literature identified approaches to age-friendly communities involving integrating physical and social environments through policies, services and structures (Lui et al. 2009). However, there is some concern that age-friendliness risks segregation and further isolation from the wider community (Liddle, Scharf et al. 2014). 'Autonomy with inclusion' was described by one study as a way of providing care and protection when they are needed, but also respecting older people's independence and dignity (Kingston, Bernard et al. 2001).

Design modifications maintain independence over time, positively impact on social relationships and networks, facilitate older people's continued engagement, and contribute to psychological wellbeing (Fange and Iwarsson 2005, Health 2006, Tanner, Tilse et al. 2008). Participants from the focus group described how communal spaces serve to not only promote social interaction amongst residents but to also offer a link with the wider community. For example, some described moving away from a 'lounge' toward a restaurant or cinema open to the public where tenants might be able to derive income from the scheme.

Although the importance of designing environments that encourage social interaction is widely accepted, one focus group participant highlighted how 'one size does not fit all'. In her experience, older tenants with learning disabilities often appreciated their independence and set less store by communal areas and activities because in the past they would have lived in group homes and not been thought able to live alone.

This is also the case when considering the needs and aspirations of tenants from different ethnic backgrounds. An exploratory study interviewed respondents from 11 housing associations providing sheltered housing and extra–care support for tenants with dementia from different ethnic backgrounds. It found that while many housing associations are developing their understanding of dementia, and have policies in place relating to diversity, none have yet fully integrated the three strands of housing, dementia care and cultural or ethnicity related needs and preferences (Lipman & Manthorpe, 2015). There is more work to be done to implement age-friendly environments, especially those that are inclusive of diverse and possibly vulnerable people.

Reducing social isolation and loneliness

Much of the literature on enhancing mental health and wellbeing for the ageing population focuses on the reduction of social isolation. Social isolation and loneliness among older people have been recognised as a national public health problem across the UK, with a need for consideration within local strategies for older people.

Estimates of loneliness vary and definitions are broad. One suggests that 12 per cent of the population aged over 65 feels socially isolated (Greaves and Farbus 2006). The risk of being

isolated increases as people get older, with the loss of social networks through illness and death (Chakkalackal and Kalathil 2014). There are known adverse effects on physical (e.g. cardiovascular health) and mental health (Steptoe, Shankar et al. 2013) including depression and cognitive decline (Cacioppo, Hawkley et al. 2010), and reduced wellbeing (Croucher and Bevan 2012).

Most recently, Parliament passed legislation in England which recognises the equal rights of all people with disabilities to live in the community with assistance necessary to support their full inclusion (The Care Act 2014). In the case of housing associations, creating an environment where every resident feels valued and included is essential, along with ensuring that any scheme is an important part of the wider community (Parry 2006).

Older people should not be obliged to live in any particular living arrangement and should have access to a range of services to support living and inclusion in the community (Convention on the rights of person with disabilities [CRPD] Article 19). In this respect, housing schemes need to equally encourage personal freedom whilst maintaining staff availability to address needs and concerns as they arise (Oswald and Wahl 2004, Depla, De Graaf et al. 2006).

Social engagement is a wider concept than simply social activity and incorporates social relationships, cultural and civic-based activities with access to basic services in the neighbourhood (Victor et al. 2009). Strengthening social networks, supporting social engagement and reducing social isolation and loneliness may therefore be ways of improving older people's mental health and wellbeing (Cattan et al. 2005, Forsman, Nordmyrand and Whalbeck 2011). For this reason we have broken down the themes around social inclusion into three interrelated areas: building trusting and supportive relationships; active participation; and engagement with the wider community.

1. Interpersonal relationships and social support

Expanding one's network of friends in midlife and late life may protect against the losses experienced with ageing (Bath & Deeg, 2005; Li, 2007; Nummela, Sulander, Karisto, & Uutela 2009). Social networks are an important component of social inclusion and recovery from mental distress, and social participation is increasingly being recognised internationally as important for health and mental wellbeing in older adults (Blazer et al., 2005).

In the focus group discussion it was evident that housing providers are aware of the importance of social networks on mental health and wellbeing for older people but informal, neighbourly interactions between people and social capital are currently not being measured. Participants anecdotally mentioned that in one locality, a telephone befriending service was found to have 'made a real difference'. This is also supported by a study of a telephone befriending service for socially isolated older people in England which found that the service enhanced confidence and independence, increased participation and meaningful relationships (Cattan, Kime et al. 2011).

Another example from the focus group was 'Dementia Friends' (not to be confused with the campaign co-ordinated by the Alzheimer's Society to improve public understanding of dementia). This is an advocacy group that develops community events to promote awareness of dementia and to help people with dementia to meet others and share skills of coping with the condition. This mirrors findings from a recent study of dementia peer support groups in extra care housing which reported a positive impact on wellbeing, social support and practical coping strategies in managing

their memory problems and day-to-day activities (Chakkalackal and Kalathil 2014).

However, findings on housing interventions to improve social relationships have not all had positive results. A recent study found that while extra care residents might have more social interactions, loneliness itself was not affected because they didn't necessarily make new friends and felt their real friends were people they knew from before their move (Burholt, Nash et al. 2013).

Practical advice for housing associations on how to promote relationship building (Croucher and Bevan 2012, Bowers 2013) includes: nurturing trust, promoting a culture of respect and raising awareness of high needs, brokering opportunities for older people to engage in the community and individuals who might be able to support this.

2. Activities and participation

An important determinant of wellbeing that is amenable to change is 'intentional activity' – which means paying attention to pursuits or activities that individuals actively engage in (Lawton, Winter et al. 1999). Regular participation in social activities and involvement with one's community, such as voluntary work or membership of local groups, is consistently shown in many studies to be associated with high levels of happiness and satisfaction (Callaghan 2008). Equally, a study of three sheltered housing schemes (Field, Walker et al. 2002) found that older tenants who were depressed or with limited social activity were the least likely to have made new friends or participate in the activities of the scheme. Groups that provide us with a sense of place, purpose, and belonging tend to be good for us psychologically (Haslam, Jetten et al. 2009).

The approach taken to social activity may vary greatly across schemes, which in turn influences the level of participation and thus impact on mental health and wellbeing. In a recent review (Callaghan 2008) it was suggested that social activity be started off by scheme managers or an 'activities coordinator' with the aim of perhaps being able to gradually hand it over to residents. Problems with this include the limited amount of development input from older people themselves and difficulties in such handovers when older people are frail or unwell.

Findings from the wider literature outside housing interventions have found some success in promoting mental health and wellbeing for older people. For example, physical activity interventions (Wagstaff 2005, Eggermont and Scherder 2006, NICE 2008, Windle, Hughes et al. 2010) and social prescribing, which involves linking patients with non-clinical activities delivered by voluntary and community groups (Taylor and Neill 2009, Baker and Irvine 2015), and programmes that engage people in the arts (Cohen, Perlstein et al. 2006) have been found to be promising.

3. Interaction with the wider community

Where age-segregated or age specific housing may increase the opportunity for social interaction and developing friendships through social activities, older people also run the risk of feeling isolated from the wider community. Studies pointing to the critical components of housing schemes that maximise wellbeing for older people have found that by integrating with the local community, housing schemes may engage with learning experiences, existing mental health and wellness services, and volunteer programmes (Anetzberger 2002, Branfield and Willis 2009, Taylor and Neill 2009).

Despite the initiatives taken by some housing associations to engage older residents, not all offer opportunities to link with the wider community and those tenants with higher support needs may find it especially difficult to do so independently (Pannell and Blood 2012). In a case study of one community approach to meeting housing needs and aspirations for older people in Bournemouth, a strategy was put in place to unite council partners to address priorities that were set by older people themselves (Terry 2010). In developing new extra care schemes, the Bournemouth approach was to create a vibrant community hub, linking with existing networks. No outcomes have been measured to date for this particular programme.

Some local councils have been or are nurturing the capacity of neighbourhoods to support older people, such as Bristol with its AgeLink programme[2] and Milton Keynes (Minocha et al. 2015). With support from Age UK, these communities engage volunteers to enhance local groups and help those in need. Such an approach is not particularly new and again reports are largely aspirational.

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2   http://www.linkagebristol.org.uk/

One example of a scheme developed in another sector that may be applied to housing is that of the Sure Start model which was instigated to tackle social exclusion among parents and young children. A parallel initiative was piloted under the banner LinkAge Plus to reduce social isolation and enhance mental health and wellbeing in older people (Davis and Ritters 2009). The pilot investment prompted housing associations to work with community resources thus 'linking up' existing and new provision so that older people would be better able to access services through single access points. The evaluation concluded that pilots had been able to demonstrate improved access, a more integrated approach to service provision and more relevant, tailored services that are popular with local people.

Housing scheme managers may be the first to notice residents who may be at risk of or are showing signs of mental health problems. Links with primary care services are not well researched to see how these different professional groups perceive each other and what works well in interprofessional communication.

4. Promoting agency, autonomy and decision making

Older people often wish to take or share in decisions that affect their lives, as does almost everybody. The concept of agency relates to how people shape their environments, make their decisions, and create opportunities (Settersten and Gannon 2005, Sallinen, Hentonen et al. 2015). As social care commissioning shifts toward personalisation, putting people at the centre of their support and decreasing block contracts and commissioning, there is growing recognition of the major role that older people play in making decisions about their own housing support (Tenant Participation Advisory Service 2010, Clark 2011). Older people benefit from being centrally involved in design and implementation of the environment and programmes that impact them (Hasler, Haynes and Long 2010).

Whilst there is an overall paucity of literature on UK housing interventions, one area that has received much attention is extra care housing. Arguably, extra care housing has been seen as an intervention in itself, with care or housing support services provided on an as-needed basis to tenants or leaseholders within their own homes (Beach 2015). In this way it aims to embody many

of the core principles of current policy: helping people maintain their independence and promote personalisation, within the scheme and wider community, and to enable people to age in place and make plans for their own futures. In a study of 19 newly opened extra care housing schemes, Netten and colleagues (2011) found that after one year most tenants reported good quality of life, were found to be less functionally dependent, and people generally felt their ability to make decisions, especially related to social life, had improved. This is good quality evidence.

More broadly, a small but growing number of people with dementia in the UK are becoming involved in influencing services and policies that affect their housing and care (Chakkalackal and Kalathil 2014). For example, the DEEP programme (Andrews et al. 2015) collected information about how dementia groups across the country engage in policy, serve on advisory panels for housing and other sectors, and advocate in their communities. The DEEP programme found that many people were taking time to come to terms with the diagnosis before getting involved in the community and some still struggled to have their voices heard.

Measuring mental health and wellbeing

Across the intervention studies a variety of measures was used to assess mental health and wellbeing of participants. In a small number of studies, validated standardised measures were used such as the Short Form Health Survey (SF-36) measuring eight domains of health and mental health (Kingston, Bernard et al. 2001, Burholt, Nash et al. 2013); Lubben Social Network Scale which has been validated with older people in several European settings (Burholt, Nash et al. 2013); the General Health Questionnaire which is useful in measuring psychiatric morbidity; and the Adult Social Care Outcomes Toolkit (ASCOT) which is designed to capture information about an individual's social care-related quality of life (Evans 2015). Other studies developed questionnaires measuring aspects of satisfaction and self-reported mental health status (Head 2009, Netten et al. 2011); changes in confidence and self worth (Cairns 2013); and some used qualitative interviews and focus groups to ascertain changes in mental wellbeing (Bernard et al. 2007, Holland et al. 2015).

Research into the use of standardised measures for older people suggests that when assessments do not include screening for cognitive impairment and depression, their existence may be missed (Moriarty, 2002), thus reducing older people's chances of being treated appropriately, and may also reduce their quality of life. Other measures of mental health and wellbeing that have been validated with older people include the Geriatric Depression Screening Scale (Yesavage, Brink et al. 1982), and the EQ-5D which has been recommended where a more succinct assessment is required, particularly where a substantial change in health may be expected (Haywood, Garratt et al. 2005).

Conclusions

A major challenge of uncovering 'what works' in UK housing interventions is related to the lack of evidence in reports that describe a housing service. This makes the process of working out how studies were conducted and whether or not they measured any desired outcome especially difficult. While we identified six key reviews in the field of housing for older people these reported on factors designed to improve overall quality of life in residents. No comprehensive review on mental health and wellbeing interventions was identified. From this broader literature we were able to identify some key themes and messages. However, this was more in keeping with 'practical advice' rather than constituting definitive evidence about particular interventions.

The key messages here were: (i) One size does not fit all in addressing mental health and wellbeing of older people (ii) Whilst reducing social isolation seems to be beneficial for most older people, privacy and the right to make one's own decisions around social interaction are also valued. As we shall explore further in the next section, there was some sense that more mainstream approaches rooted in 'personalisation' rather than sector specific, more specialist provision may be the way forward.

Integrating health, housing and social care to promote older people's mental wellbeing and ability to live well at home

Introduction

In this section, we 'drill down' further into the evidence base identified in Chapter 3 to explore the subject of integration and how health, housing and social care agencies may be working together to support older people's mental wellbeing and ability to live well at home. This is a useful exercise because integration is often viewed as an important driver of improved outcomes in its own right (and sometimes a panacea). For example, recent guidance for commissioners of older people's mental health services asserts:

> 'Older people's mental health services in particular benefit from an integrated approach with social care services. Most patients in older age mental health services have complex social needs. Commissioners should ensure service providers across agencies work together if they are to meet people's needs and aspirations effectively' (Joint Commissioning Panel for Mental Health 2013 p3)

For both research and practice, there are many challenges associated with defining the concept of 'integration'. It is often used interchangeably with terms such as 'partnership working', 'multi-disciplinary working', 'interprofessional working', 'co-ordination' and 'collaboration'. The field has been described as a 'terminological quagmire' leading to 'methodological anarchy and definitional chaos' (Petch, 2012). Here, we use the term integration in its broadest sense to encompass this allied terminology unless stated otherwise.

For the purposes of this section of the review we adopt a narrative (descriptive) approach. We focus on intervention studies designed to promote older people's mental wellbeing where integration across housing and/or health and/or social care is evident. This may be explicit (eg as in a randomised control trial of 'integrated case management') or implicit (eg where partnership working is in evidence but has not been specifically engineered or designed for). The overall aim of the review is to describe the different aspirations or levers of integration, the role that 'housing' is playing therein and the outcomes that are being achieved.

As part of the review, we also identify some of the barriers to effective collaboration at both strategic commissioning and operational levels and how these might be overcome. We explore what is distinctive about the 'housing offer' and if 'evidencing it better' really is the key to sustainability and improved service delivery. In doing so, we draw attention to some of the broader socio-cultural issues (so called 'institutional logics') which may mean that commissioning for mental wellbeing is not always the evidence based, level playing field that is assumed.

Intervention studies – Catch 22

In an aptly named discussion paper, 'Catch 22: Improving the health, housing and ageing evidence base', Care & Repair England (2014) argues that at a time of unprecedented reductions in public expenditure, higher standards of evidence are being demanded by commissioners. It suggests that the lack of investment in academic research concerning housing, health and ageing makes it difficult to cite studies of a high enough standard to make the case for housing and housing related services compared to the health sector. The 'Catch 22' is that practical housing services can't prove their worth to commissioners without academic research, but no-one is undertaking or funding the research that the commissioners and planners require.

In the 'grey literature' (ie literature which sits outside 'peer reviewed' academic journals) there are many case studies of innovative and often inspiring projects which bring together health, housing and/or social care to promote older people's wellbeing and ability to live well at home.[3] However, a defining feature of these schemes is that they are usually short term 'pilot projects' which are rarely given sufficient time to mature

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3   For examples see Porteus (2011a)

before their funding comes to an end. This makes evaluation difficult and, as noted above, even when fully established, opportunities for robust quantitative randomised trials are rare, meaning that the generalisability of any findings is often contentious (Rothera et al., 2008).

When it comes to improving older people's mental wellbeing, the commissioning guidance mentioned above sees integration as being of 'significant benefit'. However, it important to acknowledge that this assertion is not rooted in the evidence base and that many of the problems outlined above apply here also. For example, in a review of the evidence base for partnership working Glasby and Dickenson report that the assumption that partnership working leads to better outcomes is at best unproven and 'much existing partnership working remains essentially faith [rather than evidence] based' (2008, p67).

In a systematic review of joint working in the field of adult health and social care services in the UK, Cameron et al., (2014) note that studies of integrated working largely report small-scale evaluations of local initiatives and few are comparative in design, so differences between 'usual care' and integrated care are not assessed, making it difficult to draw conclusions about the effectiveness of integrated services. Additionally, evidence on cost-effectiveness is lacking and therefore there is no means of assessing the costs and benefits to service users of integrated care versus standard care or different types of integrated services. They note:

> 'This 'gap' in the evidence is problematic, given government exhortations to reduce public funding and a clear belief that joint working/ integration can improve the effectiveness of services while also delivering cost savings' (2014, p232)

A systematic review examining the effectiveness of interprofessional working (IPW) for community dwelling older people with multiple health and social care needs reported that, overall, there is weak evidence of effectiveness and cost-effectiveness for IPW, although well-integrated and shared care models improve processes of care and have the potential to reduce hospital or nursing/care home use (Trivedi et al., 2013). The authors note that study quality varied considerably and recommended that high quality evaluations as well as observational studies are needed on the outcomes of the process of IPW and on the effectiveness of different configurations of health and social care professionals for the care of community dwelling older people.

In both these systematic review reports (which cover a vast amount of literature between them) 'housing' (the 'third pillar' of health and wellbeing) does not warrant a single mention. According to Savory (2005), this may reflect that the contribution of housing agencies has tended to be seen as subsidiary to the need to ensure effective joint working between health and social services:

> 'Housing associations (who are major providers of housing support services) are not part of the main statutory framework and are classed as the independent sector. The growth in partnership working appears to have been mainly restricted to statutory health and social care agencies without involving the independent sector and other local government functions such as housing' (p59).

Set against this backdrop of methodological challenge, lack of research funding and strategic oversight, we could not find any UK intervention studies reporting (definitively) on the outcomes of three way collaborative working between housing, health and social care where the primary objective was improvement in older people's mental wellbeing and the ability to live well at home.

We did however, find one intervention study which met our older people and mental wellbeing inclusion criteria although evidence of integration was limited to health and housing. We review this paper in some detail below as it sheds further light on some of the fallibilities of working within an 'evidence based' paradigm where a key objective is securing 'health funding'.

Social prescribing pilot study

In one of the few studies we found that touches upon the issue of collaborative working between 'health' and 'housing' Baker and Irving (2015) report on the delivery of an intervention designed to promote older people's mental wellbeing. According to them a promising approach to the management of dementia is 'social prescribing'. Social prescribing involves engaging people with medical problems in non-clinical activities, typically delivered by voluntary and community groups in an effort to improve their wellbeing.:

> 'Evidence suggests that socially-prescribed activities can have positive psycho-social impacts, which could have health generating benefits and result in long-term cost savings to the NHS' (Baker and Irving, 2005 p1)

In 2010, an arts based social prescribing pilot was established in the North East of England as a possible solution to the management of dementia. The scheme was commissioned by a local Primary Care Trust (PCT) just prior to its abolition and replacement by a GP led Clinical Commissioning Group (CCG). The intervention comprised socially prescribed activities focused on dance, movement, crafts and film-making which were to be delivered by a community arts based organisation (CAO). The overall aim was to combat problems of isolation and loneliness and improve wellbeing of older people with dementia and depression. The authors note that successful social prescribing depends on the ability of multiple agencies to work together and co-produce within a network:
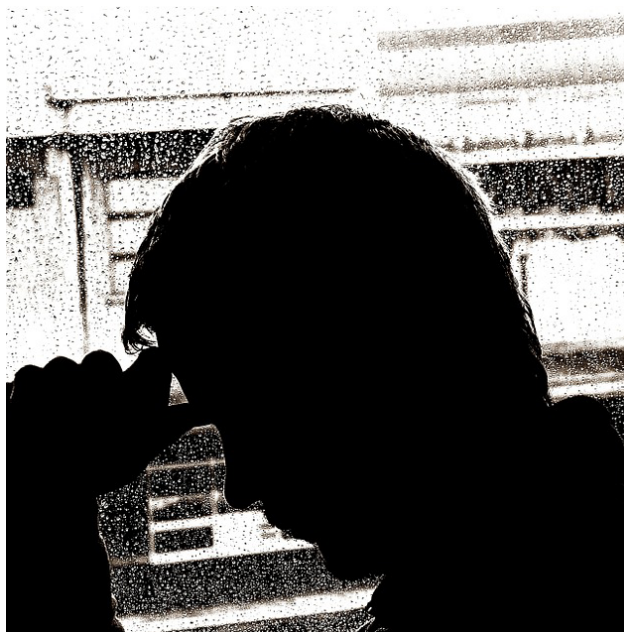
> 'Social prescribing can result in responsibility for dementia patients being transferred from the clinical sector to the social sector unless there is shared commitment to the co-production of care... The task of developing the relationships necessary to support co-production among members of a social prescribing network falls to a group of individuals known as 'boundary-spanners'. (p40)

The principal partners in the scheme were the PCT (whose staff leading the development of the scheme were identified as the 'boundary-spanners') and the CAO. Delivery of the intervention took the form of 'workshops' and these took place in a mix of community venues and within sheltered accommodation. GPs, community health workers and sheltered accommodation managers were expected to refer people into the scheme. It does not appear that stakeholders from the housing sector played a role in designing or planning of the intervention.

In an effort to evidence the effectiveness of social prescribing to GP commissioners in the new CCG, the intervention was subject to an evaluation:

> 'It was hoped that if the benefits could be successfully demonstrated, GPs might consider funding it on a longer term basis and support its embedding as a formal treatment as a care option for people with dementia and depression' (p10)

The intervention was evaluated by both quantitative and qualitative methods. This encompassed the use of a 'distance travelled' tool to measure any changes in wellbeing outcomes among workshop participants, as well as focus groups and semi-structured interviews with older people (it was not clear how ability to consent and participate were assessed) and their families plus a range of key stakeholders from health, housing and community arts (n=48). The distance travelled tool kit sought to capture baseline data on the wellbeing of patients on a number of variables to permit before and after comparisons. The authors note that the toolkit selected had not been academically or clinically validated and that it was not known why a more established tool such as 'Dementia Care Mapping' was not used.

During the life time of the scheme (October 2010 to March 2012) 60 people were referred to the workshops. From a qualitative perspective, the intervention was seen to have a number of

benefits for people with dementia in enabling them to experience a greater sense of connectedness and community (which are important variables in militating against dementia and depression). One carer for example, commented that the workshops were something special that she and her mother could do together.

The active engagement of the sheltered accommodation wardens and staff in the scheme was seen as critical to the success of the project. However, the scheme was received differently in different sheltered accommodation settings. In some locations staff actively encouraged older people to take part while in others, staff did not play a visible role giving residents the impression that social prescribing was just another 'group activity' going on downstairs:

> 'The extent to which the sheltered accommodation staff and wardens were enlisted in co-production varied based on the norms of and values that prevailed within the individual organisations. In some sheltered accommodation sites, the staff actively engaged as co-producers to advance the wellbeing of tenants. In other organisations, institutional norms and competing priorities and resources inhibited the active engagement in and ownership of the project' (p16)

Where housing staff did engage (ie understand the social prescribing rationale underpinning the scheme), the process of co-production improved the way residents were treated by staff. One warden explained that the intervention had helped humanise the residents in the eyes of housing workers by enabling them to get to know them better and to see what people's lives used to be like before their dementia.

However, the problem of engagement was even more pronounced with the GP stakeholders. It was acknowledged that the referral process did not function as intended. Although the GPs had enthused about the scheme their referral rates suggested a lack of meaningful engagement. The majority of the referrals (over 50 per cent) came from the sheltered housing managers.

The study pinpoints a number of problems rooted in what it calls 'institutional logics' to explain why the intervention could not command engagement from GPs. It was suggested that during appointments GPs tend to focus on immediate

clinical needs and often do not have the time to assess the overall wellbeing of patients, identify social prescribing activities, and make referrals. In contrast, community health care workers and sheltered accommodation wardens were seen as having a greater degree of interaction with 'patients' and may be better equipped to adopt a holistic approach to assessing their wellbeing. At the time of the pilot a new on-line directory for social prescribing had been introduced and there was a suggestion that GPs were choosing to refer through this. The pilot intervention was not listed in this directory so a lack of integration into existing systems was identified as a contributory factor.

A further problem was identified with the pilot status of the scheme itself, and the evaluation approach that was adopted. Attempts to gather robust quantitative data through the 'distanced travelled' tool failed. Only four participants completed pre and post intervention questionnaires. The authors alert us to how the difficulties associated with measuring changes in wellbeing among older people with dementia are well documented in the research literature. In this case, staff from the PCT who encountered the participants did not have the detailed understanding of the quantitative tool and resources necessary to support participants to complete the tools as prescribed. Participants had problems with completion due to the complexity, volume and format of the questions asked and several participants became anxious as a result. Furthermore:

> 'The CAO stakeholders engaged in the project operated under an institutional logic that emphasized the intrinsic and social benefits of the arts. This logic was unsurprisingly interpretative and to some extent sceptical of the extent to which quantitative data could fully capture the experiences of participants' (p15)

The social prescribing scheme was not continued beyond the pilot phase. However, this was not necessarily because it was viewed as 'ineffective' but, according to the authors, because it had failed to produce convincing evidence of the kind that appealed to the 'institutional logics' of the GP commissioners:

'The GPs interviewed in the study suggested that on the whole GPs would only likely to be convinced about the value of the intervention if the evaluation could evidence changes in wellbeing through objective quantitative methods... [Furthermore] to persuade GPs to engage with the pilot scheme, it would have had to demonstrate the clinical, rather than the social (and to some extent) fiscal benefits of the project' (p14/15).

Herein lies a further 'Catch 22' situation for housing providers seeking 'health funding'. The institutional logics of CCG commissioning may be such that even with robust quantitative evidence, if this relates to what is perceived as 'social value' rather than 'clinical improvement' then the case for funding may still be dismissed particularly if there are pressing competing demands for health care expenditure.

Creating new 'institutional logics'

In accounting for why housing and 'social value' interventions may be disadvantaged in the context of commissioning for health and wellbeing Porteus (2011a) notes that:

'There is growing evidence that housing and housing related care and support services can make a significant financial contribution to health and social care economies... However, this is often poorly understood by health and social care [commissioners]... Some of this is due to a lack of common lexicon that is shared and understood across clinical, housing and social care interventions coupled with a silo mentality and/or a mono culture ' (p1).

Reporting on a workshop designed to promote strategic collaboration across the health, housing and social care divide, Glasby, Miller and Dickenson (2014) observe how many health and social care organisations still appear to know little about housing and how it works, almost taking the housing dimension of people's lives for granted. Equally, some housing organisations were felt by participants to be very internally focused and more interested in bricks and mortar than on wider aspects of residents' lives. There was also a perception from health and social care professionals that housing associations sometimes came to health and social care commissioners for money (particularly to replace some of their previous central government grants), without necessarily wanting to share both risks and rewards:

'All too often housing, health and social care are separate worlds, with few people understanding how each sector works or the key opportunities and barriers which exist... Going forwards, there was a strong sense that health, housing and social care have more in common than perhaps they realise. They are often working with the same families and individuals, and no one agency can respond to the complexity of need on its own. In difficult financial circumstances, greater joint working has to be the only option – but local partners will need to work hard to understand each other better and to find the right way in to a new and more joint conversation' (Glasby, Miller and Dickinson, 2014, editorial)

At a strategic level, there has been increasing recognition of the need for new 'institutional logics' to address these issues. In 2011, the 'All Party Parliamentary Group on Housing and Care for Older People' produced a report of its 'Living Well at Home Inquiry' (Porteus, 2011b). This made a number of recommendations about the need for local authorities and the NHS to strategically commission integrated community based support. Noting that GPs have a much greater say in the commissioning of services within the context of CCGs, the report notes that it will be in their interest to commission 'holistic' services, at scale, that can reduce demand on primary care and prevent or delay admission (or a readmission) into hospital, including housing and housing related support services that can offset planned or unplanned healthcare. In the context of integrated commissioning, the report conceptualised the 'housing offer' and its contribution to wellbeing and mental wellbeing in the following terms:

- protecting people from serious harm - home safety checks to prevent falls or use of Telecare to provide reassurance

- tackling the wider determinants of ill health - overcoming loneliness and isolation through safer neighbourhoods and befriending services

- preventing ill health - tackling disrepair, making home improvements – 'that little bit of help'

- prolonging life expectancy e.g. 'adding life to years' through access to alternative housing with care, adaptations

- supporting health improvement - promoting healthy eating and information eg on obesity and weight, oral health, diet and nutrition (Porteus, 2011b, p24).

More recently, a Memorandum of Understanding (MoU) has been signed between a wide range of organisations across health, housing and social care to support joint action on improving health through the home.[4] This aims to achieve a step change in terms of collaboration between housing, health and social care organisations. Through working together the MoU aims to:

- Establish and support national and local dialogue, information exchange.

- Promote decision-making across government, health, social care and housing sectors

- Coordinate health, social care, housing policy

- Enable improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services

- Promote the housing sector contribution to: addressing the wider determinants of health; health equity; improvements to patient experience and outcomes; 'making every contact count'; and safeguarding

- Develop the workforce across sectors so that they are confident and skilled in understanding the relationship between where people live and their health and wellbeing and are able to identify suitable solutions to improve outcomes.

In 2013, Health and Wellbeing Boards (HWBs) were launched to act as a forum in which key leaders from across health and care would work together to promote integrated services and improve the health and wellbeing of their local populations. Although they were feared to lack 'teeth', the aim was that they would influence

CCG and local authority commissioning. In an 'opinion piece' for the Journal of Integrated Care, Lea (2014) describes developments in Stoke-on-Trent to integrate services across the housing, health and social care divide. In reflecting on what has made this possible she points out that, 'Only a small number of HWBs have an independent chair, and it is rare to see a housing perspective represented to centrally in the composition of the Board' [in this case Lea was the Chief Executive of the Housing Association and was appointed as the independent chair of the Health and Wellbeing Board](Lea, 2014 p15).

Discussing their research on partnership working with a view to supporting the development of HWBs, Perkins and Hunter (2014) note that Joint Strategic Needs Assessments (JSNAs) are not always used systematically and can have little impact on commissioning practice. They conclude:

> 'The importance of relational factors cannot be stressed highly enough... No amount of structural change or legislation can create the strength of good working relationships' (p224).

(Mis)managing mental wellbeing in front line housing practice

It might be suggested that most work to promote older people's mental wellbeing and ability to live well at home is embedded in the day to day practices of housing workers rather than in specially designated interventions or pilot projects. In the remainder of this review, we report on two small scale qualitative studies to explore what is known about collaborative front line practices in this specific area and what might be done to support it.

While intervention studies and 'evidence based' approaches place quantitative approaches and outcome data at the top of the evidence ladder, 'evidence informed' approaches recognise the equal validity of practitioner knowledge and the views of service users and carers as 'experts by experience'. Indeed, our review of how housing and housing workers are contributing to older people's mental wellbeing suggests a significant 'knowledge gap' with regard to both these areas.

Seen from inside the supported/sheltered housing sector, many workers will see themselves as fulfilling a co-ordination role, for example, managing conflict with neighbours or addressing

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4   This has been signed by a range of key agencies including the: Association of the Directors of Adult Social Services (ADASS), the Association of Directors of Public Health (ADPH), Care & Repair England, the Chartered Institute of Environmental Health (CIEH), the Chartered Institute of Housing (CIH), the Department for Communities and Local Government (DCLG), the Department of Health (DH), the Foundation Trust Network (FTN), Foundations, Homeless Link, the Homes and Communities Agency (HCA), the Housing Associations' Charitable Trust (HACT), the Housing Learning and Improvement Network (Housing LIN), the Local Government Association (LGA), the National Housing Federation (NHF), NHS England, NHS Property Services (PropCo), Public Health England (PHE), Skills for Care and Sitra

community safety. This may not be recognised by professionals in health and social care. Furthermore, as care and NHS budgets shrink, housing workers can find themselves working alone ('uni-professionally') to manage some challenging and complex situations which they are ill-equipped to deal with (Savory, 2005; Cornes et al, 2011).

In 'Going Round the Houses', Yaxley (2015) describes from a social housing professional perspective some of the problems which arise where professionals fail to work together effectively when addressing the needs of people with mental health problems (the study includes older people but is not specific to them). She describes how, due to funding cuts and the difficulties of accessing mental health and drug and alcohol services, social housing professionals often have no option but to treat the symptoms of mental ill health as 'complaints' or 'anti-social behaviour':

> 'Most housing associations use varying degrees of enforcement action to deal with mental health issues, the majority of which will classified as anti-social behaviour. This is a costly means of managing neighbourhoods that is not sustainable' (Yaxley, 2015 p6).

In handling these kinds of problems Yaxley notes that referrals are more likely to be made to the police than to mental health teams and that there is a need to widen the networks of frontline social housing professionals with health sector counterparts. She reports that the housing professionals she interviewed had few contacts with those working inside mental health services and that there was little understanding of each other's roles and pressures. Given the imperative to provide more care closer to home she alerts us as to how:

> 'This shift in focus within the NHS presents a number of opportunities for health and social housing professionals to form strategic and productive alliances. This would create partnerships that put clients' wellbeing at the heart of decision making... This is easier said than done' (p10).

In a survey of scheme managers in one Housing Trust, Grierson (2015) requested them to estimate the prevalence of dementia among residents and asked participants what support they need to respond to this. The findings mirror those of Yaxley with regard to the need for better information on where to get help, the need to strengthen links with other services providing support for people with dementia and the need for more training on mental health (eg practical skills and techniques to better support tenants with dementia, including those exhibiting aggressive behaviour). The scheme managers reported that supporting residents with dementia can be very time consuming and that there is a need to find ways of helping staff to cope.

The levers of integration in front line practice

Seamless services have been the 'holy grail' of social policy in the UK and internationally for over 40 years. Significant problems persist and these are due to a variety of reasons including
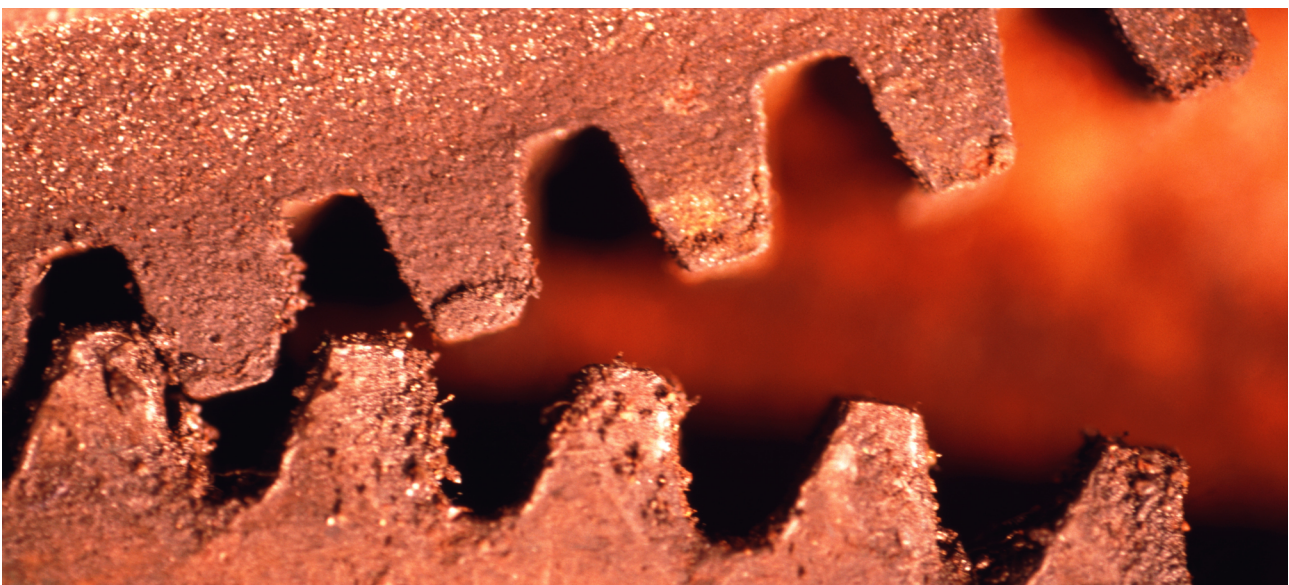
differences in culture and ways of working, funding and accountability arrangements and separate regulatory regimes that assess the performance of individual organisations but not the system as a whole (Humphries, 2014).

The principal levers or mechanisms which have sought to overcome these barriers include forms of care or case management (including liaison, navigation and brokerage) and a wide range of multi-disciplinary team and service models. These mechanisms are sometimes conceptualised as interventions to be studied objectively for evidence of improved outcomes (linked to a particular 'skill mix' for example), or as was the case with 'care management' under the *1990 NHS and Community Care Act* as the policy architecture or scaffolding for the overall coordination and management of care services.

The legislation and guidance underpinning the *1990 NHS and Community Care Act* gave little consideration to the contribution that housing could make (Savory, 2005). While the onus was on local authority social services' professionals in their role as the 'care manager' to invite housing and health services to participate, research found little evidence that housing professionals were regularly involved in community care assessments (Foord and Simic, 2005). According to Savory (2005), there has been a long history of distrust between social workers and housing workers, and health workers have not traditionally liaised well with social services or housing agencies.

O'Malley and Croucher (2005) reach a similar conclusion as regards the relative neglect of housing as a central aspect of care planning for older people with dementia. They suggest that research has tended to neglect housing in relation to ageing studies more generally and that despite recognition that housing is increasingly central to social care, research and policy tend to treat 'housing' separately from 'care' and even more so from 'dementia':

> 'The needs of people with dementia overlap with many social policy concerns: later life, mental health, housing and social care. At present it would seem that this complexity is allowing many important issues surrounding the provision of housing and care for this population to fall through the gaps' (O'Malley and Croucher, 2005 p576).

Some examples of the potential of housing workers and agencies in promoting safeguarding (adult protection) are provided by Parry (2014) whose analysis of Adult Serious Case Reviews (SCRs) found that housing agencies should take on board three internal lessons: to improve their databases; to improve their monitoring of vulnerable tenants; and to avoid taking too narrow a focus and not referring on concerns. She further identified three external problems that affected housing providers' ability to contribute to safeguarding, namely their exclusion from information sharing; other agencies' high eligibility thresholds; and poor quality adult social care assessments.

With the passing of the *Care Act* (2014), there are some signs of a return to the original approaches to case management as it is increasingly viewed as a specific intervention to be tested for optimal configuration (eg skill mix). For example, in a mixed method feasibility study of the potential for introducing and adapting a US based model of case management for people with dementia in UK primary care, which involved in the pilot two nurses and one social worker in 'lead roles' (i.e. as case managers with specific responsibility for delivering a manualised intervention to help carers), housing workers do not feature. Such a study illustrates the wide and varied meanings of case management and caution is needed to make sure that the possible attractions of such a role (suggesting co-ordination for example, are not over-claimed). In this study, most of the small number of interventions took place with family carers (Iliffe, et al. 2014).

The implication from other studies is that when addressing complex needs and situations there may be value in such case management teams having access to a dedicated housing team or forum. For example, an evaluation of a hospital discharge scheme in the Wirral which was designed for 'homeless people' found the worker taking on increasing responsibility for older people whose discharge was delayed due to housing problems. In many respects, housing as the 'third pillar' of health and wellbeing often seems to be overlooked in intermediate and reablement teams for older people.

Similar problems to those for care management are reported for Community Mental Health Teams (CMHTs) and the Care Programme Approach (CPA) which is designed to coordinate support

people for with complex mental health problems (Mental Health Foundation, 2013). According to Goodwin and Lawton-Smith (2010), the evidence is that managing across networks of diverse providers to create integrated care packages is problematic because of the lack of power that social worker and nurse coordinators often have over care delivery amongst other agencies. From a 'housing perspective', Porteus insightfully notes:

> 'We wholly acknowledge the lack of incentives for housing's active involvement in health and social care economies to support older people to 'stay put'. In the absence of [joint] funding framework, that recognises the care efficiencies achieved by housing interventions, we noted that there was often little encouragement for joint working' (2011b, p25).

With the advent of the *Care Act* (2014) and the placing of 'personal budgets' on a statutory footing there is also the increasing expectation that older people will commission and coordinate their own support packages, Therein also lies some possibility of overcoming the lack of a joint funding framework highlighted by Porteus above. In Scotland, where 'cash for care' schemes were implemented as part of the policy of 'Self-Directed Support' (SDS), Rosengard, Ridley and Manthorpe (2013) report that there is no reason why housing related support and modifications or equipment should not comprise part of a person's SDS package. In 2011-2012, while personal care was the main form of support purchased through individualised budgets in Scotland, 11% of packages also included the purchase of housing related support services. In England, the *Care Act* guidance (DH, 2014 p295) confirms that the interweaving of care with housing related and other forms of support is feasible in the context of English personal budgets (and was previously under the predecessor of Individual Budgets). This may open up significant possibilities for housing support workers to address mental wellbeing alongside other needs, but is currently uncharted waters (Cornes et al, 2013). For example, can a housing trust manage a 'personal budget' (an 'Individual Service Fund' (ISF)) on behalf of an older resident with dementia and take out payments for 'pop in' visits designed to prevent isolation and loneliness?

While problems are acknowledged with case management type approaches, the Mental Health Foundation (2013) argues, 'Such models have survived for so many years as an integrated response to people's needs... We believe improvements in how these models work could be effected by the better interprofessional education and training of staff working within multidisciplinary teams'. In the field of multiple exclusion homelessness, Cornes et al. (2013) piloted the use of 'communities of practices' to build 'relational capital' between different groups of workers, prevent workers from feeling isolated and to open-up an arena for research and knowledge exchange. Although not a 'magic solution' to the intractable problems facing many people experiencing multiple and complex needs, the communities of practice went some considerable way to tackling the feelings of isolation among workers working in stressful and emotionally challenging situations. In once case study which related to an older person who often visited the hospital A&E department at weekends due to feeling isolated and drinking more alcohol, integration was achieved whereby community police officers 'popped in' at weekends when housing support workers were unable to visit. This was not formalized in terms of a support plan but part and parcel of 'secret caseloads' whereby workers will go the extra mile where strong interprofessional relationships ('goodwill') have been built.

Conclusion

We could not find any definitive UK intervention studies in which health, housing and social care worked together in a three way collaborative relationship to improve older people's mental wellbeing and ability to live well at home. As a mechanism for levering improved outcomes the evidence base on integration is weak. There is also a significant evidence gap as regards (qualitative evidence) on service user, carer and practitioner perspectives on how housing and housing related support might work to support older people's mental wellbeing.

Taking in the literature more broadly on integration between health, housing and social care there is evidence of continued 'silo working' and a lack of understanding between the sectors, especially as regards what is distinctive about the 'housing offer'. While gathering more robust quantitative evidence on the potential contribution of housing associations to the health and wellbeing agenda is important, it will be methodologically challenging given the short term funding of many

'pilot' interventions. Manthorpe and Samsi (2012) also pointed to the potential for social care and housing providers to communicate infrequently about the circumstances of people living in sheltered housing who received support from both sectors. Furthermore, there is an urgent need to generate new 'institutional logics' around the relative contribution of each sector. Research on partnership working suggests that developing continuous strategic relationships and securing positions of influence and leadership may actually be important than either 'structure' or 'evidence harvesting'.

As part of this review, we have also sought to raise awareness as to how work to promote older people's mental wellbeing and ability to live well at home is embedded in the day to day practices of housing workers rather than in specially designated interventions or pilot projects. For the most part, the literature suggests that integration and joint working between health, housing and social care services in everyday practice encounter difficulties and that mental wellbeing is not always currently managed well in the community. Two problems in particular emerged: (i) How tightening of eligibility criteria or thresholds may give rise to unmet need leading to some mental health problems being identified as social nuisance, and (ii) How housing workers can often find themselves working alone to manage some challenging and complex situations. Supporting practice and finding ways to address these challenges, perhaps through the new funding opportunities conferred through personalisation and the *Care Act 2014* but also through local education and training resources, seem a particularly pressing priority.

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Appendices

Appendix 1

Author (year)	Title	Key findings
(Callaghan 2008)	Social Wellbeing in Extra Care Housing: An Overview of the Literature	• Identified factors influencing social wellbeing for older people to inform design in extra care housing • Good design directly impacts quality of life, especially communal spaces that encourage socialising but with options for privacy • Social activities and interpersonal relationships reduce loneliness but need direction from scheme managers • Links with local community are key increasing social interaction and minimising isolation • Relationships with staff influences views on quality of care
(Croucher, Hicks et al. 2006)	Housing with care for later life: a literature review	• Identified different models of housing with care for later life operating in the UK and elsewhere • Mapped the evidence relating to the strengths and weaknesses of different models of housing with care for older people in the UK • Reported on evidence drawn from 11 evaluations of housing with care to explore the following themes: promotion of independence, the reduction in social isolation and the provision of an alternative to institutional care, enhancing ageing in place
Dutton 2009)`	'Extra Care' Housing and People with Dementia: A Scoping Review of the Literature	Findings from studies relating to people with dementia in extra care accommodation consistently highlight the importance of person-centred care, developing staffs' knowledge and expertise in dementia, partnership working and joint working
(Evans 2007)	Best practice in promoting social wellbeing in extra care housing: A literature review	The review highlights key factors in promoting social wellbeing for older people, including: • availability of inclusive and diverse activities to promote social interaction (e.g. shop, restaurant, garden) • design that promotes a sense of community • access to social networks beyond the housing scheme • opportunities for service users to be involved in decisions about care delivery and service development
(O'Malley and Croucher 2005)	Housing and dementia care - a scoping of the literature	A scoping study designed to describe the evidence base with regard to housing provision for elderly people with dementia revealed a significant number of research gaps in the UK context, most notably in relation to end-of-life care for people with dementia and the effectiveness of integrated and segregated facilities. • a range of accommodation types is required to match the needs of people with dementia at different stages of the disease – longitudinal designs needed to understand the 'pathways' of care
Pannell and Blood 2012)	Supported Housing for older people in the UK: An Evidence review	Researchers have paid more attention to 'housing with care,' which comprises only 10% of the total supported housing stock, while sheltered housing has been largely ignored. To promote quality of life for high-need residents: • regular contact with family, ongoing community involvement • environment (e.g. space standards, location) • on-site service provision (e.g. scheme manager/support model, quality of staff) • availability of specialist care/support

Type housing/ model	Publication	Study type	AIMS	Outcomes measured	Results	Peer reviewed?
Extra Care retirement villages	(Beach 2015)	Enquiry	Sought to understand if village living could promote older people's quality of life, help to reduce feelings of isolation and loneliness, and increase sense of control over their own lives.	Examined the motivations behind why people decided to move into retirement villages, and how their experiences might reflect the concepts of independence and control. QOL measured with CASP-19 and Older People's Quality of Life (OPQOL) questionnaire	•Residents appeared to have higher QOL, experienced a higher sense of control, lower loneliness, than a similar group living in the community • Over 4 out of 5 (81.7%) respondents said they hardly ever or never felt isolated, and only 1.1% often felt isolated. Very small proportions of respondents report a high degree of loneliness.	N
Retirement Villages	(Bernard and et al. 2007)	Multi-method, participative action research design	Considers whether; the village can truly be a 'home for life' in the face of increasing frailty, and whether or not these new models of accommodation and care can cater for both 'fit' and; 'frail' older people.	Draws on participative action research including observation, diary-keeping, group meetings; interviews and questionnaires. Explores the residents' motivations for moving to the village, their views about the accommodation and their use of and satisfaction with the; social and leisure amenities. ' social masking' scale was developed (Biggs 'age satisfaction' questions were used to examine identity issues)	Dementia-type illnesses and anxiety and depression were the most common mental health disorders. Staff believed that the residents with complex conditions, typically involving both mental health issues and physical dependency, 'did not do so well' due to the size of the Village. Unfriendly attitudes were exhibited toward new residents; some found it extremely alienating. The environment was found to not lend itself to supporting people with mental-health problems, particularly because the building is so big. Staff had difficulty reaching people and supporting those in need.	Y
Sheltered: Model family Mosaic	(Mouland 2015)	RCT-interim report only available	To measure and test the impact of a new service model to see if health and wellbeing could be improved. Initial health assessment conducted and reduce NHS costs in the process.	RCT of OA in Housing Associations. Measured mental health and wellbeing, involvement in local groups and social inclusion	Interventions group 1: housing staff were trained in skills and knowledge to provide advice on health and wellbeing issues, and to signpost them to other services (welfare rights or employment teams, local services and group activities). Interventions group 2: a dedicated health and wellbeing team provided intervention for a randomised group of people, including qualified nurses, mental health specialists, health trainers and support workers. 28% anxiety, 32& depression, 49% felt lonely, and variety of physical health conditions. Nearly half reported that they felt lonely at least some of the time. The interventions encouraged and enabled people to become more active, and to meet other people in neutral settings.	N
Sheltered: Removal of wardens	(Bristol Older People'S 2010)	Survey	To evaluate the perception of service users on the quality of care following the removal of wardens	Questionnaire measuring quality of service, QOL, security/safety, environment, social activities, loneliness	The majority of participants were over 70, and 81% lived alone. Eighty five per cent had a health or disability problem. Findings revealed that 83% of respondents believed that the current service was worse than before, and 54% said it was much worse. Sixty eight per cent of the older people reported that quality of life was worse now, and 32% said much worse. The report concluded that cost cutting had an adverse effect on the overall wellbeing of many older people.	N
Extra care: Enriched Opportunities Programme (EOP)	(Brooker, Argyle et al. 2011)	RCT	This study compared the experience of people living with dementia and other mental health problems in extra care housing schemes that utilised EOP with schemes that employed an active control intervention.	Multi-level intervention focussing on improved quality of life for people with dementia.	The EOP-participating residents rated their quality of life more positively over time (4.0 (SE 0.6) units; 14% p<0.001) than the active control (1.3 (SE 0.6) units; 4% p=0.003). There was also a significant group-time interaction for depressive symptoms (p=0.003). The EOP-participating residents reported a reduction of 25% at both six and 12 months and a 37% reduction at 18 months (all p's<0.001). EOP residents were less likely than residents in the active control sites to move to a care home or to be admitted to a hospital inpatient bed. They were more likely to be seen by a range of community health professionals. The EOP had a positive impact on the quality of life of people with dementia in well-staffed extra care housing schemes.	Y

Type housing/ model	Publication	Study type	AIMS	Outcomes measured	Results	Peer reviewed?
Sheltered	(Cairns 2013)	Enquiry	Better understanding the value for money of THT's Sheltered Housing provision in a way that looks beyond THT's income and expenditure, and incorporates the social and economic impact on tenants and other stakeholders.	Wellbeing and mental health: Changes in confidence, sense of worth, independence. Number tenants receiving formal or informal support for mental health issues; Changes in learning opportunities and activities. Annual cost of Local Authority social services day care for people with mental health issues.	The support for mental health issues was valued and mapped onto 5 ways to wellbeing. Values were evenly portioned between four of the five outcomes (£880 each) and self-report changed positively overtime: the feelings of meaning and purpose (39%), self-esteem and positive functioning expressed by individuals, the emphasis on the benefits from the development of supportive relationships (36%) and the new learning (72%), keeping active and connecting with others through activities at the schemes.	N
Extra care: Peer support	(Chakkalackal and Kalathil 2014)	Pilot	Evaluation of three peer support groups for people in the early stages of dementia living in extra care housing.	Five standard measures were used to collect data on participants' physical functioning, social relationships, wellbeing, expectations of the group and orientation in time. Individual semi-structured interviews were carried out with participants at 6 months and at 9 months	Quantitative and Qualitative results: Mean wellbeing scores improved over the course of the groups, even if the change was not statistically significant. Positive changes were seen on participants' perceived social support, with participants recalling more names of people living in the schemes. Participants had improved memory recall. On average, participants felt they benefitted more than they expected. This is in line findings from the Alzheimer's Society'srecent report Dementia 2013 which found that peer support groups provide a space for people with dementia to come into contact with others who have a similar experience which helps to alleviate and reduce loneliness.	N
Housing with care: Adult Social Care Environments and Settings (ASSET)	(Evans 2015)	Survey and cases	Evaluated if extra care offers better outcomes in terms of quality of life and independence when compared with remaining in mainstream housing	Adult Social Care Outcomes Toolkit (ASCOT), Quality of Life indicators	The evidence suggested housing with care effectively reduced the need for services, and that these settings can be cost-effective compared with mainstream community housing. The average social care related quality of life score was 0.91, this is a high score compared with older people's reported Social Care Related Quality of Life (SCRQoL) in other settings. The average perceived gain for participants was 0.39 compared with not living in a housing with care setting; residents particularly valued the safety, personal cleanliness and comfort that housing with care can support.	N
Sheltered	(Field, Walker et al. 2002, Field, Walker et al. 2005)	Comparison	This study compared the needs of older people living in sheltered housing in two contrasting areas.	Residents from three inner city sheltered housing schemes (N = 51) and three new town schemes (N = 87) were interviewed using the Camberwell Assessment of Need for the Elderly (CANE. They were also asked about their social networks, health, service use, and reasons for moving into sheltered housing. Each unit's facilities, policies, and physical layout were evaluated using the Multiphasic Environmental Assessment Procedure (MEAP) and warden interview.	PAPER1 Unmet needs were more common in people with activity limitation, mental health problems, or limited social networks. Inner-city residents had poorer mental and physical health but used local resources more and viewed their placement as more successful than those in the new town. Implications. Sheltered housing units should be flexible to meet the variety of needs, and also utilise the strengths and resources of residents. In the new town area those with restricted social networks may have had higher unmet needs because of poorer access to community resources such as public transport. Those in the inner city area had less unmet needs because they had better access to community resources, such as transport. Sheltered accommodation needs to have better access to localcommunity resources to help prevent residents feeling isolated.

PAPER2 Twenty-four percent had a diagnosis of depression and 8% dementia, but few had ever seen a mental health professional. Over half (55%) had clinically signicant levels of activity limitation and 37% had signicant somatic symptoms. Despite provision of glasses or aids 31% could not see satisfactorily and 23% could not hear adequately. Locally integrated social networks were most common (41%). Residents with a private network (16%) were more likely than those with a locally integrated network to have signicant activity limitation and to report often being lonely. Most residents were happy living in sheltered accommodation. Many made use of 'sheltered' features such as the common room, the communal laundry, the warden and the alarm. A minority of residents were lonely and a few wereunhappy with sheltered accommodation. | Y |
| Sheltered: Reminiscence as a Therapeutic Intervention | (Fielden 1990) | Pre-post pilot | Evaluated the use of a reminiscence (RE) group intervention as an adaptive tool for improving psychological wellbeing, increasing life satisfaction, and facilitating social interactions | Pre- and post intervention data were collected using the General Health Questionnaire (GHQ-28), the Philadelphia Geriatric Center Morale Scale, sociometric ratings of relationships, and behavioral observations made by wardens and social activity | Results show that the RE intervention was effective in bringing about changes in psychological wellbeing, patterns of socialisation, and life satisfaction. | Y |

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