Housing with care for later life

A literature review

Karen Croucher, Leslie Hicks and Karen Jackson

This report presents a comprehensive overview of the most recent evidence related to new and emerging models of housing with care for later life.

Reflecting the current emphasis on developing evidence-based policy and practice, the review focuses on primary research and service evaluations, drawing out key messages for service providers and commissioners regarding how best to meet the housing and care needs of older people in an ageing society.

There is growing interest and investment from the public and private sector in housing schemes for older people that combine independent living with relatively high levels of care. These schemes are thought to promote independence, reduce social isolation, and reduce the use of institutional care. The primary focus of the review is on UK evidence that addresses these crucial issues of independence, social integration, and the capacity of housing with care to meet a range of care needs. Although the UK evidence base is small, it provides highly useful insights into how well housing with care serves current policy objectives, and whether housing with care meets the needs and aspirations of older people.

Although the evidence base supports the idea that housing with care promotes independence, and generates high levels of resident satisfaction, messages around key areas of interest are more ambivalent. The review will be of significant interest to all those engaged with commissioning and developing housing with care schemes for older people, including policy makers, service planners, commissioners, and those actively engaged in developing and delivering services.

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1 INTRODUCTION TO THE REVIEW

Aims of the review

There is growing interest and investment from both the public and private sector in housing schemes for older people that allow independent living to be combined with relatively high levels of care. This review draws together the most recent literature on models of housing with care for later life. Reflecting the current emphasis on developing evidence-based policy and practice, the review is focused on the 'empirical' literature that reports primary research and service evaluations. Our aims are: to provide service planners, commissioners and those actively engaged in delivering services with an overview of a complex and diverse literature, emphasising 'what we know' around key questions and assumptions related to housing and care for later life; and to direct readers of the review to key studies and documents. We have:

- 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

- drawn out themes from the wider international (predominantly American) literature.

One of the difficulties associated with the literature on housing with care for later life is the use of a variety of terms to describe and categorise different schemes. For the purpose of this review 'housing with care for later life' refers to models where the 'housing component' allows older people to be tenants, owners or leaseholders, with private living space that is theirs and theirs alone, and where the 'care' component is flexible and can address a spectrum of care needs from very low to very high dependency levels that might formerly have resulted in admission to residential care. Thus the models support the concept of 'ageing in place'. Many of the models of interest to this review are promoted as 'homes for life'.

Methods

This is a scoping review of the literature, and is one of a number of methods associated with formal systematic reviewing techniques. A scoping study applies rigorous and transparent techniques for searching and locating literature on a given topic as a mechanism for mapping the territory. It is this explicit approach to the searching and retrieval of literature that makes aspects of the scoping review different to traditional narrative literature reviews. As with systematic review methods more generally, the aim is to produce an unbiased, replicable and methodologically rigorous account of existing research in a given area (Centre for Reviews and Dissemination, 2001; May *et al.*, 2001).

In undertaking this review, we have:

- searched 14 relevant electronic databases using complex search strategies specifically designed by an information scientist

- searched for grey literature (i.e. unpublished studies and work in progress) via contacts with known experts in the field and website searching

- applied a predetermined set of inclusion/exclusion criteria to the set of references retrieved to ensure only relevant material entered the review

- extracted data from individual studies onto a pro forma set up using an Access database.

A full account of the methods adopted is presented in the Appendices, including search strategies, lists of databases and websites searched, and organisations and individuals contacted.

Table 1 below shows the inclusion and exclusion criteria that were used to develop search strategies and applied to all references retrieved. The application of criteria ensured that the review remained focused. We have limited the studies entered into the review by date of publication, by language of publication and by topic.

We excluded studies published prior to 1985 as policy, demographic and cultural contexts have changed over time, and the focus of the review was on developing models of housing with care that reflect current policy and practice concerns. Searching and retrieval of the literature took place in the summer of 2004; however, elements of the search strategy were revisited in the summer of 2005 to ensure that any new publications would be included in the review. Time and resources did not allow for translation of studies reported in languages other than English. At the outset of the review we decided not to include publications that were primarily concerned with 'traditional' sheltered housing schemes, residential care or nursing homes, or care and support

delivered to people living in their own homes in the community, as we felt this literature would detract from the main focus of the review, and has been already been reviewed by Tinker *et al.* in *With Respect to Old Age*, an in-depth report presented to the Royal Commission on the Funding of Long Term Care (Tinker *et al.*, 1999). There are a large number of technical design guides relating to building standards and design, as well as assistive technologies, and these too were excluded.

Table 1 Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Grouped housing for older people Housing setting with range of care and support provided to older people who are tenants or owners with a range of housing and care needs	Individual housing Housing schemes without care and support provided. 'Traditional' sheltered, residential care or nursing homes
Studies focused on: • strengths and weaknesses of the model(s) • dimensions of effectiveness – accessibility, flexibility and acceptability • viewpoints of a range of stakeholders • funding mechanisms, size, design and location	Studies that are purely descriptive or marketing tools. Studies using population of grouped housing as cohorts for research unrelated to housing and care
Evaluations	Descriptions; dissertations; physical design guides
Studies published between January 1985 and June 2004	Studies before January 1985 and after June 2004
English language	Non-English language

Overview of retrieved studies

The sophistication of search facilities on social science databases varies considerably. Whilst on some databases it is possible to apply a sophisticated search, for others it is necessary to methodically conduct searches using individual terms. The result of searching was the discovery of over 4,000 references relating to our subject area. Many of these, however, were not relevant to the substantive topic of the review. Further checking was required to identify relevant material. A total of 145 studies have been used to construct this review.

There were three distinctive strands of literature. The first strand reflected on and evaluated UK policy and practice. The second is mainly concerned with retirement communities and assisted living schemes in the USA. Third, there is a small, mainly descriptive, literature on models of housing with care in Europe, Canada and Australia.

The UK 'policy and practice' studies have been commissioned by a range of research funders including central government, housing providers and voluntary sector agencies. They have been undertaken to inform policy makers on a variety of issues and identify and promote good practice (for example Lloyd and Wilcox, 1997; Tinker *et al.*, 1999; Appleton, 2002). Perhaps a limitation of some is the willingness to promote models as being 'good practice' solely on the basis of fairly limited descriptive accounts of elements of different schemes. On close examination we could only identify 11 UK papers reporting primary research and evaluation studies of housing with care schemes that have been published since Tinker *et al.*'s report to the Royal Commission noted above, and a further paper (Vallely, 2002) that presented an overview of two unpublished service evaluations carried out for one of the leading UK housing providers, Anchor Trust.

The studies from the USA are almost without exception

reported in academic journals. This might be as a result of our search strategy (although various US government websites were searched, as well as databases that list the grey literature), or it may be due to dominance of the private sector in provision of housing with care for older people. Critiques of services and service evaluations are unlikely to find their way into the public domain if they may be useful to competitors or damaging to business. The American studies also tend to focus on particular aspects of life in different housing settings: for example, social integration, experience of bereavement, friendship formation, patterns of volunteering and so forth. Their relevance to practitioners is perhaps more limited, although they provide a useful counterpoint to the British literature as they explore particular themes in some depth, and many provide discussions and critiques of theories of ageing and social integration in later life. There is also a tendency to use quantitative methods, drawing heavily on data surveys of residents.

There is also a small literature on models of housing with care in Europe. These are mainly descriptive papers (and so of limited usefulness to this review). Limiting the search to English language papers will have restricted the papers retrieved. Similarly we could only identify a very small number of papers that addressed housing with care in Australia and Canada. Again this may be due to limitations of the search strategy, although we undertook additional searches of Australian and Canadian academic and government websites in an attempt to locate additional studies. From this literature it can be seen that across the industrialised world the responses to changing demography, attitudes to citizenship and constraints on public funding have resulted in broadly similar responses to the provision of housing with care for older people to those current in the UK.

Structure of the review

In structuring the review we were concerned first to highlight the evidence that would be most useful to a 'practitioner' audience, and that would assist them in developing, planning and delivering services. We have, therefore, in presenting the evidence, focused on that which will be most relevant to our audience. In Chapter 2 we present an overview of the models of housing with care both in the UK and elsewhere that were identified by the literature. In Chapter 3 we consider the themes that emerged from the more theoretical (and mainly American) studies. In Chapter 4 we draw together the evidence from 11 British studies. These are all recent evaluations of a range of housing with care schemes in the UK. We felt it was important to 'spotlight' these studies as their findings constitute the main UK empirical evidence base. In the final chapter we discuss the overall findings of the review, offering our thinking on 'what we know' about housing with care, and reflect on the apparent gaps in the knowledge base and the value of conducting reviews of this kind.

2   DEFINITIONS, MODELS AND TYPOLOGIES

Definitions in the UK: what's in a name?

One of the difficulties associated with the literature on housing with care for older people is the use of a range of terms to describe and categorise different schemes. As noted in the Introduction, a variety of terms – such as 'very sheltered housing', 'enhanced sheltered housing', 'supported housing', 'integrated care', 'extra care', 'ExtraCare', 'close care', 'flexi-care', 'assisted living', 'retirement village', 'retirement community' and 'continuing care retirement community' – are used to refer to grouped housing schemes for older people.

This range of definitions reflects the ways in which housing with care has been developed in the UK. As Oldman (2000) and Tinker *et al.* (1999) note, over the past 20 years or more housing providers, largely local authority housing departments and housing associations, have been 'quietly' responding to the changing needs of the tenants in their sheltered housing schemes. Only more recently have social and health care professionals become more interested in housing with care models, particularly in their potential capacity to reduce the need for residential care and facilitate the maintenance of independence, resulting in an increasing number of developments of housing with care that, as Oldman (2000, p. viii) states, 'conform neither to pure sheltered housing nor pure residential care'. Different provider organisations

have placed different emphasis on the housing or care element of their provision, depending on whether they were trying to promote their schemes as alternatives to residential care, remodelling existing provision, or setting out to promote something they felt was conceptually different from what had gone before.

Definitions also vary because no one scheme is quite the same as another (Baker, 2002). Even when schemes are run by the same organisation and share similar design features and facilities, they can be fundamentally different in regard to the type of needs that the schemes are intended to meet (reflected in the varied allocation criteria described in the literature), the services that residents can access and the levels of dependency that can be accommodated (see for example Greenwood and Smith, 1999). This appears to relate to how particular schemes were developed, the local partnerships that were established, and local priorities in terms of funding and service development.[1]

More recently, the Department of Health's Housing Learning and Improvement Network (LIN) has promoted the term 'extra care housing', which it describes as:

> … a concept rather than a housing type that covers a range of specialist housing models. It incorporates particular design features and has key guiding principles. It can be referred to by several different names.
> (Riseborough and Fletcher, 2003, p. 1)

The inference here is that definitions do not really matter, as long as there is conceptual clarity. But do schemes share guiding principles, particular design features and conceptual clarity?

Various authors have outlined the services and facilities that might be expected in housing with care schemes. Oldman (2000)

highlights three key points that distinguish 'very sheltered housing' from 'traditional sheltered housing': the provision of a meal; the provision of additional services; and the possibility of a more barrier-free environment. In describing an 'ExtraCare' scheme, Baker (2002) is more specific, noting not just care services, but support with domestic tasks and opportunities for social interaction both within and outside the scheme.

Defining elements of very sheltered housing/ExtraCare

- Self-contained accommodation

- Equipment for care

- Care staff, probably including 24-hour cover

- Catering and communal facilities

- Social activities and probably religious worship

- Appropriate level of care for tenants based on individual assessments and care plans

- Help with domestic tasks and shopping

- Wider activities and services (e.g. interacting with the wider community).

Source: Baker (2002).

In a similar vein to Baker, King (2004) identifies six key defining features of ExtraCare housing.

Defining features of ExtraCare housing

- Self-contained flats or bungalows incorporating design features and assistive technologies

- Provision of appropriate care packages 'to a high level' if required

- Catering facilities with one or more meals available every day

- 24-hour staff and support

- Communal facilities such as restaurant, lounge, activity rooms, library, health suite

- Staff offices and facilities.

Note: In addition other services and facilities may be available including: domestic support services; specialist equipment for frail or disabled residents such as assisted bathing and hoists; social and leisure activities; and mobility and access facilities.

Source: King (2004).

Riseborough and Fletcher go further than other authors in defining what makes extra care housing distinctive from other types of provision for older people. They highlight four 'ingredients': principles; design; care and leisure; and assessment and allocation. These combine together to promote 'a better quality of life, not just quality of care' (Riseborough and Fletcher, 2003, p. 3).

Principles
- Focus on individuals
- Rehabilitation
- Independence
- Residents have control – tenancy rights separate from care
- Neighbourliness
- Access to community activities
- Community resource.

Care and leisure
- Flexible care
- Working with, not doing for, residents
- 24-hour support
- Care team based in scheme
- Access to meals
- Domestic support
- Supporting social and leisure opportunities.

Quality of life

Design
- Individual flats are seen as 'home'
- Design allows for a range of social activities
- Progressive privacy is built in for residents.

Assessment and allocation
- Joint assessment and allocation
- Balance of dependency levels
- Positive approach to mental health
- Step up and step down places
- Home for life.

Source: Riseborough and Fletcher (2003).

Riseborough and Fletcher suggest that these ingredients combine to offer a replacement for 'some or all residential care', in a housing setting that offers greater autonomy to older people as they have legal rights to occupy, with tenancy rights separate from care, where people can age in place without having to move to alternative care settings if their needs change. This is an ambitious agenda. Not only is extra care very inclusive (note the highlighting of a positive approach to mental health and balancing

of dependency levels), it offers a home for life, promotes social and community activities, is person-centred, and focuses on autonomy and independence.

Reflecting on these various and apparently evolving definitions of housing with care, certain common and related aims can be drawn out:

• promote independence

• reduce social isolation

• provide an alternative to residential or institutional models of care

• provide residents with a home for life

• improve the quality of life of residents.

First, the *promotion of independence* seems to stand out as the primary function of these schemes, fostered by individual accommodation or your own front door, residents being tenants or owners, barrier-free environments that are enabling rather than disabling, and the use of assistive technologies, as well as the 'philosophy' of some schemes of 'working with' rather than 'doing for' residents. Second, schemes are intended to *reduce social isolation*, by allowing greater opportunities for social contact, neighbourliness and mutual support. Third, these schemes are certainly intended to be an *alternative to residential or institutional models of care*, by placing the emphasis on housing and its associated autonomy. However, they share certain common features with residential care settings: for example, the provision of a meal, communal facilities or shared spaces, all residents being in one age group, and 24-hour staffing. These features are

also those that in theory allow '*ageing in place*'. Care is flexible, tailored to individual needs, so as needs change people can remain in the same place. Ageing in place suggests that these schemes can offer a *home for life*, and according to some definitions that is what they are intended to do. Finally an overarching ambition is to *provide a good quality of life* – better than people would otherwise have either in the community – via greater opportunities for social contact, barrier-free environments and access to care – or in a residential setting via greater independence and autonomy.

Housing with care in the UK: variations on a theme

There are clearly great expectations of housing with care. Below we consider the different ways in which providers are shaping their services to respond to these expectations, trying to identify current 'models' of practice. Our understanding is that no single model dominates.

Extra care housing and retirement communities

King (2004) has recently constructed a typology of extra care housing and retirement communities which identifies four key variables that combine independently to create a particular model:

- housing and support-provider relationships

- buildings (scale of development, range of facilities, type of accommodation)

- lettings policy

- tenure.

In many ways this typology is attractive. It provides one way of imposing a framework, albeit a very broad framework, and some order on a wide range of provision. We consider calling the third variable 'lettings policy' to be misleading, given the range of arrangements over tenure (see below), and we prefer to use the term 'allocation and eligibility'. We would agree that these four variables do highlight key distinctions between different models, as each variable will – to a certain extent – shape a scheme in different ways. What the typology cannot, however, demonstrate is the variation in 'philosophies' of different schemes, which are usually specific to a particular provider organisation, and are then reflected in how services are delivered, the type of entry criteria for the scheme and the facilities present. For example, The ExtraCare Charitable Trust (ECCT) places particular emphasis on well-being and on developing and sustaining a positive lifestyle in old age (Appleton and Shreeve, 2003). Thus ECCT has been active in the development of retirement villages (including Berryhill and Ryfield Village) to allow more mixed and 'vibrant' communities that offer a wide range of facilities as well as care provision. Similarly Hartrigg Oaks, the continuing care retirement community operated by the Joseph Rowntree Housing Trust, is designed to allow community development and promote social interaction, not simply provide care. Some schemes, particularly those in rural areas, are designed to be the hub of services that serve the wider community. Others are seen very much as a replacement for residential care and their occupants were formerly resident in care homes.

Relationship of housing and care providers

A distinction can be made between different models of housing with care, depending on whether the accommodation and care are provided by the same or different organisations. There are

perceived to be advantages and disadvantages to both. Where a single agency provides both housing and care services, control over all aspects of the scheme rests with one organisation. The principal argument in favour of this arrangement is that it permits a more seamless service that does not require a demarcation between care, support and housing management – a demarcation that residents themselves often do not make or understand – allowing a more holistic approach to meeting residents' needs. There is no fragmentation of management responsibility between organisations, or potential conflicts over care philosophies. The arguments against this arrangement are that residents have no choice over care provider, and may be less likely to complain about care services if they feel their tenancy might be threatened. Schemes where accommodation and care are provided by different organisations are thought to allow greater choice and empowerment to residents. Residents can complain about their care, or change their care provider without fear of losing their accommodation. Separation of care and housing functions is also thought to allow different organisations to play to their strengths. However, as we shall see later, evidence suggests that the relationship between care providers and housing managers can be problematic. There can be differences between philosophies of care as well as lack of clarity regarding where boundaries between the responsibilities of different agencies are drawn.

Buildings: scale of development, range of facilities, type of accommodation

A further distinction is the scale of schemes. Some services and facilities – particularly leisure and community facilities – become more viable with larger numbers of residents (see Phillips *et al.*, 2001; Appleton and Shreeve, 2003). Larger schemes are thought to offer more opportunities to accommodate both fit and frail

older people, and thus allow the development of a 'vibrant' community. Retirement villages or communities are a relatively recent phenomenon in the UK, and as their names suggest they tend to be larger developments of more than 100 dwelling units. Examples include Berryhill Village and Ryfield Village, both operated by The ExtraCare Charitable Trust, and Hartrigg Oaks continuing care retirement community operated by the Joseph Rowntree Housing Trust (see Rugg, 2000; Sturge, 2000; Croucher *et al.*, 2003). Large schemes, however, are criticised as they can more readily be seen as 'ghettos', segregating older people from the wider community.

A distinctive feature of some schemes – usually, although not exclusively, in the private sector – is the presence of an on-site registered care home. Residents may move into the care home for short periods, or on a permanent basis.

A range of different types of accommodation can be found across different schemes, most usually flats but sometimes bungalows or small houses. There is considerable variation in space standards within the individual accommodation, as well as site or building layout. For example, some schemes are large blocks with the flats opening off a corridor, much like a hotel. In others the accommodation is more dispersed across a site. Clearly the type and quality of the accommodation will vary depending on how a particular scheme is developed and the capital investment available.

Allocation and eligibility criteria

There is a range of allocation or entry criteria for different schemes. There are those schemes that aim to divert prospective tenants from residential care, thus those who move to these schemes would otherwise have been admitted to residential care. Some schemes employ the same entry criteria for applicants as would

be employed for entering residential care. Some local authorities are remodelling or replacing their residential provision with housing with care schemes (see Fletcher *et al.*, 1999; Oldman, 2000). Other schemes aim to accommodate people with a range of care needs (see for example Baker, 2002), from people who are relatively fit through to those who need considerable care and support. The intention here is to have a 'dependency mix'. The presence of fitter and more active residents is supposed to introduce 'vibrancy' into the scheme, and assist in motivating and encouraging those who are less well. Others offer accommodation on the basis that the resident is still capable of independent living at the point of entry. Others are specifically aimed at people with dementia-type illness (see Molineux and Appleton, 2005). This variation seems bound to ensure that different schemes will have a very different resident profile and be serving very different needs.

Tenure

As noted above, there are both public voluntary sector and private sector providers of housing with care. Residents can be tenants, leaseholders or owners. Some schemes offer mixed tenure with the possibility of buying or renting a property, while others are for rent only. There are increasing numbers of older people who are home owners, and seeking housing with care from the private sector.[2]

Models outside the UK

A further layer of definitional complexity arises when considering housing with care schemes outside the UK. Authors may use terms that are either unfamiliar to UK readers, or are familiar but with quite a different meaning in the UK context. Furthermore

different housing, health and social care finance systems, patterns of tenure and policy formation impact on the amount and type of resources available and the development and/or dominance of different models in different countries. Perhaps the most significant difference here is between northern European countries with traditional welfare states and Canada, the USA and Australia where there has been a heavy reliance on non-governmental sectors for housing provision.

Despite these differences, housing programmes for older people across the industrialised nations show many similarities, notably a determination to restrict the number of places in institutional settings, and to merge the housing and long-term care systems by developing age-specific housing that serves the frail elderly within the community. Process solutions are also remarkably similar, with decentralised planning and services delivery stimulated by national guidelines and finance (Pynoos and Liebig, 1995).

Europe

A number of publications by the Housing for Older People in Europe (HOPE) Network provide relatively recent accounts of current policy and examples (rather than evaluations) of current practice (see de Boer and Roose, 1997; Lindstrom, 1997; Riseborough, 1998; Thomas and Roose, 1998). These and other papers (Coleman, 1995; Pynoos and Liebig, 1995; Scharf, 1998; Phillips *et al.*, 1999; Houben, 2001; Giarchi, 2002) illustrate some key points regarding the industrialised nations of northern Europe, particularly Denmark, the Netherlands (see also Houben, 1997; van den Heuvel, 1997), Finland and Sweden where there are similar types of welfare provision to those in the UK. In these countries, in the past ten to 15 years, housing and care provision for older people has developed in very similar ways to the UK

with a dual emphasis on increasing the provision of community care services that can be delivered to the home and developing provision of housing with care – both new-build schemes and remodelling of older provision – to reduce the use of institutional settings. These developments have been driven by the same factors that have promoted change in the UK, notably growing concerns about the costs of institutional models of care and how the costs of care for increasingly older populations will be met (see particularly Riseborough, 1998), as well as a determination to promote the independence and social inclusion of older people. In southern Europe, however, there is still a reliance on family care to support older people.

Our literature searches did not identify any *evaluations* of housing with care schemes in European countries.[3]

As noted above, European provision on the whole shares many similar characteristics with the UK and, despite extensive searches, we were only able to find a small number of examples of housing with care that were distinctively different from UK provision. These were usually reported in the sketchiest details. For example, Pynoos and Liebig (1995) report an experimental *age-integrated sheltered housing* scheme in Israel where a number of ground-floor flats in a purpose-built suburb in Jerusalem were allocated to older people from poor housing in the local area who were functionally independent but socially isolated. Services on site included a clinic, social club, laundry and intercom link to a warden or 'house mother'. Families living in the scheme were 'screened' to exclude problem families. The scheme was evaluated within two years of opening, and demonstrated increasing acceptance of intergeneration living among the older people and growing degrees of intergenerational integration, particularly between older people and teenagers. The authors note that the study ended long before people were likely to become very frail or confused. Another relatively well-known

project, the Anton Pieckhofje housing scheme in the Netherlands for people with dementia (Marshall and Archibald, 1998), provides 'warm care' in group houses with separate accommodation within the scheme for spouses and care givers. A further project – the Skewiel Trynwâlden[4] – in a rural part of the Netherlands has also received much attention recently, although again we could find no evaluations. This scheme was developed following the closure of a care home and its replacement with apartments. Older people can rent these apartments or continue to live in their own home in the surrounding seven villages. A number of service brokers help co-ordinate a range of housing, social care and health services to older people and others in the community. The apartments and villages are served by five multidisciplinary teams. A social services centre with a range of primary and welfare services, as well as a restaurant, respite care centre, crèche and playground, serves the whole community.

CoHousing is a feature of provision in the Netherlands, where there are more than 200 CoHousing schemes, and Denmark, where the idea was developed. This model does not feature in UK provision but it has been actively promoted mainly by the work of Brenton (Brenton, 1998, 1999, 2001) and has generated some interest among UK policy makers. There have been efforts to develop a CoHousing scheme for older women in the London area (supported by the Joseph Rowntree Foundation: see Brenton, 2001) and a further scheme is at initial development stages in Scotland.[5] CoHousing schemes vary in size and design. They are characterised by: shared communal areas, private accommodation for individual residents, resident-structured routines, resident management and resident participation in the development process. Their most distinctive feature is that they are initiated and controlled by the residents (see Fromm, 1991). Brenton (2001) suggests that the CoHousing model may be particularly appealing to the 'soon-to-be-old' in the UK who will

have very different expectations of later life. It could be questioned whether such schemes should be considered 'housing with care', as no care element is designed into the schemes.

United States

In the USA the literature identified two primary models of housing with care: continuing care retirement communities (CCRCs) and assisted living. Assisted living is a relatively new development in the USA, whereas CCRCs have been operating since the end of the Second World War. Both are predominantly provided by private sector or not-for-profit organisations, including many religious organisations. There is little state-funded or federally funded housing provision for older people of any kind (see Pynoos and Liebig, 1995).

Continuing care retirement communities

Continuing care retirement communities (CCRCs), sometimes called life care communities,[6] provide a package of housing, health care and social care services to their residents. There are approximately 2,000 CCRCs in the United States. They vary enormously in size from those that have several thousand residents (for example, Sun City in Arizona, one of the first CCRCs to be opened) through to those that are much more modest in scale with just several hundred residents. They are operated by both private and not-for-profit organisations. Many are located in the sun-belt states of Florida, California and Arizona.

Most CCRCs operate on an insurance principle, where individuals can protect themselves from the uncertainties of escalating health care costs by paying regular premiums to cover the costs of their future care including nursing home care (see Sherwood *et al.*, 1997). Residents can move into independent accommodation units when they are fit and well. Changes in care

needs can be accommodated within the CCRC – in the residents' homes, in assisted living facilities or in nursing homes on site. Other facilities for recreation and leisure are also provided on site. A longitudinal study of 2,000 residents living in 19 CCRCs (Sherwood *et al.*, 1997) clearly indicates that CCRCs tend to service white, well-educated, middle- to upper-class people from the older segments of the older population, the majority of whom are women, aged 75 and above. In comparison with a community sample, CCRC residents were more likely to live alone and have fewer children living nearby.

Such schemes are not without their critics (see Phillips *et al.*, 2001; Haas and Serow, 2002; Golant, 2003). Retirement communities generally (along with other types of community interest developments) are seen to be indicative of social fragmentation in metropolitan America. They are also seen to be segregating older people from the wider community and inherently ageist, as well as elitist. There have also been concerns about their regulation and financial viability (see Netting *et al.*, 1990; Conover and Sloan, 1995).

Assisted living
Assisted living is the fastest growing type of provision in the USA (see Frank, 2001). Recent estimates of the numbers of assisted living facilities vary, depending on the definitions used, from between 15,000 and 40,000 residences serving up to one million older Americans. There is a general consensus that this type of provision will increase (Tinsley and Warren, 1999). As with CCRCs, assisted living residents are self-funded.

There is no one standard definition of 'assisted living'. Reflecting that the definition has never been, and probably will never be, precise, Regnier (1999, p. 3) suggests assisted living is:

> … a long term care alternative that involves the delivery of professionally managed personal and health care services in a group setting that is residential in character and appearance; it has the capacity to meet unscheduled needs for assistance, while optimizing residents' physical and psychological independence.

Regnier then goes on to identify nine attributes of assisted living. These are shown in Table 2.

There are many elements here that seem similar to much of the UK's provision of housing with care. The debates about definitions, roles and care philosophies of assisted living provide interesting parallels with the UK debates over housing with care. Frank (2001) notes considerable variation in the difference in emphasis between different schemes, some offering 'non-health care services' only, but others providing personal care, health monitoring and 24-hour on-site nursing staff. The ambiguity around definitions creates uncertainly for providers and consumers, and regulations vary from state to state. There are no standard entrance and discharge criteria.

Authors have questioned whether older Americans will continue to choose assisted living over staying at home with home care services. Similarly, although the emphasis in assisted living is on home and maintaining independence, authors question its ability to maintain people whatever their care needs (Golant, 1999). For a fuller discussion of assisted living and its development see *Aging, Autonomy, and Architecture: Advances in Assisted Living* (Schwarz and Brent, 1999).

Canada

Currently in Canada older people who are able to stay in their own homes can be supported by state-funded home care

Table 2 Attributes of assisted living

Residential appearance	Residential look of building important – design should reflect family dwellings rather than hospital
Smaller-scale arrangements	Lessening scale of building by breaking into small unit clusters arranged on a site
Person as a unique individual	Programme should deal with each resident as unique individual. Assessment and treatment plan and role of the person in the setting should be recognised as unique
Family involvement	Family members should be encouraged to participate in lives of their relatives, socially and as active partners in care-giving process. Common spaces provided to support family interaction
Mental and physical stimulation	Activities that build competency – physical therapy and intellectually challenging activities
Residential privacy and completeness	Dwelling unit should be private, have at least a kitchenette, large enough to accommodate overnight guests, and accessible bathroom
Surrounding community	Environment should integrate residents into surrounding community rather than isolate them from its resources and contacts. Residents should use community services, and community groups should be invited in
Independence, interdependence, and individuality	Focus of care should be on self-maintenance, with assistance. Residents should be encouraged to help each other. Building designed to support informal exchanges, and community development
Frail older person	Facility should be targeted towards a frail, dependent population, age range between 82 and 87. The population should meet 40/40 rule: at least 40% having difficulties with incontinence, and 40% some problem with memory loss or dementia

Source: Regnier (1999).

services, with additional financial support to assist with home maintenance and with the costs of adapting the home if necessary. However, the next step for many people is institutional care in a nursing home, and there are growing concerns about the availability of nursing home places and the costs and quality of care. Canadian government policy documents (Golant, 2001; National Advisory Council on Aging, 2002; Canada Mortgage and Housing Corporation, 2003) highlight the relative lack of supportive housing options for older Canadians and the requirement for federal and provincial government to address this shortfall to meet the needs and changing expectations of growing numbers of this group and thereby reduce unnecessary admissions to nursing homes. The defining elements of supportive housing are: accommodation which is residential in character with private living spaces; a supportive physical environment to encourage socialisation and mutual support as well as reduce risks of accidents; access to necessary support services including meals, housekeeping, transport, personal care, and social and recreational activities; involving residents in decisions and promoting realistic expectations of what can be provided; affordability and choice for upper-, medium- and lower-income seniors.

The currently very limited supply of supportive housing provision has been dominated by the private sector. Developers have focused on 'congregate housing', comprising private self-contained accommodation in one or more buildings with supervision, provision of meals and emergency assistance (not medical care) and some level of support services. In addition the literature describes 'campus model housing', again predominantly private sector developments, which seems very akin to continuing care retirement communities, providing a continuum of care or 'multi-level care' to residents ranging from independent apartments to congregate supportive housing for frail older people and nursing home care on site.

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As private sector developments are unaffordable to many older Canadians, policy documents emphasise the need for partnerships between the for-profit, not-for-profit and public sectors in order to develop different forms of supportive housing with a mixed range of tenures and accommodation options that are more accessible to older people with medium and lower incomes.

More recent literature critiques legislation introduced by some provincial governments to promote the development of assisted living, a model drawn from the USA (see above) and predominantly developed by American operators who see a growing market for these facilities in Canada. Spencer (2004) is highly critical of recent legislation introduced in British Columbia, reflecting that consumer input and influence have been absent from the development of the model of assisted living proposed by the provincial government, and that the proposed legislative and regulatory frameworks do not provide sufficient safeguards and standards to protect consumers from unscrupulous operators. In addition, a confusing array of definitions, and questions over who assisted living is for, mean that the actual model of delivering services and mix of services will vary from facility to facility depending on the individual operator and the particular health authority's interpretation of their responsibilities to provide 24-hour emergency response systems.

Australia

Reflecting concerns regarding the ageing population, Australian housing policies have focused on enabling older people to age in place by providing home- and community-based programmes to them in their own homes, or supporting the development of alternative housing such as special-built medium-density accommodation and hostels.[7] Retirement villages are one type

of medium-density housing. There is no single model, and different villages provide different amenities and services, although the emphasis has been on leisure rather than care services. Villages can be operated by a variety of organisations including for-profit and not-for-profit or religious organisations (Manicaros and Stimson, 1999). Recent figures suggest that there are 44,000 people (about 5 per cent of Australia's older population) living in approximately 1,700 retirement villages. Most retirement housing requires the payment of an initial entry contribution that can be substantial. Non-profit organisations are the main providers of rental accommodation for older people, although private developers have begun developing purpose-built rental accommodation for older people directed at the lower end of the market (http://www.itsyourlife.com.au).

Conclusion

Drawing on the UK and international literature, it is clear that models combining housing with care are being seen as a means to support older people and reduce the use of institutionalised care across the industrialised world. There are various definitional problems, and very few schemes are exactly alike, although a number of common features emerge, notably a focus on a 'homely' rather than institutional environment and services that promote independence and autonomy. Based on the literature that we retrieved there is little to suggest that other countries with similar welfare traditions are taking significantly different approaches from the UK.

3 DOMINANT THEMES FROM THE WIDER LITERATURE

In this section of the review we draw together key themes from the wider literature identified in the search. As we noted in the Introduction, we searched for international literature that reported research or evaluations of housing with care. Almost all the empirical literature from outside the UK was from the USA. We found no evaluations of any European or Canadian schemes, a small number of evaluations from Australia and one evaluation from Israel.

Much of this predominantly American research was reported in refereed academic journals. Overall the studies focused almost entirely on the social aspects of moving to and living in continuing care retirement communities (CCRCs) and were located in single communities. Perhaps surprisingly given the relatively long history of the CCRC in the USA, our search only identified one large, comparative evaluation of a number of CCRCs undertaken in the USA (Sherwood *et al.*, 1997).[1] There were only five studies that addressed assisted living facilities, as might be expected given the relatively recent development of these schemes. There were also a number of key British studies that focused on identity and community formation in age-segregated environments, notably the work of Percival (2000, 2001, 2002), and this has been included here. Overall this literature represents a body of carefully considered and theoretically informed academic work.

We present the themes and findings from the literature under the following headings:

- moving to live in retirement communities

- social integration

- care services and facilities

- assisted living facilities.

The first three sections are concerned with the literature relating to retirement communities, and the final section draws on the much smaller literature relating to assisted living facilities.

Moving to live in retirement communities

The reasons for moving most cited in the literature were: aspiring to live in a more amenable community or climate; needing help with some aspect of deteriorating health; seeking more affordable housing; and needing more services. 'Late life migration' was also documented in terms of developmental transitions most usually encountered in older age, i.e. sets of age-related needs as experienced over the life course. Some commentators suggested that successfully adapting to these developmental stages is optimised by specific migration behaviour.

From the US literature we know that overall receptivity towards retirement communities is increasing. However, insight into this area is patchy, and is drawn from the field of consumer research. Two 'consumer' studies (Gibler *et al.*, 1997, 1998), while noting a shift from planned choice to 'distress sale' in the light of increased support being provided in people's own homes, indicated that most residents of retirement facilities began looking

to move at or after retirement and searched for a fairly short time, and relied heavily on their children as sources of information and guidance. Another study confirmed children as occupying an important supporting role in choices while maintaining that decision making was carried out independently by the parent (Knight and Buys, 2003). Another study (Moen and Erickson, 2001) pursues the marketing importance of so-called 'planfulness' in terms of decisions to move in relation to satisfaction with moving and subsequent experiences.

Decisions to move

Studies of older people's patterns of decison-making behaviour relate mainly to discerning the reasons for a move which has taken place recently or some time ago, or for moves which are being planned or considered. Given the longer history of the concept of the retirement community found in the United States, data are mostly drawn from America, while comparative data and secondary analyses of large data sets include other countries and are mainly American in authorship (see for example Parr *et al.*, 1988; Hazelrigg and Hardy, 1995; Golant, 2002); however, the small number of Australian studies also consider decision-making behaviour (Manicaros and Stimson, 1999; Kupke, 2000; Wolcott and Glezer, 2002).

Planning for the future

Planning for the future is clearly indicated across various studies as a major 'push' factor in deciding to move to a retirement community, and is one of the key themes explored in the literature. Some parts of the literature included in the review highlight what might be defined as speculative aspects of individuals' planning for their future lives. Future care needs are regarded as a complex area of consideration, and raise issues linked to planning and

control in more general terms. In one study (Pinquart and Sorensen, 2002a), the main reasons for planning for future care needs were linked to security and coping. People mainly made plans which could be adapted if they needed help, or they avoided thinking about possible future health crises; making flexible plans was seen to be a way of coping with contradictions between the wish to control life and the difficulty of an unknown future. In the same study, enhancing resources and knowledge about available resources were suggested as providing opportunities to reduce individuals' barriers to planning for future care needs.

Choosing to move

A number of studies set out to determine the reasons why people choose to move (see for example Laws, 1995; Krout *et al.*, 2002). These studies range from post hoc, simple surveys to large-scale complex analyses of national data sets aimed at being able to predict patterns of needs and services, for both theoretical and practical purposes.

While there is debate about whether retirement communities are to be seen as facilitating independence and continued well-being or as assisting people in leaving adverse situations, the motivation to move to a retirement community is influenced by several generally agreed factors (Netting and Wilson, 1991; Gupta and Galanos, 1996; Manicaros and Stimson, 1999; Kupke, 2000). First, there are factors which can be defined broadly as 'geography'. These include climate and the proximity of relatives and friends. One study shows that the people most likely to move are those with the fewest ties. Second are factors linked to convenience in daily life, such as the amenities and activities provided by the retirement community. Third are factors associated with providing security for a spouse, particularly when the need arises for one partner to live independently. Fourth are health and concerns regarding the provision of health care,

including services currently received, and those services which will meet perceived future needs. Access to medical care services and long-term care services in order to maintain independence and avoiding the potential problems of 'ageing in place' are of high importance (Longino *et al.*, 2002) as well as the guarantee in the contract between provider and residents that services would be delivered (Sherwood *et al.*, 1997). Freedom from maintenance of property and more security in housing are factors influencing choice (Tell *et al.*, 1987; Sheehan and Karasik, 1995), albeit apparently reported to a lesser degree than other factors.

One study (Silverstein and Zablotsky, 1996) showed that the likelihood of moving to two particular types of retirement community increases as disability advances to moderate levels, but declines as disability becomes severe, and that choosing to move is more likely for those older people who live alone and for those whose children do not live nearby. While there are social and amenity considerations in middle to late older age, there are also factors to be considered which arise from the need for assisted living due to physical frailty. The study concludes that: 'Retirement housing where formal services are provided may become increasingly attractive to moderately disabled older people who need assistance but prefer to live independently in an age-homogenous community' (Silverstein and Zablotsky, 1996, p. S156).

The study by Kupke (2000) in Australia indicates that motivations for moving vary depending on marital status and gender. Companionship and the desire to be nearer family were much stronger 'pull' factors for widows/widowers. For women, the opportunities for more company were considered an important attraction of village life; however, men in general considered companionship to be unimportant. Similarly, for women the illness or death of a partner was a significant motivator to move to a village; for the majority of male respondents it was not important.

A study from Australia indicates that motivations to move differ according to the types of tenure from which people move (Gardner, 1994). For those residents who moved as home owners, concerns were closely linked to the likely changes in health and neighbourhoods. For those who were not home owners, affordability of the living situation was the main concern.

Another Australian survey (Kupke, 2000) showed that the factors of major importance to residents in terms of selecting a particular village were the size, design and price range of the accommodation units. These findings are somewhat contrary to the findings of an earlier Australian study (Manicaros and Stimson, 1999) that suggested that factors such as existing friends, cultural links and organisations were important elements in attracting new residents to particular villages.

From the US literature, there is limited discussion of the implications of differing financial arrangements. Residents of CCRCs in the USA are from affluent backgrounds, and one study briefly makes reference to improvements in the economic status due to growth of private pensions which make CCRCs affordable to more older people. The study also notes that access to and insurance for medical and long-term care services are most important concerns. Another suggests that CCRCs attract members because they desire insurance and access to services as well as wanting more secure and less isolated housing situations.

Social integration

There is an extensive theoretical literature regarding social integration and social identity in later life (see for example Jerrome, 1992; Potts, 1997; Moen *et al.*, 2000; Pillemer and Moen, 2000; Hockey *et al.*, 2001). Moreover a large body of research has demonstrated that greater social integration leads to positive

outcomes in later life. Age-segregated housing is often promoted as a means of reducing social isolation and loneliness in later life and increasing opportunities for social interaction and companionship. Many of the studies focused on the types of social networks that were evident in congregate settings, how these networks developed, and how they impacted on the health and well-being of residents. There was also considerable interest in how residents maintained or developed social networks with the wider community located outside particular housing settings. On reflection, there is conflicting evidence with respect to whether there is a socially beneficial aspect to age-segregated housing; it may be conducive to friendship and community formation, but it may also be alienating for some people.

Adjustment to age-segregated communal living

Age segregation was regarded by some authors as negative in terms of maintaining optimal levels of social interaction (Cohen *et al.*, 1987, 1988). The benefits/drawbacks of age integration were dependent upon the wider local environment, demonstrating the requirement for balance between security and social/ geographical isolation (Cannuscio *et al.*, 2003).

Issues concerning social segregation meant that some residents were ambivalent about their identity as residents of retirement communities, and there were underlying negative assumptions about incremental ageing, dependency and disengagement held both by residents and those outside the community (Williams and Guendouzi, 2000). 'Complaining' was shown to be a means of expressing the felt tensions between independence and social constraint, independence and dependence, and independence and interdependence (Aleman, 2001).

Manicaros and Stimson (1999) found that wide disparities in age could generate tensions between younger and older residents who may desire or need different services and facilities, and competition can arise over how fees are allocated.

The work of Sherwood *et al.* (1997) indicated that, following a move to a retirement community, attitudes towards ageing improved significantly, suggesting that CCRCs provide an environment conducive to a positive picture of one's own ageing. However, other studies indicated that many residents did not like to consider the possible problems of ageing (Streib and Metsch, 2002). Where residents were fairly young and mobile, chief concerns were with quality of life in the present and not with the possibilities of difficulties in later life (Brokaw *et al.*, 1988).

At times this manifested as concrete examples, such as residents disliking the implications for their self-image involved in the building of a nursing home on a site where most residents were young-retired and fairly active (Streib and Metsch, 2002).

Other work (Hays *et al.*, 2001) indicated that a considerable percentage of residents (40 per cent) included death-related planning in their decision to move to CCRCs. More educated and more religious older people were seen as being more likely to prepare for death although the limitations in activities of daily living do not predict levels of preparation for death (Pinquart and Sorensen, 2002b). Anxiety about death might be increased in retirement communities where residents are surrounded by older people vulnerable to illness and death and some research highlighted the association between low death anxiety (DA) and attendance at religious services, as distinct from privately practising religion (Duff and Hong, 1995).

Friendship formation and close relationships

Evidence suggests that it is more intimate and confiding relationships that are the most important in terms of maintaining health, a sense of well-being and self-identity in later life. One study found marriage to be a stronger predictor of life satisfaction than either 'activity in the community' or 'interaction with friends' (Hong and Duff, 1994). The marital composition of retirement communities was important. Kupke's survey showed that couples are more likely to be independent of village social networks, and perhaps happy to retain a level of seclusion within the village community (Kupke, 2000). Many of the studies highlighted that more intimate relationships reported by residents were often with family and long-standing friends from outside the housing setting (for example Perkinson and Rockermann, 1996; Potts, 1997), or with people within the housing setting who had been friends prior to relocation. Perkinson and Rockermann note that dynamics of friendship formation vary from community to community and are highly dependent on whether residents are all newcomers and relative strangers, or whether residents have lived in the setting for years and developed histories of shared experiences, complex networks and strong ties of mutual support; thus generalisations across different settings are problematic.

Notwithstanding the importance of long-standing, intimate relationships, various studies reported larger social networks and more frequent social contacts following a move to a retirement community (Potts, 1997; Sherwood *et al.*, 1997; Stoller, 1998; Erickson *et al.*, 2000) and in comparison with community samples (Sherwood *et al.*, 1997). Potts (1997) suggests that residents tend to interact more frequently with co-residents regardless of the intensity of their emotional bonds, and casual friends and acquaintances are more likely to be regular companions of older people in age-segregated settings. In one study greater 'place

attachment' was reported for those living near the main activity centre, where there was increased likelihood of unplanned encounters (Sugihara and Evans, 2000).

In a UK study of social interaction in three sheltered housing schemes, Percival (2000) highlighted the prominent role of gossip in the daily life of older people, as it reinforces social norms and values that assume great significance in a close-knit, predominantly female environment. Percival concludes that while gossip may serve a useful, social purpose in sheltered housing, it may also have important and paradoxical consequences for the individual. In particular, gossip is understood to be a form of interaction that encourages the individual to strike a balance between their personal and social needs in the communal setting.

Mutual support

In many studies residents often described their schemes as 'friendly' or 'neighbourly'. Neighbourliness might include observational behaviours such as regular signals, for example a handkerchief tied to the door handle every morning to indicate all was well (McDonald, 1996), or brief telephone checks on people in an informal network. Requests for help were seen to signify the transition from acquaintance to friend. Many studies reported residents giving and receiving support and assistance from other residents, for example lifts to church, or exchanges of food or other items, and occasionally more intensive support if people were recuperating from illness or recently discharged from hospital. Where reciprocity existed, this could be disturbed by increasing dependency (McDonald, 1996; Zaff and Devlin, 1998). Increased length of stay led to declining reciprocity, perhaps due to age-related limitations of activity (Netting, 1990; Litwin, 1998). Friendship was described as a dangerous source of long-term care, as there were apparent limits to what a friend will do, thus

expectations of assistance were not always met (Stacey Konnert and Pynoos, 1992).

Such 'neighbourly' and assistive behaviours are described by Lawrence and Schiller-Schigelone (2002) as 'communal support', and demonstrate a social context in which residents work together to benefit those who suffer to various degrees from age-related stressors (identified as physical disability, sense of impending dependency, and loss of loved ones, social roles, home and financial security). Communal support 'elicits coordinated action for mutual benefit, whereas social support is a process that does not require coordination among providers or mutual benefit' (Lawrence and Schiller-Schigelone, 2002, p. 689). Problems become shared problems, with a shared responsibility to address them as residents help one another in a way that reinforces a sense of community and security for all, promoting solidarity in ageing – a feeling of being in the same boat as others – that can pave the way for a culture of communal coping.

Formal social activities

Where dining rooms were in place, these were frequently noted as the main social hub or 'social microcosm' of different settings (Stacey Konnert and Pynoos, 1992; Perkinson and Rockermann, 1996; Williams and Guendouzi, 2000). Mealtimes were consistently seen as influential within community life. Much social interaction occurred in dining rooms, which were places of special significance for both friendship development and social exclusion within CCRCs as various groupings offer a highly public daily display of current alliances and dissolutions. Residents noted the 'cliques, the loners, the socially gracious and amiable and those who battled openly in this most public area' and could also observe how others behaved from afar, and maybe rule out certain people as potential friends because of the way they behaved (Perkinson

and Rockermann, 1996, p. 166). However, communal meals were not without problems. For example, in one study set mealtimes reduced the opportunity for other activities (Abbott *et al.*, 2000). In another study, difficulties and stress were reported regarding continually altered seating arrangements due to communication problems and others' eating habits/abilities.

Studies (Jenkins *et al.*, 2002; Evans *et al.*, 2004) considered levels and types of physical and non-physical activities undertaken by residents in two large CCRCs and the impact on health-related quality of life. Findings suggested that engaging in activities, physical and non-physical, is associated with better health-related quality of life, and that recreational programmes in CCRCs play an important role in enhancing the quality of life of the residents. In particular social activities are important for those in poorer health.

Volunteering

Communal settings also offer opportunities for formal volunteering. Studies (Netting, 1990; Okun and Eisenberg, 1992) identified that residents have multiple motives for volunteering, including status recognition, socialising and social value, suggesting the need for a range of volunteering opportunities. For example, some people will more readily engage in formal or visible activities such as chairing residents' councils, others will be more interested in socialisation activities such as arranging social events or groups, and yet others want to engage in activities that support their social values, such as assisting others with small tasks, visiting and befriending. A small number of studies noted that the high-status resident positions in communities were frequently occupied by married men, although they were a minority in predominantly female communities.

Volunteering among a cohort of newly arrived residents in a new CCRC was shown to increase significantly (Erickson *et al.*, 2000): 79 per cent were engaged in volunteering after the move, compared to 61 per cent prior to moving. Residents in this study were also giving considerable amounts of time – on average 39.9 hours per week for men, and 22 hours for women. However, as noted by the authors, this was a well-educated and healthy sample. Those who stopped volunteering or did not volunteer were the oldest and had more functional limitations. Residents were motivated by wanting to 'build the community'.

Social isolation

Not all social interaction within age-segregated settings is harmonious. Various authors report instances of conflict and negative interactions, and as noted above some residents may find themselves isolated, or struggle with adjustments to communal living and retaining privacy. The level of social engagement is a matter of individual choice, and residents across studies reported difficulties in balancing privacy with living in a community; thus a reluctance to 'join in' could in some instances be seen as a strategy to preserve privacy and self-identity in a communal setting.

Awareness of the negative stereotypes of ageing and determination to preserve self-identity and represent oneself as mentally and physically competent can result in a reluctance to engage with those who are not mentally and physically competent. There were consistent reports of groups of residents across all types of settings that were socially inactive (for example Stacey Konnert and Pynoos, 1992; McDonald, 1996; Perkinson and Rockermann, 1996). Most frequently these people were older, suffering from cognitive impairment or significant hearing loss, widows and care givers. Co-residents with hearing problems (e.g.

loud TV), paranoid beliefs or uninhibited behaviour could cause anger, resentment or fear and reduced desire for social contact.

The social marginalisation of those who are or become cognitively impaired or suffer with other mental health problems is particularly evident. The greater weight of evidence suggests that people with cognitive impairments or other types of mental health problems (and their carers) may find themselves isolated, and sometimes the focus of resentment and hostility (Streib and Metsch, 2002).

The very old were aware of their decreasing social networks which were largely due to bereavement and moving. They also found difficulties integrating with newcomers (Stacey Konnert and Pynoos, 1992). Regular bereavement could restrict residents' willingness to develop close friendships (Percival, 1996).

Newcomers, seasonal residents and the widowed presented challenges to integration (van den Hoonaard, 2002). There were strong divisions in the community which were invisible to the married, full-time, original residents. New residents were initially unaware of pre-existing conflict and societal divisions, and marketing which highlighted positive aspects whilst omitting possible social problems was blamed for new residents' unrealistically optimistic outlooks (Streib and Metsch, 2002).

Gender and social integration

As noted in the introduction, many age-segregated forms of housing have a much higher proportion of women than men. Although most of the participants in the studies were women, only a small number of studies reflected on any gendered differences in patterns of social integration and activities (see for example Netting, 1991; Perkinson and Rockermann, 1996; Siegenthaler and Vaughan, 1998).

One study from the USA considered marital status and friendship formation specifically among older women in a relatively new CCRC (Perkinson and Rockermann, 1996). The authors noted considerable variation among women in their strategies for developing friendships and their friendship styles. Most women seemed to adjust well and indeed thrive, although certain types of residents had difficulties, notably those who identified themselves as 'private persons', and faced a real dilemma preserving privacy in a communal setting. The authors noted various 'distancing mechanisms', such as development of cliques to exclude others, strategies of getting to know everybody superficially but no one well, and suggested that these mechanisms may be important for residents who are overwhelmed in their attempts to adjust to a more communal lifestyle. Marital status seemed to be a major criterion for friendship formation. Married couples mixed with other married couples, and single women with other single women. The social activities of husbands either constrained or enhanced the social activities of their wives. Women who had never been married appeared to be more socially integrated as friendship had a particular significance for them, and also were more likely to have a peer group of other single older women (see also Erickson *et al.*, 2000). Once widowed, women had to make the transition between groups as an unattached woman was perceived by married couples to be threatening. The change in social status of widows as a result of bereavement in CCRCs has been noted by other authors: widows had low status and became marginalised, friendships did not survive the death of a spouse and there was considerable rebuilding of social networks (van den Hoonaard, 1994; Hockey *et al.*, 2001), although widows had an 'easier time' than widowers as they knew how to look after themselves (van den Hoonaard, 1994).

Social connectedness with the world outside

A number of studies addressed how older people resident in congregate settings interacted with the world outside their boundaries (Stacey Konnert and Pynoos, 1992; Sherwood *et al.*, 1997; Okun, 1993; Erickson *et al.*, 2000; Buys, 2001; Streib and Metsch, 2002). Most (although not all: see for example Hong and Duff, 1997) concluded that activities that connected people to their local communities (for example going to church, voluntary work, accessing local services) were highly valued. There appeared to be little evidence to suggest that moving to a retirement community reduced opportunities for contact with people and activities outside, although studies showed inevitably that it was the younger and fitter residents who were more active outside their congregate setting (Sherwood *et al.*, 1997). Levels of outside activities declined as people became older and/or more infirm. The language used by residents to describe these activities clearly indicated that they saw their own living environments as being boundaried – distinct from, and separate to, the world outside.

Krout and Pogorzala (2002) report on 'intergeneration partnerships' between a comprehensive college and a retirement community, concluding that these partnerships increase the understanding of ageing and provide social, recreational and educational benefits for residents.

In the USA, poor rural states are often eager to assist the development of CCRCs as they draw in wealthy incomers, create work for local people and generally are seen to stimulate the local economy. However, there may be unforeseen consequences for host communities – there is a small but interesting literature that demonstrates how in recent years the residents of a number of larger CCRCs have flexed their political muscles. In California, three CCRCs have come together to form the first city in the

USA, Laguna Woods, that is almost exclusively populated by older people. The citizens have successfully fought the development of a new airport (Andrews, 1999; Andel and Liebig, 2002). There are other examples of communities defeating school funding measures and seeking to avoid certain local taxes. McHugh *et al.* (2002) provide a useful overview of various examples where communities of wealthy 'seniors' have begun to wield substantial political influence and power.

Use of care services and facilities

Care services

It is clear from the literature that a key 'pull' factor for residents of CCRCs is access to care services. Sherwood *et al.* (1997) found that CCRCs do meet residents' expectations in this respect, and provide direct and financial access to nursing home care even if residents' financial circumstances changed. We found very little literature that considered care services utilisation within CCRCs. Two relatively dated studies (Bishop, 1988; Cohen *et al.*, 1989) considered the use of nursing care in retirement communities, concluding that this varied according to the nature of the scheme, its intake and selection criteria and its accessibility to non-residents as well as access to home support services, entry costs and charges. Nursing home use in CCRCs differed from the wider population in terms of greater usage for short-term respite care: 'The integration of the nursing home with acute and in-home services may encourage more cost-effective patterns of use' (Cohen *et al.*, 1989, p. 80). More recently Sherwood *et al.* (1997) noted that CCRC residents used more days of institutional care (nursing home- or hospital-based) in the last year of life than a community sample. Newcomer *et al.* (1995) suggest that between 50 and 70 per cent of residents entering a CCRC can be expected

to use either assisted living or nursing units, or both, at some time in their tenure.

Sherwood *et al.* (1997) suggest that the pool-risk model, where CCRCs include almost all or a large percentage of costs of nursing home care in entrance and monthly fees, could be considered as a means of promoting cost-conscious interventions and reducing the likelihood of permanent institutionalisation. They also suggest that because CCRCs deliver a full health care package, they represent a form of managed long-term care within a system that actively embodies a concept of health promotion. CCRCs could be proactive in promoting health and reducing overall health costs to the CCRC and, in those CCRCs where residents are expected to make maximum use of all public forms of health insurance, reducing costs to the public purse.

Facilities

A limited amount of material examined the patterns of service use within CCRCs, usually in relation to demand and supply. For example, one study indicated that 'convenience' services such as banking and pharmacies are most frequently used. The study showed that community service use before moving to live in a CCRC predicted later use after moving (Krout *et al.*, 2000). Another study showed that so-called 'necessity' services such as transport and shopping were more likely targets for marketing than were non-essential recreational and cultural activities (Cangelosi and McAlhany, 1989). The survey of more than 2,000 CCRC residents by Sherwood *et al.* (1997) indicated that the majority of residents used library facilities and chapels, with fewer using crafts/activity rooms and only a minority using health clubs; the differences in levels of use of facilities between CCRCs were attributable to the health and functional status of the residents rather than the availability of facilities.

One study (Carmon, 1997) undertaken in a life care community in Israel focused on how residents used public spaces. The study showed that residents never or rarely used the communal and public spaces and gardens although these had been highly rated by professionals; however, the craft room that was rated poorly by professionals was used by almost 80 per cent of residents on a weekly basis. Residents attached more importance to the quality of their own living spaces.

The management of retirement communities is not widely discussed. One study provides insight into the skills that managers need in terms of working with residents and staff to maintain a positive community environment (Hurley and Brewer, 1991), suggesting that CCRCs blend health care and hospitality industries.

Assisted living facilities

As noted in Chapter 2, assisted living facilities are a relatively new and developing form of provision in the USA; consequently there are some definitional problems that are not unlike the definitional debates around extra care housing in the UK. We located five evaluations of assisted living, each considering different topics (Mitchell and Kemp, 2000; Crook and Vinton, 2001; Frank, 2001; Thompson *et al.*, 2001; Cummings, 2002) and a collection of essays reflecting on current provision and practice and possible future developments (Schwarz and Brent, 1999). The evidence base is therefore relatively limited.

Of particular interest is the study of two assisted living schemes (Frank, 2001), where the author examines to what extent assisted living facilities allow ageing in place. The author concludes that the ambiguity surrounding a universal definition of assisted living creates both flexibility and confusion for providers and consumers. Consequently most schemes offer

'prolonged residence', rather than 'ageing in place'. Residents are asked to move on if their care needs become too great, although the specific circumstances under which they would be asked to move were not clear to residents or to the organisations. This resulted in residents wondering how long they could stay, concealing their frailties or health problems, and created a sense of stress, anxiety and displacement that was compounded by an overemphasis on assistance with the tasks of daily living (such as cooking and shopping) that reduced residents' sense of self-worth and identify. Crook and Vinton (2001) concluded that the involvement of residents in decisions regarding moving on was more likely to occur in non-profit assisted living facilities. They surveyed a sample of one in five assisted living facilities in Florida, only achieving a 33 per cent response rate, with responses from 140 facilities. They concluded that highly formalised 'corporate' organisations tend not to include residents in decision making, whereas non-profit facilities, because they are governed by voluntary boards of directors whose members are more responsive to residents' norms, were more likely to involve residents in decisions regarding moving on.

Other studies were concerned with residents' quality of life in assisted living (Mitchell and Kemp, 2000) psychological well-being (Cummings, 2002) and visitation patterns (Thompson *et al.*, 2001). Mitchell and Kemp surveyed 55 assisted living facilities in California. Almost 90 per cent were for-profit, and almost half of these were corporately owned or managed. Services offered included medication management and assistance with activities of daily living (ADL) such as bathing, dressing, toileting, ambulation or wheelchair assistance. Of the 201 residents involved in the study, 74 per cent were female, 96 per cent were white, 69 per cent were widowed, and the average age was 81. Seventy per cent of residents received assistance with ADL. Quality of life and life satisfaction were related to the quality of the social

environment: facilities where staff were supportive of residents and residents were involved with each other were described as low conflict and predictive of higher levels of satisfaction and quality of life. The study by Cummings (2002) was more limited in scope; it too demonstrated the importance of social support for bolstering residents' well-being. When strong social support was present the effect of functional impairment and poor health on well-being was no longer significant. Thompson *et al.* (2001) investigated the value of visits to residents in assisted living. The average age of the sample was 83, 90 per cent were female and 87 per cent were widowed. Ninety per cent of residents said visits were very important as they gave a sense of connection and emotional support, and role continuation, although residents did not want their family members to feel obliged to visit them.

Overview and conclusions

In terms of CCRCs, this literature provides a relatively detailed account of the reasons why older people move to retirement communities, as well as insights into the social world of communities of older people. The populations of these CCRCs are predominantly white, well-educated, relatively affluent people, thus the literature tells us very little about the motivations and experiences of different ethnic groups in retirement communities, or people with different educational backgrounds. We also know surprisingly little about the cost-effectiveness of services or levels of service provision. As noted above the studies presented here provide a useful counterpoint to the UK evaluations reviewed in the next chapter.

4   What do we know? Evaluations of UK models of housing with care

Given the high expectations of housing with care, here we consider in some detail what is known about housing with care in the UK, drawing on the most recently reported empirical research. As noted in the previous chapter, housing with care is thought to serve a number of functions including the promotion of independence, the reduction in social isolation and the provision of an alternative to institutional models of care, allowing ageing in place.

Below we have used the evidence drawn from 11 recently published evaluations of housing with care to explore what we know about each of these themes. In addition, other key themes have emerged from this literature, notably cost-effectiveness and affordability, the role of informal carers within schemes and the impact of housing with care on the health status of residents. We begin by outlining the empirical evidence base.

The evidence base

There have been two large national surveys of very sheltered housing: *An Evaluation of Very Sheltered Housing* (Tinker, 1989); and *Living Independently: A Study of the Housing Needs of Elderly and Disabled People* (McCafferty, 1994). We were unable to

identify any more recent surveys of provision. Tinker *et al.* (1999) provide an overview of these two important studies in *Alternative Models of Care for Older People,* a research review presented to the Royal Commission on the Funding of Long Term Care. This review is key reading as it outlines the main evidence available at the time. Key points in relation to very sheltered housing suggested that:

- Although there were high levels of satisfaction with very sheltered housing among tenants, a minority would have preferred to remain in their own homes.

- The ability of schemes to provide an alternative to institutions was questionable as there was evidence of a lack of care services.

- Very sheltered housing was more expensive in terms of resource costs to the public purse than staying at home.

There were particular concerns that many older people had been directed towards very sheltered housing, rather than making a positive choice for this type of provision. In addition, haphazard allocation procedures resulted in a lack of clarity regarding the kinds of needs that very sheltered housing was addressing. Evidence suggested that there were more 'fit' than 'frail' residents, which begged the question of whether these residents needed the levels of care that were provided, and highlighted the lack of clarity around the purpose of very sheltered housing. Tinker *et al.* concluded that very sheltered housing was one of a range of options available to older people and 'not a panacea'.

We identified 11 empirical studies published since Tinker *et al.*'s key report that have further investigated housing with care

models in the UK. Overall these studies provide a more recent evidence base in regard to housing with care. They demonstrate a gradual change in ethos in these schemes which appear to be more directed towards promoting and maintaining independence, providing a better quality of life, and reducing social isolation as well as providing care. These studies also provide a better understanding of older people's experiences of living in housing with care, something that Tinker *et al*. noted was largely under-researched. Table 3 (at the end of the chapter) details these 11 studies. Different authors report different levels of detail about the schemes they were evaluating, thus comparable information for each study was not available. It must be noted that many of these studies were conducted or commissioned by the provider agencies to evaluate their own schemes.

The scale and focus of these studies vary considerably. There are two recent large-scale longitudinal studies, both of retirement communities (Bernard *et al*., 2004, and Croucher *et al*., 2003). The study by Bernard *et al*. is concerned with Berryhill Village, a retirement community with more than 150 tenants operated by The ExtraCare Charitable Trust, serving a predominantly working-class community in the West Midlands. A variety of methods were used to study the community over a two-year period, and there was a determined focus on resident participation. Croucher *et al*. investigated Hartrigg Oaks, a continuing care retirement community operated by the Joseph Rowntree Housing Trust, with more than 200 residents. Residents in Hartrigg Oaks are predominantly self-financing. They buy the lease on their bungalows, and care costs are covered by a Community Charge which works in a similar way to an insurance premium. Predominantly the residents of Hartrigg Oaks are relatively affluent, retired professionals. Again the study is characterised by considerable resident involvement through two resident surveys and extensive resident interviews and discussion groups.

Both these studies offer in-depth accounts of living in a large community of older people and address a range of themes.

The studies by Bartholomeou (1999) and Greenwood and Smith (1999) were undertaken in the same seven ExtraCare schemes operated by Hanover Housing, with care provision provided by local social services. Bartholomeou's study focuses on residents' experiences of living in ExtraCare. Seventy-three per cent of residents ($n = 185$) across the seven schemes participated in her study, and their residents were aged between 73 and 87. Greenwood and Smith address issues related to the development of partnership working between Hanover Housing and social services, using interviews with key stakeholders to explore the lessons learned during the development of the schemes. A more recent evaluation of a single Hanover scheme – Runnymede Court – is presented by Baker (2002). The Hanover schemes varied in size; however, all are on a much smaller scale than the retirement communities investigated by Bernard *et al.* and Croucher *et al.*

The studies by Brooks *et al.* (2003) and Phillips and Williams (2001) are more limited in scope. Brooks interviewed 59 residents across four very sheltered housing schemes operated by different organisations, and made a series of recommendations for good practice drawn from the experiences reported. Few details are provided regarding the services and facilities available in each scheme. The report directs the reader to the guidance produced by the Department of Health and the Office of the Deputy Prime Minister regarding particular aspects of practice. Similarly Phillips and Williams (2001) draw on interviews with 31 residents in four very sheltered housing schemes operated by Housing 21, and present data regarding length of tenure and reasons for moving to explore the extent to which very sheltered housing can offer a home for life.

Biggs *et al.* (2000) and Kingston *et al.* (2001) respectively report the qualitative and quantitative elements of a single study undertaken in a retirement community with 42 tenants. The qualitative element of the study involved iterative discussions with residents regarding their experiences of living in a retirement community. The quantitative element investigates the health implications of living in a retirement community, matching the health status of the community's residents with a sample of local people in the same locality.

The report by Fletcher *et al.* (1999) is quite distinctive as it addresses the strategic role of very sheltered housing. A variety of data sources were used to identify different models of very sheltered housing, and these are presented as illustrative case studies. A number of telephone interviews with key informants from national organisations, service providers and planners were undertaken. Primary research with small groups of residents in three very sheltered housing schemes is also reported.

Finally the work of Oldman (2000) provides a valuable commentary on the distinction between residential care and very sheltered housing, and reports on the evaluation of two very different housing with care schemes.

These studies have been undertaken in a range of settings from relatively small schemes described as 'very sheltered housing' (Phillips and Williams, 2001) through to large retirement villages with 100 residents or more and a variety of on-site services (Croucher *et al.*, 2003; Bernard *et al.*, 2004). Some studies were undertaken in one setting (for example Baker, 2002; Croucher *et al.*, 2003; Bernard *et al.*, 2004), while others considered a number of different schemes (Bartholomeou, 1999; Fletcher *et al.*, 1999; Oldman, 2000; Phillips and Williams, 2001; Brooks *et al.*, 2003). Each study has a different focus, has adopted different methodologies, and presents different types of data and different levels of detail about the schemes under investigation.

At the end of this chapter we present a detailed matrix outlining the studies, their focus, settings and methods (Table 3).

Needless to say, residents' profiles across settings in terms of age, social class, health status and financial status were not the same. Different schemes had different eligibility criteria – for example, entry criteria for one of the schemes considered by Phillips and Williams were the same criteria used by local social services for assessing needs for residential care; other schemes required applicants to be in receipt of home care services or Attendance Allowance prior to entry; others were attempting to maintain a balance of fit and frail people. Thus it is not surprising that residents' profiles vary. The average ages of residents varied (note, however, that in some settings there was a wide age range, thus averages can be misleading), although most usually the residents in schemes were in their late seventies to early eighties, and were predominantly women.

We have also drawn on an additional brief report (Vallely, 2002) of the findings of two unpublished evaluations undertaken for Anchor Trust.

Collectively these studies present a heterogeneous body of work. They can be seen as pieces of a mosaic of evidence which when placed together show various emerging themes. The rather patchy nature of the evidence informs the debate around housing with care rather than providing answers to some of the key questions; indeed some of the research raises more questions than it answers. We have structured the review around the following themes:

- promoting independence

- health, well-being and quality of life

- social integration

- home for life

- alternative to residential care

- cost-effectiveness

- affordability.

Promoting independence?

One of the advantages of housing with care as opposed to residential care is considered to be its potential to allow tenants, owners or leaseholders greater independence and autonomy. There is a considerable body of evidence from across these studies, based on interviews, surveys and discussions with residents across a variety of settings, to indicate that one of the main advantages and most valued aspects of housing with care is independence. It is the *combination* of independence and security that older people seem to particularly value.

Physical environment

Independence was mainly promoted by having self-contained accommodation, 'your own front door'. This enabled privacy as well as autonomy in terms of activities, possessions and company, and changed the dynamic of the residents' relationships with care staff, creating the sense of being 'at home' rather than 'in a home'. Importantly family relationships could continue as usual, and family members could still offer support and assistance.

Frequently the reason for moving was related to increasing mobility problems which had been exacerbated by the circumstances of people's previous accommodation. Living in more accessible, warm, comfortable purpose-designed

environments also promoted and maintained independence. People were able to do more for themselves (for example, take a shower unassisted), and in some cases return to activities that they had previously given up because of the difficulties presented in their former accommodation.

Philosophy of care

The philosophy of care in some schemes had also helped some residents to regain or maintain some skills and this had increased their sense of confidence. Fletcher *et al.* report residents' preferences for services that focused on what they could do rather than what they could not do. Vallely (2002) also reports how working to rebuild confidence can help people regain skills. These findings need to be interpreted with some caution, however, as a number of studies also report that residents' expectations of care services were not always met (see below).

Security

Combined with independence, the security derived from knowing help and care were at hand was also a highly valued aspect of the different schemes. Across the studies 24-hour cover by on-site staff was consistently reported to be greatly valued even by those who were relatively well and not receiving regular assistance from care staff. Knowing staff were there to help in emergencies or provide more regular care also reduced people's feelings and/or fears of being dependent on family members. Similarly responsiveness of care staff was important in providing a sense of security as people needed to feel confident that someone would come if they did call for assistance. In some settings this could be problematic, particularly for those who needed assistance going to the toilet (see Brooks *et al.*, 2003).

Security was also related to feeling safe from crime and intruders as well as knowing that someone was at hand if people fell or were unwell. An accessible environment also made people feel less fearful of falling or injuring themselves and this in turn added to their sense of security.

Choice and control

Independence and autonomy are not just about things related to the individual but also reflect the organisation of different settings and whether residents feel they have a voice in the running of the scheme and choices around what they do on a daily basis, for example whether or not to take part in outings or social activities or the timing of carer visits and so forth.

Some studies asked residents why they had chosen to move to a particular scheme. Clearly some decisions had been influenced by relatives and care professionals, and residents had not really understood what the scheme offered before they moved in. Nevertheless people's circumstances prior to moving had often been untenable mainly due to inappropriate accommodation, increasing health and mobility problems, bereavement and/or changes in care arrangements and, in some instances, victimisation. Staying put had not been an option for many (see for example Vallely, 2002). Others had been determined to move while they were still able to make a decision. Of particular interest here are the findings from the study of Hartrigg Oaks (Croucher *et al.*, 2003) where residents consistently reported their determination not to be a 'burden' on their families as they got older as a factor influencing their decision to move. For some residents, choosing to move to a setting purpose-designed for older people, where any current and future care needs would be met, was a statement of their independence, and a means of ensuring independence in the future.

Evidence from the recent evaluations considered here demonstrates a variety of ways in which residents were involved or consulted about what was happening in their schemes.[1] In the study by Brooks (involving seven different settings), residents' meetings often focused on planning social activities, with less consultation or discussion with residents about care services, leading Brooks to recommend that regular tenants' forums should review care services. This study also found some evidence of residents' reluctance to complain for fear of the repercussions from staff. Other studies, while not addressing resident participation in any depth, also support the notion that the bigger issues (for example, whether a scheme should be remodelled or extended) are not frequently open to wider discussion with residents, and the imposition of management decisions could cause dissatisfaction and sometimes resentment among residents. Hartrigg Oaks, the continuing care retirement community investigated by Croucher *et al.* (2003), had a number of residents' committees and other consultative mechanisms; however, residents themselves had mixed feelings about participation. Some were eager to be involved, and glad to utilise their management and organisation skills. Others, however, felt that active participation could be very onerous, particularly for the very old and frailer members of the community.

Across the studies a consistent view from residents was the importance of not being forced to take part in social activities, of being able to choose when to participate in activities and social events and when to withdraw. Choices in other aspects of daily life were also welcomed. The provision of meals is seen as an important feature of housing with care, although this is not without its critics. Some commentators feel the provision of meals moves a scheme more towards being an institution and stops people from preparing their own food, thus constraining their independence. Others, however, note the importance of good

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nutrition and a regular hot meal, particularly for people who are not able to cook. A communal meal also provides opportunities for people to come together. There were a variety of arrangements regarding the provision of meals across the studies, from the delivery of meals from outside for those who needed them to restaurant and dining-room facilities. Sometimes meals were included in the service charge, thus residents had no choice about paying for meals whether they wanted them or not. This appeared to cause some resentment. Similarly choice over menu and the type of food on offer was not always available. Quality of the food was also important. In some schemes residents could choose between cooking for themselves or taking meals in the dining room, and some preferred to do this, not only because it was easier than cooking, but also because it was more sociable than eating alone.

There seemed little indication from any of the studies that people exercised choices regarding their care, for example whether their care came from a particular carer or care agency, or was delivered in a particular way at particular times. This is not to say people did not speak highly of the care they received, and in most studies care services were praised.

Health, well-being and quality of life

In the context of housing with care, it might be expected that a purpose-built or adapted environment, along with increased opportunities for social interaction with a peer group as well as the care and support on offer, will generate a greater sense of well-being and improved health status or maintenance of health status. Demand for health services may even be reduced. Only two studies (Kingston *et al.*, 2001; Bernard *et al.*, 2004) attempted to measure the health status of residents, and they both adopted self-reported health status measures.

In terms of assessing well-being and quality of life, it is noticeable that few studies have adopted any 'measure' of quality of life, although authors draw on residents' expressions of satisfaction and contentment to infer that housing with care offers a good quality of life, or better quality of life than other settings (Oldman, 2000; Baker, 2002).

Impact of housing with care on health status of residents

It is important not to underestimate the difficulties of trying to measure the impact of housing with care schemes on health status. Even in the settings studied in these 11 evaluations a wide range of entry criteria were being used. For example, those moving to the very sheltered housing evaluated by Phillips and Williams were already in receipt of care services prior to moving. In complete contrast the majority of the residents of Hartrigg Oaks had to pass a medical before they could move to the scheme (Croucher *et al.*, 2003). Different schemes are therefore accommodating people in different states of health at the point of entry, and also drawing their residents from different populations, as noted by Bernard *et al.* (2004) in their study of a retirement village in the West Midlands where life expectancy generally is well below the national average. Thus health status is likely to be related to factors beyond the housing with care setting. Moreover, when considering the reasons why people move to housing with care, often underlying health problems are one of the main driving factors. Comparisons with community samples, although helpful, are perhaps limited in what they can tell us about the potential health benefits of housing with care.

The focus of the study of a large retirement village in the West Midlands (Bernard *et al.*, 2004) was on how living in a purpose-built retirement community affected the health, identity and well-

being of the residents. Many of the village residents had moved to the village primarily because of health problems or physical impairments. Three out of four residents suffered from a limiting long-standing illness (LLI) and this was higher than rates of LLI reported in community samples in other studies. Scores on scales designed to assess physical and mental health showed that residents had somewhat lower mental health functioning than their community counterparts, but the same or better physical health status. Levels of functioning were maintained over the three years of the study.

A study of a smaller retirement community reported in two papers (Biggs *et al.*, 2000; Kingston *et al.*, 2001) found that although many people had moved to the community due to poor health, they rated their own health as significantly better than a community sample of people drawn from the locality, where many of the retirement community's residents formerly lived. Over time there were few changes in the self-reported health status of the retirement community residents (measured on a number of scales); however, the self-reported health status of the community sample declined. The retirement village residents had fewer contacts with health visitors and social workers than the community sample although this was expected to a certain extent, as substitutes for these types of services were provided by retirement village staff. Kingston *et al.* conclude that security (reported to be at the heart of people's decision to move to the community), high levels of peer support and a general sense of optimism in the community, as well as the knowledge that care and support needs would be met by scheme staff rather than by relatives, all contributed to the maintenance of the residents' physical and mental well-being. Residents appeared to have developed a shared culture and identity that emphasised the positive effects on health of living in the village – some attributing almost 'miraculous' health-restoring properties to the community

– and a collective narrative that was notable for the absence of 'illness talk'.

In Greenwood and Smith's (1999) study, care staff and estate managers interviewed were convinced of a positive impact on the health and well-being of residents consequent to their moving to the study schemes. This positive impact was attributed to being in a safer, warmer, more accessible environment in comparison to where people had lived before, a reduction in social isolation due to increased social contact and companionship, and often the recognition by staff of previously unrecognised health and care needs. Baker (2002) also noted the increase in care provision to residents following their entry to the scheme he studied. Again this was attributed to better assessment and monitoring of the health and care needs of residents rather than a deterioration in health or increase in dependency levels.

Authors also stress the importance of the built environment in promoting health both by being accessible and risk free. A note of caution can be drawn from the study of Berryhill, a large retirement village, regarding the size and layout of the building and its impact on those with mental health problems. Professional staff noted that any tendency to be disorientated or confused was exacerbated by the environment – particularly by features such as long corridors and the layout of the building. Furthermore, for people with anxiety or depression, the size of the building, the number of residents and 'cliques' of residents could also be problematic, and compound their anxiety or depression.

Impact of housing with care on the use of health services

There is some evidence from two studies, Kingston *et al.* (2001) and Croucher *et al.* (2003), that indicates that housing and care schemes might reduce demands made on the health services.

In both cases, staff and services in the scheme were providing substitutes for NHS care, thus demands were being redirected rather than reduced. Kingston *et al.* showed fewer contacts with community health workers and social workers among the residents of the retirement community studied; however, staff based in the retirement community were in effect delivering these services. Hartrigg Oaks was able to offer respite and convalescent care to residents in the on-site care home. These residents then returned to their bungalows. Care costs were covered as part of the Community Charge paid by residents. Figures show that over a period of three years, the care home provided on average 700 bed nights per year to an average of 30 bungalow residents (approximately 15 per cent of the total number of bungalow residents), allowing early discharge from hospital directly to the care home, or preventing hospital admission.

Baker (2002) interviewed local general practitioners who reported that the presence of care staff on site was one of a number of factors which would influence their decision to admit residents to hospital; however, higher levels of care would be required if this were to be a major deciding factor. The area manager for the scheme felt that some respite admissions could have been cared for on site had additional care staff been available.

Greenwood and Smith (1999), in their discussion with care staff, social services staff and estate managers, noted that problems with early hospital discharge were not unusual, and required further development of joint protocols. In this case, health care staff had over-optimistic expectations of the levels of care on offer in the schemes.

Quality of life and well-being

Recent work for the ESRC's programme 'Growing Older in the 21st Century' has explored the concept of quality of life in later

life (see for example Bowling *et al.*, 2003). It is essential to see quality of life as being related to more than just health and functional status. There is considerable interplay between people's own characteristics and circumstances and their surrounding social structures. Social relationships and roles, activities, health, home and neighbourhood, psychological well-being, financial circumstances and social and political issues all frame quality of life for older people. None of the studies considered here have attempted a complex analysis of the quality of life for people living in housing and care schemes. Some authors do, however, conclude that the scheme being evaluated does confer a better quality of life, basing this judgement on how residents expressed satisfaction with the scheme, or whether residents felt their lives had improved since moving to the scheme, or what they liked best (Fletcher *et al.*, 1999; Oldman, 2000; Phillips and Williams, 2001; Baker, 2002). Currently the evidence base lacks a robust assessment of quality of life for those living in housing and care schemes.

Despite the absence of quality of life measures, the evidence consistently reports positive accounts from residents of their experiences of living in housing with care settings. For many the move had been a positive choice and compared well with the other alternatives that had been available to them – continued residence in the community, reliance on family support, nursing or residential homes.

Authors tend to link satisfaction with the features of housing with care that older people say they value: independence, security and reduction in social isolation. Consistently high levels of satisfaction were reported by Croucher *et al.* (2003) among the residents of Hartrigg Oaks. However, the most satisfied residents were the fitter, more able people who were more socially active and involved in activities within and outside the community. Levels of satisfaction decreased among those who were older and less

mobile and who reported fewer social activities. In Oldman's study, satisfaction was determined by the residents' prior circumstances. Residents were more satisfied if they had moved positively and were in control, or the move was considered to be inevitable but they were getting on well. People who had been opposed to the move were not well adjusted (Oldman, 2000).

Oldman (2000) concludes that supported housing models confer enhanced quality of life and can make a contribution to preventative community care. The perception of the majority of residents interviewed in her study was that their lives had greatly improved. They felt they could do more and had a new lease of life, and enjoyed being part of a community. Similarly Fletcher *et al.* (1999) conclude that residents of housing with care enjoy a better quality of life than they would in residential care.

Social integration

Social opportunities were often cited as one of the reasons for moving into a scheme, although independence and security were generally stronger motivations. Residents clearly enjoyed having the companionship of others (see Oldman, 2000; Croucher *et al.*, 2003, Bernard *et al.*, 2004), although importantly having 'your own front door' allowed privacy and the choice of whom you entertained in your own private space. Across the studies examples of good neighbourliness and general support from other residents were evident. Biggs *et al.* (2000) reflect on the development of a shared cultural narrative in a small retirement community, where residents shared a feeling of being pioneers in a new development, and perceived the scheme to promote health and well-being and prevent loneliness and social isolation.

Communal living

Some residents had found it hard to adjust to communal living, particularly in larger schemes (see for example Croucher *et al.*, 2003; Bernard *et al.*, 2004). Gossip and rumour, although part of the life of any community, could be stressful, and individuals strived to protect their personal privacy. Many studies reported that cliques of residents had developed, and this could generate tensions and sometimes open hostility between different groups (see for example Greenwood and Smith, 1999; Brooks *et al.*, 2003).

Social activities

Across the studies residents noted that life could still be lonely (see Biggs *et al.*, 2000; Baker, 2002; Croucher *et al.*, 2003). Authors also note that those who are most marginalised and socially isolated in schemes are often people with sensory, physical and cognitive impairments. It is difficult to know whether these people are any more or any less isolated than they would be elsewhere. The evidence from various settings consistently reports groups of people who are not able to 'join in' with social activities because of their impairments. Many schemes were eager to promote resident-led social activities and staff were reluctant to organise social events for fear of making schemes seem institutional. Many residents were glad not to be 'corralled' into organised entertainment. There is, however, a tension between reflecting the interests and capabilities of the more active and able-bodied in resident-led activities and ensuring that the frailer and disabled residents are not excluded. Evidence indicates that older and infirm residents would welcome more organised activities (Bartholomeou, 1999; Greenwood and Smith, 1999; Croucher *et al.*, 2003; Bernard *et al.*, 2004). Generational differences were

also highlighted by Bernard *et al.* at Berryhill, where there could be a 40-year difference in ages between the youngest and oldest residents. Activities that appealed to the very old did not appeal to the younger residents and vice versa.

Attitudes towards ageing and disability

The studies by Bernard *et al.* (2004) and Croucher *et al.* (2003) both reflect on the experience of living in communities of older people. In both these retirement villages there could be a considerable age gap of up to 40 years between the youngest and oldest residents. Residents appeared to have mixed feelings about living in age-segregated settings. Some did miss the presence of younger people and children; however, others did not, and felt more secure than they would have felt in the wider community. Croucher *et al.* found that although initially some residents had been disturbed by living in a community where they encountered people with severe disabilities so regularly, over time attitudes towards disability in Hartrigg Oaks had become more positive. Residents also reported that initially they felt overwhelmed by the needs of their more elderly and frail neighbours. Over time people tended to create their own boundaries for their 'good neighbourly' activities, usually focusing on people who lived in their section of the estate. Both Bernard *et al.* (2004) and Croucher *et al.* (2003) reflected on the impact of death and bereavement on the residents of these communities. As might be expected in communities of older people, death was a regular occurrence and the loss of residents was keenly felt. Over time this might become a more negative aspect of communal living.

Schemes that have a mixture of fit and frail residents are thought to provide an environment where the less able are helped

by those who are fitter, and where what Baker (2002, p. 26) describes as 'an optimal psychological group equilibrium' can be achieved. Various studies, however, report tensions between 'fit' and 'frail' residents. What emerges across the different studies (see also Chapter 3) is a sense in some schemes of extreme prejudice, hostility and discrimination towards those who are disabled (see particularly Greenwood and Smith, 1999), and in others disquiet on the part of some more able residents who reflected that schemes were becoming 'like nursing homes', or that other residents were 'too far gone'. This appeared particularly to be the case when sheltered housing schemes were remodelled to become very sheltered housing and new residents were often likely to be very frail. As Oldman (2000) noted, there can sometimes be a contradiction between what people want for themselves and what they think should happen to other residents who are becoming increasingly frail or cognitively impaired.

Integrating with the wider community

Some housing with care schemes have facilities for use by outsiders, with the intention of integrating the schemes and the residents into the 'wider community'. Fletcher *et al.* (1999) provide case study examples where 'progressive privacy' is designed into schemes and some facilities can be accessed only by residents. However, across the studies there were mixed views from residents as to the desirability of allowing access to outsiders. Some residents liked having links with the community, while others preferred schemes to be closed to outsiders usually on the grounds of security, but sometimes because the presence of a day centre or other such facility promoted a more institutional feel.

Home for life?

One of the proposed advantages of housing with care is that the schemes can offer a 'home for life'. While many housing with care schemes may aspire to offer a home for life, current evidence suggests that this may be problematic (see for example Greenwood and Smith, 1999; Oldman, 2000; Phillips and Williams, 2001; Baker, 2002; Brooks *et al.*, 2003; Croucher *et al.*, 2003; Bernard *et al.*, 2004). We did not locate any studies that identified or evaluated housing and care schemes in the UK where residents could age in place *under any circumstances*. This is not to say that such schemes do not exist; however, if they do, they remain unreported in the current literature.

The term 'home for life' seems quite straightforward; however, on reading these studies it becomes clear that the idea of a 'home for life' is muddled and poorly defined, although its appeal is obvious. It suggests that rather than people being moved from care setting to care setting as their health and care needs increase, care services are increased *in situ* according to individual needs. This appears to offer older people the reassurance that the upheaval and distress of further moves, or moves to institutional settings, will be avoided. For providers there is an underlying assumption that institutional models of care, which may be more costly, can be replaced. Evidence from these studies, however, suggests that generally housing with care does not easily accommodate people with more severe dementia-type illnesses or with high levels of dependency, although the ability of housing with care to cope with different needs varies from scheme to scheme. Factors that promote moving include: challenging behaviours associated with dementia and the associated levels of disruption or risk caused to other residents; difficulties in providing the necessary flexibility of care within particular schemes; the dependency mix of the residents and the numbers

of people with high-level needs that can be cared for at any one time; the availability of placements in other facilities; and the willingness of funders to pay for increasing levels of care for individuals. It may also be related to the choices and preferences of residents and their relatives. In many cases people leave for a complex combination of reasons.

The evidence base also raises questions about the desirability of having explicit 'exit' criteria regarding circumstances under which residents would be asked to leave. In principle this would seem a more open approach but in practice it seems that this is likely to be difficult to achieve, as there is an apparent ad hoc approach to decisions regarding whether move-on placements in a different care setting are sought. Oldman (2000), in discussions with various housing providers, highlighted the absence of explicit policies on home for life, and the lack of clarity regarding who was the key decision maker when people could no longer stay – landlord, GP or other health professional, older person or family member.

Dementia-type illnesses were frequently highlighted across the studies as a cause for seeking alternative care settings, and there is much debate regarding the capacity of housing with care to meet the needs of people with dementia and how their needs can be balanced against those of other residents. As Greenwood and Smith (1999) note, the prevalence of dementia is high among very old people and it is not easily detectable in the early stages, thus many people in housing with care will either develop dementia or already have mild dementia at the point of entry. While the evidence seems to suggest that housing with care can accommodate people with relatively mild to moderate cognitive impairment, there is no evidence from these studies to indicate that the schemes evaluated could successfully accommodate people with dementia over the full course of their illness. There

are housing with care schemes that are specifically designed for people with dementia; however, we found no *evaluations* of such schemes in the public domain.[2] Greater clarity is required regarding the capacity of housing with care to accommodate people with cognitive impairment, particularly severe impairment. There are issues here regarding the skills and training of staff, the communal dimension to housing with care and the well-being of all residents, the design of buildings and spaces, as well as the appropriate use of technologies (for example, security systems to prevent exit or access, surveillance measures and so forth).

Only one of the schemes that has been evaluated, Hartrigg Oaks, the continuing care retirement community investigated by Croucher *et al.* (2003), had an on-site registered care home. Residents of the bungalows can have up to 21 hours of care per week in their bungalows; beyond this a permanent move to the care home is considered. Thus although people did not stay in their own bungalows, they remained on site, with access to the site facilities and in touch with the wider Hartrigg Oaks community. As noted above, bungalow residents could also have temporary periods of care in the care home, for example convalescence following an operation, and then return to their bungalows. At the time of the study, these arrangements appeared to be working well for the most part, and on the basis of the evidence considered here, this model appears to come closest to offering a 'home for life'; however, it was not possible at the time of the study to care for people with dementia-type illnesses who were exhibiting challenging or very difficult behaviour in the care home. The Joseph Rowntree Housing Trust sought specialist dementia placements outside of the scheme.[3]

Phillips and Williams (2001) examined the reasons why tenancies were ended over an 18-month period in four very sheltered housing schemes that aimed to offer a 'home for life'.

Twenty-six tenancies were terminated. Sixty-six per cent of tenancies ended with the death of the tenant, 11 per cent ended because the tenant moved to residential care, 16 per cent ended because the tenant moved to nursing care, and 7 per cent were admitted to specialist elderly mentally infirm (EMI) provision. The average care package at the end of a tenancy was 10.7 hours per week, but for those going on to other forms of care it was higher, 11.8 hours per week for those going to residential care and 13.8 hours per week for those going to nursing care. Note that the average age of entry to the four schemes in the study was 80.1 years, and the average age at the end of tenancy was 82. In fairness, this is a small data set, but can a scheme be said to be offering a 'home for life' if one in three tenancies that end are due to people moving into more intensive care settings? The authors of the report clearly think it does, stating 'it is fair to conclude that Housing 21 Very Sheltered Housing is offering a home for life for most tenants' (Phillips and Williams, 2001, p. 47). The data also suggest that the hours of care people were receiving were not that substantial prior to departure, although the presentation of average figures may mask considerable variation. Note that Hartrigg Oaks residents can receive up to 21 hours of care in their bungalows before a move to the care home is considered.

At Runnymede Court, the scheme evaluated by Baker (2002), a small number of residents were being supported to a nursing home level of dependency. Staff felt this was possible but only for one or two individuals at a time, as care staff would be overstretched and other residents would suffer. There had been discussion about whether to set clear criteria to govern when residents are to leave (notably when they have clear nursing needs, or when medication needs to be administered, a task that carers were not qualified to carry out). Hanover Housing, managing the scheme, was reluctant to do this, preferring to

stress that the scheme aspires to offer a home for life, but this cannot be guaranteed as local social services may not be able to support a person with high care needs indefinitely.

Brooks *et al.* (2003) noted uneven quality of care between different care teams across a number of schemes, particularly in schemes where care services were not provided in-house. Flexibility was not always easy to achieve and this created the impression among residents that services were unreliable. In one scheme the care team had refused to undertake certain tasks and pushed for tenants whose needs were increasing to be moved on, resulting in one-third of the residents moving on in the year previous to the study; this was attributed to the care team's inflexibility.

Greenwood and Smith (1999) report that 22 tenants who previously lived in ExtraCare schemes had moved on: 15 had moved into nursing homes, and seven into residential care. It is difficult to identify the baseline number of residents (although the study was concerned with seven schemes with more than 200 units of accommodation) and the time frame in which these moves occurred. Nevertheless these data suggest that the capacity of the schemes to offer a home for life to everyone was limited.

Four studies reported residents' attitudes towards ageing in place or whether they believed they had a 'home for life'. Bartholomeou (1999) reported that 86 per cent of the residents felt confident that care provision would meet their needs in future. Bernard *et al.* (2004) note that one in five residents of Berryhill Retirement Village were worried about what would happen if their physical and mental health deteriorated to a point where they could no longer stay. At Hartrigg Oaks, evaluated by Croucher *et al.* (2003), residents were reassured by the knowledge that a registered care home was on the site, should they (or their partner) need those levels of care. This arrangement was particularly valued by couples, as one partner could continue living in their

bungalow but be close to their partner in the care home. Most people did feel confident that their future care needs would be met, although there were concerns about the availability of places in the care home. There were mixed views among residents regarding the appropriateness of moving people with dementia off the site. Some thought it was entirely right to seek specialist care, and others felt that dementia care provision should be part of the care package on offer. Finally Oldman (2000) found that residents and their relatives were largely unclear as to the position on 'moving on'.

One of the advantages to older people of housing with care compared to residential care is the security offered by assured tenancies. No studies comment on how the process of relocating tenants to more appropriate forms of care was conducted. Only Oldman (2000) mentions the potential for landlords to evict tenants (assured tenancies require landlords to make alternative living arrangements), commenting that in practice recourse to the law appears to be very rare.

Alternative to residential care?

Another key aim of housing with care is to provide an alternative to residential care, and some schemes do seem to provide equivalent levels of care. However, on the basis of the data presented above, where evidence indicates residents moved on to both residential care and nursing home care, it is clear that housing with care may be an alternative to, but not a replacement for, residential care settings.

Care provision

Various studies (notably Bartholomeou, 1999; Baker, 2002; Vallely, 2002; Croucher *et al.*, 2003; Bernard *et al.*, 2004) present care

services data indicating how much care was delivered over a given period. There is a general focus here on process (i.e. numbers of hours and numbers of residents receiving care) rather than reporting outcomes or quality assessment. There are anecdotal reports from staff of apparent improvements in residents once they move in, and the regaining of skills and confidence.

Many authors note the importance of making clear what exactly is on offer in each scheme before people move, as often people's expectations of care were not fully met. Independence was cited so regularly as a benefit by residents that it is interesting to note in some studies that a number of residents clearly expected more care than was on offer in particular schemes (Baker, 2002; Brooks *et al.*, 2003; Croucher *et al.*, 2003), or were not clear what amount of care was in their care plan and whether they were receiving it (Bartholomeou, 1999; Brooks *et al.*, 2003). A number of authors note the requirement for accurate, promotional literature that does not generate unreasonable expectations, and the importance of highlighting independence as being at the heart of the care philosophy both to residents and those nominating tenants (see Greenwood and Smith, 1999; Baker, 2002; Vallely, 2002).

At Berryhill, the retirement village studied by Bernard and colleagues (2004), there were four levels of support provided to residents. The first two levels were relatively low, and the third and fourth levels were the equivalent of residential care but stopped short of nursing care. Twenty-eight per cent of residents were receiving support services from the organisation; this rose to 31 per cent over the course of the three-year study period. The highest proportion was receiving Level 2 care (two or three calls per day).

At Hartrigg Oaks, the contract with residents allows up to 21 hours of care per week to be delivered to their homes. Beyond this, care is provided in the on-site care home. Over the period of

the evaluation, approximately 30 per cent of residents were receiving home care (assistance with housework, washing etc.), about 7 per cent were receiving personal care, and about 10 per cent were receiving regular daily 'pop-in' visits. Data indicate that most residents receiving care were receiving in total three hours of care per week or less. Over time at Hartrigg Oaks, the number of permanent admissions to the care home from the bungalows gradually increased, from one in 1999 to ten in 2002. The care home could also be used for short admissions. On average there were 30 short admissions to the care home in a year, and these 'short' admissions lasted on average between 25 and 37 days. It is important to note that residents at Hartrigg Oaks are required to pass a medical before they move to the scheme.

The scheme evaluated by Baker (2002) was intended to accommodate both fit and frail residents. Allocation of tenancies worked on the thirds principle – one-third of the residents should be high dependency, one-third middle dependency and one-third low dependency. On average, those residents who were receiving care (approximately 50 per cent of residents) received 12 hours of care per week; however, this masked considerable variation between individuals, from a minimum of three hours to 44 hours. Residents were in general receiving more care hours than they did prior to moving to the scheme. This was thought to be due to two main factors: unmet needs being identified when residents moved in; and people moving in at a point of crisis where they needed more care. The increasing dependency of residents had made it difficult to maintain the intended balance between fit and frail. At the time of the report, few residents were in the middle-dependency bracket, although there remained a mix of higher and lower. As noted above, it was clear that residents could not be supported come what may.

Vallely (2002) presents care data for 15 residents in a housing and care scheme, showing the number of hours of care received

in previous settings, and the care received six months after the move to the housing with care scheme. It is not clear whether these are all the residents from one scheme or just a sample, so caveats need to be placed around these data. The data demonstrate an overall reduction of 44 hours per week in the total number of hours of care delivered to residents following their move to the housing with care scheme, an average reduction of 3.16 hours per resident. Averages mask significant variations. Note also that the residents whose care hours were most reduced moved from very poor accommodation where previous care needs were related very much to the disabling effects of the person's home rather than to their actual level of impairment. Vallely advises caution regarding the interpretation of these data, noting that more detailed study is required that would take account of health, dependency, quality of life and average support needs before assumptions can be made about the role housing and care played in reducing care needs.

In Bartholomeou's (1999) study, over 95 per cent of the sample of residents received regular care from a care worker. This included assistance with laundry (47 per cent), housework (34 per cent) and shopping (27 per cent), as well as assistance with personal care such as getting up (17 per cent), getting into bed (15 per cent) and bathing (42 per cent). On average each care plan consisted of 9.5 hours per week.

Generalisations across the studies regarding levels of care are difficult to make as the resident profiles (related to admission/allocation criteria) are so different. The studies tend to demonstrate increasing care needs over time, as might be expected. From the Hartrigg Oaks data we can see that the 'short' admissions to the care home lasted between 25 and 37 days. From a baseline population of approximately 250 residents, 30 residents required this type of admission. These and other data seem to suggest that if care services are going to be flexible it is

not simply a question of a few extra hours here and there. There will be periods when the increased care needs of a few individuals may require significant increases in carer input over relatively prolonged periods of time. Baker's (2002) study suggests that carers could only cope with one or two residents with high-level needs, otherwise other residents would suffer.

There were very few complaints about care staff in any of the studies. Where residents' satisfaction with the quality of the care was reported, there were usually very favourable reports of the staff (see Bartholomeou, 1999; Croucher *et al.*, 2003). A consistent concern of residents was the availability of the care staff. Brooks *et al.* (2003) noted that in the schemes where residents did have difficulties, these often related to different practices by care teams from different providers. In this study, there were no complaints about care staff in the 'integrated schemes', where one agency provides both housing and care services.

Both Greenwood and Smith (1999) and Bernard *et al.* (2004) identified residents who were not eligible for day care services because they lived in a housing and care setting where theoretically their social care needs were met, but who were not taking part in on-site social activities either because they were not appropriate for their needs or because of hostility from other residents.

Informal care

It is also notable how often it was reported that family members continued to give considerable care and support to their older relatives (Oldman, 2000; Phillips and Williams, 2001; Bernard *et al.*, 2004). This is seen by residents and their relatives to be an important aspect of housing with care as opposed to more institutionalised settings, as it allows the continuation of family

relationships and bonds, but also allows residents and relatives the opportunity to share the responsibility of caring with others (see Oldman, 2000).

The two studies of retirement communities (Croucher *et al.*, 2003; Bernard *et al.*, 2004) attempted to quantify the amount of informal support received by the residents. At Berryhill (Bernard *et al.*, 2004) more than 70 per cent of residents reported their families to be the most important source of help. At Hartrigg Oaks (Croucher *et al.*, 2003) 12 per cent of the residents said they received care from children or other relatives, 23 per cent reported they received care and support from their partner, and 11 per cent reported support (usually with simple tasks such as shopping) from neighbours. These differences in reported levels of informal support might be related to the very different populations of these two schemes. Berryhill residents were predominantly local and working class, and it seems more likely that family were close by. The residents of Hartrigg Oaks were predominantly retired professionals who had moved from a range of locations and were less likely to have family nearby. It may also be related to different levels of need in the two populations. These data suggest that in some circumstances families are providing significant assistance, but where people do not have families they will be more dependent on staff within the schemes. A further issue is that of informal carers within schemes. We know very little from the current evidence base regarding how well housing with care supports people who are looking after a sick or disabled partner.

Cost-effectiveness

As yet the evidence does not demonstrate that housing with care offers a cost-effective alternative to residential care, or to care in the home. The complexities of costing services must be

noted, alongside local variation in costs and charges, as well as the personal financial resources available to individuals.

Perhaps the best discussion of the financing and estimation of the costs of housing with care is provided by Oldman (2000). She provides a useful critique of the different cost models, highlighting the lack of transparency in some models, and the difficulties in making generalisations when costs and services can vary from area to area. Moreover, one of the shortcomings of some costing models has been to calculate cost transfers rather than economic costs. For example, Housing Benefit may be paying the bricks-and-mortar element of very sheltered housing, and social services paying for the care element, whereas in residential care social services will be paying the total costs of the placement. As noted by Oldman, the appeal to ease the pressure on hard-pressed social services budgets by transferring costs to other agencies is obvious. However, transferring costs to other budgets does not equate to cost savings overall.

Oldman's preferred cost model is that adopted by the Royal Commission on the Funding of Long Term Care (see Tinker *et al.*, 1999), as the assumptions made are explicit. Tinker *et al.*'s model uses six vignettes (or description of individuals in particular circumstances). For each vignette an appropriate package of care in different care settings was estimated and its associated resources were costed. These costs were then apportioned to different public bodies or to the individual, using alternative assumptions about how much individuals would contribute. Informal care was not costed. Tinker *et al.* conclude that, for a given level of need, the costs of *care* in very sheltered housing are less than they are in ordinary housing. This is due to the assumption that lower levels of care would be needed in very sheltered housing, as adaptations to individuals' homes would not be needed and staff are not required to be on a one-to-one ratio with residents as would be the case in home care. However,

if *housing* costs are taken into account, the apparent cost advantages of very sheltered housing appear to diminish. Tinker *et al.* note the difficulties of calculating how much of the care costs would be borne by individuals, as different local authorities operate different charging systems.

Of the studies undertaken since Tinker *et al.*'s report that are reviewed here, Baker (2002) and Bartholomeou (1999) attempt to estimate the cost-effectiveness of the schemes they evaluated. Neither study comes near to the methodological thoroughness of Tinker *et al.*'s work, and both could be considered simplistic in their approaches, thus their findings need to viewed with some caution.

Baker (2002) concluded that the costs to the public purse overall from providing housing and care in the scheme he evaluated were lower than they would be in the wider community for people who were self-funding, but higher than in the wider community for people who were funded by a range of benefits. It was cost-effective to the public purse to support someone in the scheme compared to private residential care if they required no more than 11 hours of care per week; beyond that, private residential care became the more cost-effective option. From the point of view of social services, it was cost-effective to provide up to 30 hours of care to residents in the scheme; beyond that, private residential care became a better option.

Bartholomeou (1999) estimates the different costs to the public purse of a single 'average' client across four settings: living at home in the private rented sector; living in Category 2 sheltered housing; living in ExtraCare housing; and registered residential care. She concludes that living in ExtraCare housing is more expensive than residential care (the cheapest of the four options) but considerably cheaper than living in Category 2 sheltered housing or at home in the private rented sector. ExtraCare also

provides the additional benefits of dignity, independence, control, choice and citizenship.

Baker (2002) also notes that cost estimates of services do not take into account any additional and more intangible benefits such as independence, improved quality of life or reduction in social isolation that may be enjoyed by residents.

Fletcher *et al.* (1999) also highlight the difficulties in arriving at an overview of cost-effectiveness, due in part to the lack of a suitable cost model, and also the many differences in the ways the costs of care are calculated by different local authorities. Fletcher *et al.* also highlight the capital investment required to build and develop new schemes. Again generalisations were difficult to make; however, new build was clearly expensive (costs per unit varied from £51,000 to £70,000) compared to remodelling existing sheltered housing. An important point made here is that higher capital costs of very sheltered housing have an impact on rent levels.

All these studies, including the report to the Royal Commission on the Funding of Long Term Care, were undertaken prior to the changes in funding systems for housing-related support services generated by the Supporting People programme. It seems unlikely that this different funding stream has reduced the complexities of calculating costs and cost-effectiveness of services. Currently the literature can tell us very little about the consequences of the Supporting People programme for housing with care.

Oldman (2000) also notes that the costs of informal care should not be ignored when calculating the costs of housing with care, given that evidence suggests many older people still receive considerable support from their families.

Hartrigg Oaks, the retirement village operated by the Joseph Rowntree Housing Trust, is the only example in the UK of a housing with care scheme that operates on an insurance principle.

A criticism of the scheme has been that it is only accessible to the relatively affluent. This may be so; however, in terms of costs to the public purse, Hartrigg Oaks appears to make the least demand on the public sector and, with the exception of NHS care, most of the costs of both housing and care are met by the residents themselves. The working of the actuarial model and how this is translated into fees for residents are detailed by Sturge (2000).

Affordability

In many of the schemes that have been evaluated the majority of tenants were at least partly funded by benefits, although there were a minority of residents who were self-funded. Very few studies asked residents about value for money or affordability, perhaps assuming that as residents were not directly paying for themselves they would have little to say. Where people were asked (Oldman, 2000; Croucher *et al.*, 2003, Bernard *et al.*, 2004) it seemed that affordability was an issue, particularly for those who were self-funding (this was usually because they had released equity from the sale of a house and were not eligible for benefits). In the study of Berryhill Retirement Village, 26 per cent of residents said they could not afford the support available in the scheme (note that a further 43 per cent declined to answer the question about affordability). Of interest here is that more than 70 per cent of Berryhill residents said their family was their most important source of help. This seems to suggest two things. In the first instance, although there are opportunities to access care services, some residents may decline these services simply on the grounds of cost. Second, informal care appears to play a significant role, and this may be related to the affordability of care services, or indeed reflect personal preference. It seems

those who do not have sources of informal support, and cannot afford care services, may have unmet needs.

One scheme, Hartrigg Oaks, charged considerable monthly fees to residents. As might be expected, residents in this scheme were more reflective about value for money and affordability. Hartrigg Oaks, a continuing care retirement community, operates on an insurance principle. Most residents pay a monthly fee regardless of the amount of care they receive (ranging from no or minimal care to permanent residence in the on-site care home).[4] Fees do, however, rise in line with inflation. Residents here reflected that the scheme was expensive, but many felt they were purchasing 'peace of mind for the future'. Those residents who had considered other types of insurance for future care felt that Hartrigg Oaks compared well with these types of policies. However, any increase in fees generated concerns among residents who had fixed incomes. Over time, as fees rose, and some incomes remained static, increasing numbers of people reported finding difficulties in affording the monthly fees.

Conclusions

The literature reviewed here indicates that for many older people housing with care offers a valued combination of independence and security. There is also evidence that housing with care offers opportunities for companionship and mutual support. However, the evidence consistently reports marginalised groups, particularly those who are very frail or with cognitive and/or physical impairments. The evidence regarding whether housing with care provides a home for life, or can be a substitute for residential or nursing home care, is more ambivalent. In the next chapter we consider the main messages from the evidence base.

Table 3 UK evaluations of housing and care

Study	Setting, facilities and services	Resident profile	Methods
Baker, T. (2002) *An Evaluation of an ExtraCare Scheme: Runnymede Court, Estover, Plymouth.* London: Hanover Housing Group *Study focus:* Quality of care and other quality of life measures for residents; success of the scheme in sustaining independence and providing a cost-effective model of housing and support for older people.	Runnymede Court – block of 38 ExtraCare flats, opened in 2001. Located on a large housing estate with range of services in immediate vicinity. On-site facilities: common room/dining room, kitchen, estate manager's office, care staff office and flat (for sleeping cover), two assisted bathing rooms, hairdressing room, and wheelchair accessible lift. Involves three agencies: Hanover Housing responsible for housing management; social services assess residents' care needs, agree care plan and commission home care services to provide care. On-site care team provide 24-hour cover. Between two and four carers on duty through the day, and one carer sleeping in at night. No nursing staff employed on the site. Twenty-eight hours of care in total provided per day	40 residents. 32 single and four couples. 32 women and eight men. Average age: 80 (range 56 to 95). Allocation of places on the 'thirds principle', one-third high, one-third middle, one-third low dependency. 50% of residents receiving care. Median number of hours per week of care received by individuals = 17	Mixed methods. Semi-structured interviews with 12 residents, staff from Hanover Housing, social services and home care staff. Questionnaire to local GPs. Finance and care data from social services
Bartholomeou, J. (1999) *A View of the Future: The Experience of Living in ExtraCare.* London: Hanover Housing Group *Study focus:* Evaluate ExtraCare housing and its services from a resident's perspective. Identify and disseminate good practice. Assess level of partnership working between Hanover	Seven of Hanover's ExtraCare schemes. Schemes consist of between 25 and 40 flats, each similar in design but not identical. Facilities include: dining room (usually serving one hot meal per day), assisted bathroom, hairdressing/chiropody salon, activities room, lounge, guest room, laundry, small shop. Before entry Community Care Assessment carried out by social services and a care plan agreed.	73% (*n* = 165) of residents from seven schemes interviewed. 95% of the sample residents in ExtraCare received regular care from a care worker. 77% of the sample had at least one health problem. 74% receiving Housing Benefit; 58% receiving Income Support; 42% receiving Attendance	In-depth interviews with 165 residents, estate managers and social services staff

(Continued)

Table 3 UK evaluations of housing and care (continued)

Study	Setting, facilities and services	Resident profile	Methods
Housing and social services	Care provided by social services either directly or through external contractors. Staff on site 24 hours per day. Hanover's own monitoring centre provides continuous back-up via residents' personal alarm system. On average each care plan consisted of 9.5 hours per week	Allowance. Average age of Hanover residents is 81 years. 98.8% white. Entry to ExtraCare subject to assessment process conducted by social services, Hanover, and housing departments. All applicants must meet social services entry criteria	
Bernard, M. *et al.* (2004) *New Lifestyles in Old Age: Health, Identity and Well-being in Berryhill Retirement Village.* Bristol: The Policy Press *Study focus:* The effect of living in a new purpose-built retirement community on health, identity and well-being of residents	Berryhill Retirement Village is a single three-storey building containing 148 rented flats, located on the edge of a working-class urban area in the Midlands. Facilities include: gym, craft and computer rooms, village hall, restaurant and bar, shop, hairdresser, library, greenhouse and communal gardens. Residents either live independently or receive one of four different levels of support package. The first two levels were relatively low level, and the third and fourth levels were the equivalent of residential care, but stopped short of nursing care. Twenty-eight per cent of residents were receiving support services from the organisation, this rose to 31% over the course of the three-year study period. The highest proportion was receiving Level 2 care (two or three calls per day). Staff cover 24 hours a day. Key worker system in operation for all residents.	159 residents. 69% women and 31% men. All white British. Average age over course of study 75/6 years (range 55 to 85+). All residents previously lived within ten-mile radius.	Three-year multi-method, participatory action research approach including: participant observation, resident and staff questionnaires, participation groups, community conferences, individual and group interviews, etc.

(Continued)

Table 3 UK evaluations of housing and care (continued)

Study	Setting, facilities and services	Resident profile	Methods
Biggs, S. et al. (2000) 'Lifestyles of belief: narrative and culture in a retirement community', *Ageing and Society*, Vol. 20, No. 6, pp. 649–72 *Study focus*: Exploration of the representational, experiential and imaginative dimensions of life in a retirement community	Retirement community in West Midlands. 42 tenants. Small number of staff, largely concerned with the housing elements of residence and facilitating of leisure pursuits, although some support offered for self-care	Average age of tenants was 82.2 years. Women outnumbered men two to one. Four in five of tenants recruited from local working-class neighbourhood, with all tenants in skilled or semi-skilled manual occupation prior to retirement	Qualitative. Three groups of tenants participated in the research, each group meeting three times over a period of nine weeks. Total number participating = 15
Brooks, E. et al. (2003) *Care and Support in Very Sheltered Housing*. London: Counsel and Care *Study focus*: Perceptions and experiences of tenants of very sheltered housing regarding quality of care and support	Four schemes in one county. Scheme A: Abbeyfield Society, housing and care provided by different organisations. Schemes B and C: housing association schemes with care provided by different organisations. Scheme C: local authority scheme with housing and care provided by different branches of the same organisation. Care services not detailed	48% of sample were 85 or over. 63% were female, 37% male. One-third of sample had no income other than state benefits and pensions. 86% of sample lived alone. Note: no further information given regarding tenants' profile in different schemes, or total number of tenants. Eligibility criteria varied across schemes	Interviews with 59 tenants drawn from four different schemes.
Croucher, K. et al. (2003) *Living at Hartrigg Oaks: Residents' Views of the UK's First Continuing Care Retirement Community*. York: Joseph Rowntree Foundation *Study focus*: Residents'	Hartrigg Oaks is a CCRC operated by Joseph Rowntree Housing Trust, located in a suburban setting. It consists of 152 bungalows clustered round a central complex containing communal amenities – café, restaurant, library, arts and crafts rooms, fitness centre – and a 42-bed care home.	Residents undergo a health and finance check prior to entry. Minimum age at entry 60. 205 residents in 2003, with average age of 78.5 years. Ratio of women to men 2:1. One-third of residents lived	Three-year longitudinal study consisting of two resident surveys, and two phases of interviews and focus groups with residents (one in three residents participated in qualitative element of study)

(Continued)

Table 3 UK evaluations of housing and care (continued)

Study	Setting, facilities and services	Resident profile	Methods
perceptions of living in a continuing care retirement community (CCRC)	Hartrigg Oaks offers a range of support to residents including domestic help, personal care and temporary short-stay and permanent residence in the on-site care home. Care is provided following needs assessment by in-house care staff. Note that Hartrigg Oaks has a unique funding mechanism where the majority of residents purchase the lease of their bungalow and pay a monthly fee (akin to an insurance premium) to cover (future) care costs	with a partner, one-third remained single and one-third were widowed. 40% of residents previously county of North Yorkshire, 10% from London and South East, 19% from other parts of UK or returning from abroad	
Fletcher, P. *et al.* (1999) *Citizenship and Services in Older Age: The Strategic Role of Very Sheltered Housing.* Beaconsfield: Housing 21 *Study focus:* Focus on very sheltered housing and rethinking strategy and service models	Three schemes: Scheme 1: Very sheltered scheme, 38 places, part of a larger complex on one urban site. Aim to take people who would otherwise be in residential care, with main focus on rehabilitation. Scheme 2: Very sheltered scheme, 42 places, commissioned by social services as a replacement for residential care. Scheme accepts people with high care needs including confusion and dementia. Care provided by social services, housing management by housing association. Scheme 3: Very sheltered scheme, 32 units, with mixed range of care needs. Housing association managing the scheme holds the care contract. On-site care team provide personal and domestic services on 24-hour basis.	No information about the resident profile in the different schemes or levels of care. Note that 25 residents took part in discussion groups from three different schemes	Mixed methods including: literature review; analysis of 50 Joint Investment Plans for older people's services from local authorities and health authorities; telephone interviews with local authority staff and case study visits; small group discussions with residents in three very sheltered housing schemes; telephone interviews with relevant national organisations and government departments

(Continued)

Table 3 UK evaluations of housing and care (continued)

Study	Setting, facilities and services	Resident profile	Methods
Greenwood, C. and Smith, J. (1999) *Sharing in ExtraCare*. London: Hanover Housing Group *Study focus*: Explore the relationship between ExtraCare schemes and local authority social services departments	Study undertaken in same setting as Bartholomeou (1999); see above for details	See Bartholomeou (1999) above	Structured interviews with major stakeholders
Kingston, P. *et al.* (2001) 'Assessing the health impact of age-specific housing', *Health and Social Care in the Community*, Vol. 9, No. 4, pp. 228–34 *Study focus*: Health implications of retirement community living; compare health status of retirement community sample with community sample; explore impact of retirement community living on tenants	Retirement community in West Midlands. 47 tenants in scheme	Majority of residents previously lived within one-mile radius of scheme. Average age of residents 80.1 years. 72% female, 28% male	Mixed methods. Cross-sectional and longitudinal questionnaire interview including SF36 (generic health status measurement tool), Life Satisfaction Index, 18 semantic differentials. All residents in retirement community, compared with a community sample
Phillips, M. and Williams, C. (2001) *Adding Life to Years. The Quality of Later Life in Sheltered and Very Sheltered Housing: The Voices of Older People*. Beaconsfield: Housing 21	Four 'very sheltered housing' schemes. Building and care services are managed by Housing 21, and all offer 24-hour cover. Size range from 46 units to 10 units. Facilities vary across schemes. Care services not detailed	Eligibility criteria varied across the four schemes. In Scheme A tenants need to be in receipt of Attendance Allowance. In Schemes B and C, tenants offered a place if they require at least four hours of care per	Draws on evidence from previous studies and primary research in four very sheltered housing schemes (participating residents = 31), and 27 residents in sheltered housing

(Continued)

Table 3 UK evaluations of housing and care (continued)

Study	Setting, facilities and services	Resident profile	Methods
Study focus: Explores the extent to which sheltered and very sheltered housing is able to offer a home for life and support residents and older people in the local community		week. In Scheme D the same entry criteria as used for residential care by local social services	
Oldman, C. (2000) *Blurring the Boundaries: A Fresh Look at Housing and Care Provision for Older People*. Brighton: Pavilion Publishing in association with JRF. *Study focus*: To look systematically and analytically at various forms of housing and care provision with the aim of providing some guidance to both providers and consumers	Two case study schemes: Case Study 1: a 'flexi-care' Category 2 sheltered housing scheme with up to 13 of its sheltered units registered as residential care places with tenants becoming residents and remaining in their own homes. Number of units registered could vary. Communal facilities and a day centre on site. Accommodates tenants and residents. Residents pay an inclusive fee for all services, accommodation, living costs and care. Tenants pay separately for various services. Accommodation, care and support operated by the same independent not-for-profit organisation. Case Study 2: Two supported housing schemes each with about 30 units. Communal facilities. It is intended to divert people from residential care. Accommodation, care and support are provided by one organisation, a local authority. Ten on-site support workers provide full range of personal care and domestic support to residents who need it. Night cover is not available, but residents are connected to central cover and mobile warden cover	Case Study 1: Accommodates people with a wide range of needs. Case Study 2: One-third of tenants required a great deal of help, one-third were designated medium dependency, and one-third low dependency	Mixed methods including a literature review, semi-structured interviews with selected providers and other key players, and qualitative case study evaluations of two innovative schemes.

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5 REFLECTING ON THE EVIDENCE: MEETING EXPECTATIONS?

There are great expectations of housing with care. In this review we have drawn together the evidence from empirical studies undertaken in the UK and abroad, in order to draw our attention to what is known and highlight the consistencies, contradictions and gaps in the evidence base. Here we present the main messages for provider organisations and those commissioning housing with care.

The UK evidence base: main messages for providers

Despite the growing interest and investment in housing with care, there is only a small body of *empirical* evidence from the UK to illustrate how well different schemes actually work. The diversity of provision is obvious even among the relatively few schemes evaluated and reported here. This makes generalising (and evaluating) problematic. The UK evidence base supports the idea that housing with care promotes independence and generates high levels of resident satisfaction, in keeping with current policy and practice agendas. However, for frailer residents in particular, the messages regarding social isolation and the capacity of housing with care to be an alternative to more institutional models of care and provide a home for life, as well as the capacity of housing with care to support people with severe dementia-type

illnesses, are far more ambivalent. In addition key questions still remain regarding, for example, the cost-effectiveness of housing with care, the potential for schemes to maintain a balance between fit and frail residents, how end-of-life care is delivered, and how well different models of housing with care work for people from different ethnic groups. Existing and newly developing services cannot therefore rely upon an extensive evidence bank; however, various studies (see below) are currently ongoing, and the evidence bank is set to grow considerably.

Promoting independence

- High levels of satisfaction are consistently reported by residents of housing with care schemes.

- It is the combination of independence and security that is valued by residents.

- Residents and providers do not always have a shared understanding of independence.

There are clear messages from residents across a range of settings that housing with care offers them independence, privacy *and* security, and these are greatly valued. Housing with care appears to occupy an area somewhere between housing (linked to independence and privacy) and residential care (linked to security and care). Clearly, to those residents involved in these evaluations, this combination of independence and security appears to offer an effective solution to some of the challenges and uncertainties of later life. High levels of satisfaction are consistently reported by residents across different schemes.

Having 'your own front door' was a key feature of residents' perceptions of independence, but other aspects of the schemes

– such as a barrier-free, purposefully designed, warm environment, positive philosophies of care that emphasised the maintenance of skills and abilities, consultation with residents, real choices over taking part in activities, whether or not to prepare your own food or eat in the dining room, having guests to stay – were also integral to promoting independence.

Although independence was regularly cited by residents as one of the major benefits of housing with care, there is some evidence that residents' expectations of care were not always met, and various authors highlight the need for accurate promotional material that makes clear exactly what is on offer in different schemes. On reflection the evidence seems to indicate that providers' understanding of 'independence' is not always in line with the understanding of older people themselves. As noted above, older people consider independence to be related to privacy and autonomy, having choices and so forth. For some older people, having help with certain key tasks (housework, making the bed, doing the laundry) does not compromise their concept of independence, particularly when these tasks are no longer easily carried out, and consume disproportionate amounts of energy and time relative to the enjoyment and sense of satisfaction/achievement they offer. For providers, however, independence is closely linked to the notion of being encouraged and assisted to do things for yourself (rather than having them done for you).

Residents' perceptions of security were also complex. A sense of security was derived from a number of different elements of the schemes, in particular knowing staff were on-site 24 hours and that someone was at hand if people were unwell, the purposefully designed environments that reduced risks of accidents – especially falls – and made people feel more confident, and the reduced fear of crime and intruders.

Reducing social isolation?

- Housing with care offers opportunities for social interaction and companionship; however, the very frail and people with sensory and cognitive impairments are consistently reported to be on the margins of social groups and networks.

In terms of reducing social isolation, one of the key objectives of housing with care, the evidence is much more ambivalent. Within housing and care schemes many older people do find greater opportunities for social interaction and companionship and there is much evidence of mutual support and neighbourliness. However, those with physical, cognitive and sensory impairments are consistently identified across studies as being on the margins of social groups and networks, and in some cases the focus of hostility. The integration of the fit and frail does not appear – on the basis of these studies – to always work well from the perspective of residents. On the basis of this evidence it seems that providers need to take a proactive approach to promoting the *social* well-being of frail older residents in housing with care schemes.

An alternative to residential care?

- In some circumstances housing with care can provide an alternative to residential care. However, the evidence suggests that it is not a substitute for these settings.

From these studies it appears that housing with care can provide an alternative to residential care for some people in some circumstances, but the numbers of people moving on from

housing with care into both residential care and nursing homes indicate that housing with care is not always a substitute for these settings. Residents in some studies clearly expected more support to be available *in situ*. If the policy emphasis remains on investment in housing with care, it will be important to find ways either to resolve these dilemmas or to ensure that other forms of essential provision are not marginalised.

Home for life?

- The evidence indicates that 'home for life' is a potentially misleading description, and that 'ageing in place' will not always be a reality for some people.

What is meant when a scheme is described as a 'home for life'? Clearly this term is open to wide interpretation. The evidence clearly shows that in many schemes, residents moved on from a housing with care setting to other forms of care, both nursing home and residential care. Only the scheme with an on-site care home came near to offering a home for life, albeit within the boundaries of the scheme rather than the residents' homes. People with challenging or high-risk behaviours associated with severe dementia were not easily accommodated within the schemes evaluated here. Reasons for moving on can be mediated by a number of factors including increasing care needs and residents' and relatives' preferences for something different or maybe something more.

On a related point, a major gap in the evidence relates to end-of-life care in housing with care settings. None of the studies addressed the issue of how end-of-life care is provided in housing with care settings, or how palliative care services have been integrated into care provision.

Providers need to consider how they promote their developments to residents. If schemes are promoted as 'homes for life', then the implications for the provision of services to support high levels of need must be considered, as well as the types of needs that cannot easily be accommodated in a housing setting.

Health, well-being and quality of life?

- Where health impacts have been measured, evidence suggests that housing with care can have a positive impact on the health and well-being of residents.

- In terms of assessing quality of life, authors have drawn on residents' expressions of satisfaction and contentment to infer that housing with care offers a good or better quality of life than other settings.

Only two studies attempted to measure the impact of housing with care on health status. These studies indicated that housing with care helps maintain health status over time in comparison with community samples. However, it is difficult to generalise from such a small body of evidence, particularly when the health status of residents on entry to different schemes can be highly variable, depending on the particular entry criteria operated by different service providers. There is also some evidence that housing with care may reduce the demands made on NHS services.

A number of studies showed care needs increased following entry to housing with care. However, this increase in care was attributed to better needs assessment and the identification of formerly unmet needs rather than a deterioration in health status.

By drawing on residents' expressions of satisfaction, many authors infer that housing with care offers a better quality of life. However, the evidence base currently lacks more robust quality of life assessments. Providers may wish to consider how quality of life measures can be built into service evaluation and review.

Balance between fit and frail

It is self-evident that care needs will increase over time as the residents get older, and this does raise the question of how well schemes can maintain the balance between fit and frail residents if that is a scheme's stated intention. The little evidence we have here seems to suggest that maintaining this balance may be particularly challenging for providers (see particularly Baker, 2002).

Is housing with care cost-effective?

- The evidence on the cost-effectiveness of housing with care is very scant, and such as there is remains contradictory, although it seems to indicate that housing with care is more expensive overall than residential care, and possibly cheaper than home care.

The complexities of costing services are well documented. Where studies have attempted to make comparisons between different types of provision, the evidence is contradictory, although it seems to indicate that housing with care is more expensive overall than residential care, and possibly cheaper than home care. However, direct comparisons are difficult to make as housing with care is supposedly offering a better quality of life, alongside greater independence and autonomy. How can these relatively intangible factors be brought into the costing equation? Another

key question here relates to the ability of residents to afford the services within housing and care schemes. Evidence seems to suggest that affordability is an issue for those who are not eligible for means-tested benefits.

When presenting arguments to support the development of housing with care schemes, providers need to emphasise the additional benefits of housing with care over residential care, particularly in relation to quality of life, maintenance of health status and consistently reported high levels of resident satisfaction.

Gaps in the UK evidence base

An important role for an evidence review is to identify the gaps in the evidence base. Currently the UK evidence base tells us little if nothing about a number of key topics. These include:

- how well different models of housing with care work for older people from different ethnic groups

- quality of life in the specific context of housing with care

- the role of telecare and other assistive technologies – their usefulness and acceptability to residents, and impact on staffing requirements

- gender roles and relationships in highly feminised environments

- end-of-life care

- who is best served in a housing with care environment – the fit and the frail, or just the frail?

- under what circumstances should people be expected to move on to different forms of care provision, and who decides?

In addition, we know little about the particular stressors associated with living in mixed-dependency, communal settings in later life. Some studies have touched on the regular experience of bereavement, and many have noted the difficulties that some older people have when confronted regularly by disability and infirmity, as well as the marginalisation of certain groups, the presence of cliques, and difficulties in preserving personal privacy in a communal setting. Is it possible that the benefits of housing with care for older people – independence, security and the potential for companionship – are matched by different and perhaps unforeseen stressors?

Evidence base from outside the UK: messages for providers

In terms of the literature from outside the UK, we could find no evaluations of schemes from countries that have similar state welfare provision, for example the Netherlands, Sweden and Denmark. The evidence base is predominantly from the USA (where the private sector dominates provision across all areas of health and social welfare), with a small number of studies from Australia. As noted in Chapter 3, the literature from the USA tended to have a more academic focus, thus the messages for UK service providers and commissioners are more muted, and comparisons are problematic given the minimal provision in the USA for people on low incomes. The international literature does not significantly assist in filling the gaps in the UK literature identified above, although there are some useful insights into

areas that have yet to be explored in the UK, particularly the gendered nature of continuing care retirement communities and the different types of social networks developed and utilised by single women and married couples.

Retirement communities: a positive choice for later life

- The evidence base indicates that retirement communities are a positive choice for many older people, offering a combination of accessible accommodation, access to health and support services, and other amenities.

The literature regarding CCRCs in the USA presents a number of consistent themes. Various studies indicate similar motivations for choosing to move to and live in a CCRC, including the requirement for a better (and sometimes warmer) living environment, access to health care and support, and other services and amenities. It is also clear that the personal and family circumstances of individuals influence decisions to move.

Social support and networks

- Social support, social networks and activities both within and outwith retirement communities have a positive impact on health and well-being.

- In parallel with the UK literature, evidence points to the social marginalisation of the very frail, carers, and those with sensory and cognitive impairments.

- Evidence regarding residents' attitudes to living in age-segregated settings is contradictory: some studies indicate

that communities of older people promote more positive attitudes towards ageing; others, however, indicate greater ambivalence towards age-segregated settings.

The literature highlights the importance of social support, social networks and activities both within and outwith CCRCs, and their positive impact on health and well-being. There is considerable evidence of mutual support and 'neighbourly' activities, and opportunities for companionship within CCRCs, although the evidence does indicate that residents' most supportive relationships are usually with long-standing friends and families. However, generalisations are difficult, and friendship formation may be dependent on factors such as the length of time living within a CCRC, and whether residents arrived together. The marginalisation of particular groups of people – the very old and infirm, people with cognitive impairments, carers and widows – is also evident, and yet social support is particularly crucial for these groups.

There is conflicting evidence regarding residents' attitudes towards living in age-segregated settings. Some evidence suggests that CCRCs provide an environment that allows the development of positive attitudes to ageing, and where there is 'solidarity in ageing' among the residents. Other studies indicate people's ambivalence to living in an ageing community.

In terms of assisted living facilities, the fastest growing type of provision in the USA, the evidence base is much smaller, although it too highlights the importance of social networks and supports for the frail elderly in these settings. We also have some indication that 'ageing in place' can be problematic.

Limitations of the international evidence base

There are limitations to this evidence base, in particular the absence of European evaluations. Given the different systems of health and welfare provision in the USA, it is difficult to generalise from the predominantly American literature to the UK context. Many USA providers are for-profit organisations, although there is also a large not-for-profit sector where organisations usually have religious affiliations. Consequently residents of both CCRCs and assisted living facilities are predominantly white, well-educated, relatively affluent people. The situation in Australia is largely similar, with retirement villages occupied by predominantly affluent, well-educated, healthy older people. We found no studies that related to different ethnic groups or social classes. There was little regarding cost-effectiveness of services, or considerations of levels of service provision, care planning and so forth. Perhaps one of the notable absences was that of issues regarding resident empowerment, consultation or participation.

Current and future research in the UK

Perhaps the key point that emerges from this review is the limitations of the current evidence base on models of housing with care. The empirical knowledge base is, however, expanding. We are aware of a number of ongoing research projects, including our own ongoing comparative evaluation of different models of housing with care for later life, funded by the Joseph Rowntree Foundation, and work currently being undertaken by Housing 21, Dementia Voice and the University of the West of England[1] to explore the extent to which people with dementia can be looked after in very sheltered housing. In addition the Personal Social Services Research Unit (PSSRU) at the University of Kent will soon be evaluating the extra care housing schemes that have

been recently funded by the Department of Health. We welcome these and other similar investigations into this crucial area of policy and practice. We also acknowledge the work of the Department of Health's Housing Learning and Improvement Network (LIN) in promoting and developing good practice in this rapidly developing area (see www.changeagentteam.org.uk/housing).

NOTES

Chapter 2

1   For further discussion of definitions and the problems associated with the lack of agreed and shared definitions particularly for consumers, see Riseborough *et al.* (1999).

2   The Housing LIN Factsheet 7, *Private Sector Provision of Extra Care Housing* (ASRHM, 2004), offers an overview of the type of provision and models developed by the main providers. In addition a number of studies (for example Rolfe *et al.*, 1995; Dalley, 2001; McLaren and Hakim, 2002) have examined the role of the private sector in providing retirement housing (i.e. private housing purposely designed for older people that offers limited services to facilitate independent living).

3   This is most likely to be a consequence of limiting our search to papers published in English.

4   See http://www.skewiel-trynwalden.nl/engels/engels.html

5   For further details see http://www.paperclip.org.uk/Social_Housing/vivarium.htm

6   Continuing care retirement communities are not to be
    confused with other types of retirement communities
    where there is little care or support provided within the
    scheme, for example leisure-orientated retirement
    communities (LORCs). For typologies of retirement
    communities see Stallman and Jones (1995), Phillips *et al.*
    (2001) and Streib (2002).

7   Australian 'hostels' would probably be described in the UK
    as residential homes.

Chapter 3

1   It is worth noting a frequently cited ethnographic study, *Fun
    City: An Ethnographic Study of a Retirement Community*
    (Jacobs, 1974). Although this study sits outside the time
    frame of this review it is perceived by many authors to be a
    classic study.

Chapter 4

1   There is a broad literature on resident participation (see for
    example Riseborough, 1996; Lloyd and Wilcox, 1997;
    Midgley *et al.*, 1997). More recently Latto and King (2004)
    conclude that there is no one model of resident
    participation that is most effective in extra care settings.

2   See, for case study examples, *Supporting People with
    Dementia in Extra Care Housing: An Introduction to the
    Issues*, Housing Learning and Improvement Network
    Factsheet 14 (Molineux and Appleton, 2005).

3   Since publication of the study of Hartrigg Oaks, it is our understanding that the Joseph Rowntree Housing Trust has restructured and further developed dementia services at Hartrigg Oaks.

4   Although the majority of residents paid a monthly Community Charge, there were also other methods of paying for care (see Sturge, 2000), including 'fee for care', where residents pay for care services as they used them. In addition, on entry to Hartrigg Oaks residents could pay a lump sum to cover future care costs.

Chapter 5

1   See http://www.dementia-voice.org.uk/Projects/ Projects_V_Sheltered_Housing.htm

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Appendix 1: Search strategies

May–July 2004
Limits: English language

AgeInfo http://www.elsc.org.uk/socialcareresource/
databases.htm
searched 30/06/04
retirement village
retirement communities
retirement place
independent living
sheltered Housing or sheltered homes (limit to title only)
residential care (limit to title or keyword only)
inclusive housing or inclusive houses
Co housing
Collaborative Living
Grouped Housing
housing care
Extra Care
intermediate care
lifetime home
continuing care (limit to title only)
almshouse or almshouses
Anchor
Housing 21
Beld

Hanover

Guiness Trust

supported housing

Due to the limitations of this database each term was searched individually. Where a lot of false hits (irrelevant results) were generated the search was limited to title or keyword only.

A total of 861 records were retrieved and downloaded into individual textfiles.

ASSIA: Applied Social Sciences Index and Abstracts 1987 – current (searched 08/06/04)

(TI=(supported hous*) or AB=(supported hous*) or TI=(housing association*) or AB=(housing association*) or TI=Hanover or AB=Hanover or TI=(Housing 21) or AB=(Housing 21) or TI=almshous* or AB=almshous* or TI=(continuing care) or AB=(continuing care) or TI=((assisted living) near hous*) or AB=((assisted living) near hous*) or TI=((communal living) or (communal housing)) or AB=((communal living) or (communal housing)) or TI=(lifetime home*) or AB=(lifetime home*) or TI=((intermediate care) or intermediate-care) or AB=((intermediate care) or intermediate-care) or TI=(extracare or extra-care or (extra care)) or AB=(extracare or extra-care or (extra care)) or TI=(housing care) or AB=(housing care) or TI=(housing within3 care) or AB=(housing within3 care) or TI=(grouped hous*) or AB=(grouped hous*) or TI=((collaborative living) or collaborative-living) or AB=((collaborative living) or collaborative-living) or TI=((hous* within3 model*) or hous*-model*) or AB=((hous* within3 model*) or hous*-model*) or TI=(CoHousing or co-housing or (co housing)) or AB=(CoHousing or co-housing or (co housing)) or TI=((inclusive hous*) or inclusive-hous*) or AB=((inclusive hous*) or inclusive-hous*) or TI=(residential-care or (residential care)) or TI=(sheltered-hous* or (sheltered hous*)) or AB=(sheltered-hous* or (sheltered hous*)) or TI=(independent-living or (independent living)) or

AB=(independent-living or (independent living)) or TI=(retirement-place* or (retirement place*)) or AB=(retirement-place* or (retirement place*)) or TI=((retirement village*) or retirement-village*) or AB=((retirement village*) or retirement-village*) or TI=((retirement communit*) or retirement-communit*) or AB=((retirement communit*) or retirement-communit*)) and (AB=(pensioner* or (senior citizen*) or senior-citizen*) or TI=(pensioner* or (senior citizen*) or senior-citizen*) or TI=(elderly or elderly-people) or TI=((old* men) or old*-men or (old* women) or old*-women) or TI=((old* people) or old*-people) or TI=(OAP* or (old* age) or old*-age) or AB=(OAP* or (old* age) or old*-age) or TI=(senior or seniors) or AB=(senior or seniors) or TI=((fourth age) or fourth-age) or AB=((fourth age) or fourth-age) or TI=((third age) or third-age) or AB=((third age) or third-age) or TI=(laterlife or (later life) or later-life) or TI=(retired or retirement))
358 records downloaded into the Endnote Library

Caredata searched 9/6/04 and 30/6/04

http://195.195.162.66/elsc/caredata/caredatasearch.htm
retirement community
retirement village or
retirement place or retirement places
independent living (limit to title only)
sheltered housing (limited to title only)
inclusive housing
co housing
collaborative living
grouped housing
housing care
extra care
intermediate care
lifetime home or lifetime homes

communal living
communal housing
almshouse or almshouses
Abbeyfields
Anchor
Housing 21
Beld
Hanover
Guiness trust
supported housing
All terms limited to title or abstract. Due to the limitations of this database each term was searched individually, the term residential care was not included as this produced too many irrelevant results. This search retrieved some false hits.
193 results downloaded into Word files.

Dissertation Abstracts searched 07/07/04

http://wwwlib.global.umi.com/dissertations/search
lifetime homes
retirement villages
retirement communities
extra care
almshouses
The free version of this database was searched which automatically limits searching to the most recent 2 years of citations and abstracts.
1 relevant result was downloaded as a word document.

EconLit searched 01/07/04
#44 #43 and #32
#43 #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42

#42 ((senior or seniors) in AB)or((senior or seniors) in TI)

#41 ((fourth age) in AB)or((fourth age) in TI)

#40 ((third age) in AB)or((third age) in TI)

#39 ((laterlife or later life) in AB)or((laterlife or later life) in TI)

#38 ((retired or retirement) in AB)or((retired or retirement) in TI)

#37 ((OAP* or old* age) in AB)or((OAP* or old* age) in TI)

#36 ((pensioner* or senior citizen*) in AB)or((pensioner* or senior citizen*) in TI)

#35 ((elderly or elderly-people) in AB)or((elderly or elderly-people) in TI)

#34 ((old* men or old* women) in AB)or((old* men or old* women) in TI)

#33 ((old* people) in AB)or((old* people) in TI)

#32 #22 or #31

#31 #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30

#30 ((supported hous*) in AB)or((supported hous*) in TI)

#29 ((housing association*) in AB)or((housing association*) in TI)

#28 (((Guiness near hous*)) in AB)and(((Guiness near hous*)) in TI)

#27 (((Hanover near hous*)) in AB)or(((Hanover near hous*)) in TI)

#26 ((Beld) in AB)or((Beld) in TI)

#25 ((Housing 21) in AB)or((Housing 21) in TI)

#24 (((Anchor near hous*)) in AB)or(((Anchor near hous*)) in TI)

#23 ((Abbeyfields) in AB)or((Abbeyfields) in TI)

#22 #10 or #21

#21 #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20

#20 ((almshous*) in AB)or((almshous*) in TI)

#19 ((continuing care) in AB)or((continuing care) in TI)

#18 (((assisted living near hous*)) in AB)or(((assisted living near hous*)) in TI)

#17 ((communal living or communal housing) in AB)or((communal

living or communal housing) in TI)
#16 ((lifetime home*) in AB)or((lifetime home*) in TI)
#15 (intermediate care)or(intermediate care)
#14 ((extra care) in AB)or((extra care) in TI)
#13 ((housing care) in AB)or((housing care) in TI)
#12 ((grouped hous*) in AB)or((grouped hous*) in TI)
#11 ((collaborative living) in AB)or((collaborative living) in TI)
#10 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9
#9 ((inclusive hous*) in AB)or((inclusive hous*) in TI)
#8 ((co housing) in AB)or((co housing) in TI)
#7 (residential care) in AB
#6 (residential care) in TI
#5 ((sheltered hous*) in AB)or((sheltered hous*) in TI)
#4 ((independent living) in AB)or((independent living) in TI)
#3 ((retirement place*) in AB)or((retirement place*) in TI)
#2 ((retirement village*) in AB)or((retirement village*) in TI)
#1 ((retirement communit*) in AB)or((retirement communit*) in TI)
36 records were downloaded into the Endnote Library.

International Bibliography of the Social Sciences (1951–2004 searched 07/07/04)
Retirement Villages
Retirement Communities
Inclusive Housing
Co housing
Lifetime homes
Almshouses
Supported housing
22 records were downloaded into the Endnote Library

Medline Ovid (1966 – May week 4 2004, searched 3/06/04)

1 ((old$ adj people) or old$-people).ti,ab.
2 ((((old$ adj men) or old$-men or old$) adj women) or old$-women).ti,ab.
3 (elderly or elderly-people).ti,ab.
4 (((pensioner$ or senior) adj citizen$) or senior-citizen$).ti,ab.
5 (OAP$ or old$ age or old$-age).ti,ab.
6 (retired or retirement).ti,ab.
7 (((laterlife or later) adj life) or later-life).ti,ab.
8 ((third adj age) or third-age).ti,ab.
9 (senior or seniors).ti,ab.
10 or/1–9
11 ((retirement adj communit$) or retirement-communit$).ti,ab.
12 ((retirement adj village$) or retirement-village$).ti,ab.
13 (retirement-place$ or (retirement adj place$)).ti,ab.
14 ((independent-living or independent) adj living).ti,ab.
15 (sheltered-hous$ or (sheltered adj hous$)).ti,ab.
16 ((residential-care or (residential adj care)).ti,ab.
17 ((inclusive adj hous$) or inclusive-hous$).ti,ab.
18 ((CoHousing or co-housing or co) adj housing).ti,ab.
19 ((hous$ adj model$) or hous$-model$).ti,ab.
20 ((collaborative adj living) or collaborative-living).ti,ab.
21 (grouped adj hous$).ti,ab.
22 (housing adj3 care).ti,ab.
23 ((extracare or extra-care or extra) adj care).ti,ab.
24 (lifetime adj home$).ti,ab.
25 ((communal adj living) or (communal adj housing)).ti,ab.
26 (assisted adj living).ti,ab.
27 (continuing adj care).ti,ab.
28 almshous$.ti,ab.
29 (housing adj association$).ti,ab.
30 ((supported adj hous$) or supported-hous$).ti,ab.

31   (((model$ adj3 home) or hous$) adj3 care).ti,ab.

32   or/11–31

33   10 and 32

1252 results downloaded into the Endnote Library

PAIS (searched 01/07/04)

#44 #43 and #32

#43 #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42

#42 ((senior or seniors) in AB)or((senior or seniors) in TI)

#41 ((fourth age) in AB)or((fourth age) in TI)

#40 ((third age) in AB)or((third age) in TI)

#39 ((laterlife or later life) in AB)or((laterlife or later life) in TI)

#38 ((retired or retirement) in AB)or((retired or retirement) in TI)

#37 ((OAP* or old* age) in AB)or((OAP* or old* age) in TI)

#36 ((pensioner* or senior citizen*) in AB)or((pensioner* or senior citizen*) in TI)

#35 ((elderly or elderly-people) in AB)or((elderly or elderly-people) in TI)

#34 ((old* men or old* women) in AB)or((old* men or old* women) in TI)

#33 ((old* people) in AB)or((old* people) in TI)

#32 #22 or #31

#31 #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30

#30 ((supported hous*) in AB)or((supported hous*) in TI)

#29 ((housing association*) in AB)or((housing association*) in TI)

#28 (((Guiness near hous*)) in AB)and(((Guiness near hous*)) in TI)

#27 (((Hanover near hous*)) in AB)or(((Hanover near hous*)) in TI)

#26 ((Beld) in AB)or((Beld) in TI)

#25 ((Housing 21) in AB)or((Housing 21) in TI)

#24 (((Anchor near hous*)) in AB)or(((Anchor near hous*)) in TI)

#23 ((Abbeyfields) in AB)or((Abbeyfields) in TI)

#22 #10 or #21

#21 #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20

#20 ((almshous*) in AB)or((almshous*) in TI)

#19 ((continuing care) in AB)or((continuing care) in TI)

#18 (((assisted living near hous*)) in AB)or(((assisted living near hous*)) in TI)

#17 ((communal living or communal housing) in AB)or((communal living or communal housing) in TI)

#16 ((lifetime home*) in AB)or((lifetime home*) in TI)

#15 (intermediate care)or(intermediate care)

#14 ((extra care) in AB)or((extra care) in TI)

#13 ((housing care) in AB)or((housing care) in TI)

#12 ((grouped hous*) in AB)or((grouped hous*) in TI)

#11 ((collaborative living) in AB)or((collaborative living) in TI)

#10 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9

#9 ((inclusive hous*) in AB)or((inclusive hous*) in TI)

#8 ((co housing) in AB)or((co housing) in TI)

#7 (residential care) in AB

#6 (residential care) in TI

#5 ((sheltered hous*) in AB)or((sheltered hous*) in TI)

#4 ((independent living) in AB)or((independent living) in TI)

#3 ((retirement place*) in AB)or((retirement place*) in TI)

#2 ((retirement village*) in AB)or((retirement village*) in TI)

#1 ((retirement communit*) in AB)or((retirement communit*) in TI)

101 records downloaded into the Endnote Library

Planex http://www.i-documentsystems.com/iii/index.htm
(searched 01/07/04)
Anchor Trust
Guinness trust
Hanover Trust
Beld
Abbeyfields Trust
Collaborative Living
Almshouse
Retirement Village
Retirement Community/communities
Lifetime Homes
186 records downloaded into word documents

PsycINFO (searched 09/06/04)
(((((OAP* or old* age) in AB)or((OAP* or old* age) in TI)) or
(((pensioner* or senior citizen*) in AB)or((pensioner* or senior
citizen*) in TI)) or ((elderly) in TI) or (((old* men or old* women) in
AB)or((old* men or old* women) in TI)) or (((senior or seniors) in
AB)or((senior or seniors) in TI)) or (((old* people) in AB)or((old*
people) in TI)) or (((fourth age) in AB)or((fourth age) in TI)) or (((third
age) in AB)or((third age) in TI)) or (((third age) in AB)or((third age)
in TI)) or (((laterlife or later life) in AB)or((laterlife or later life) in TI))
or (((retired or retirement) in AB)or((retired or retirement) in TI)))
and (((((retirement village*) in AB)or((retirement village*) in TI)) or
(((retirement communit*) in AB)or((retirement communit*) in TI))
or (((inclusive hous*) in AB)or((inclusive hous*) in TI)) or
(((residential care) in AB)or((residential care) in TI)) or (((CoHousing
or co-housing or co housing) in AB)or((CoHousing or co-housing
or co housing) in TI)) or ((hous*) in TI) or (((sheltered hous*) in
AB)or((sheltered hous*) in TI)) or (((independent living) in
AB)or((independent living) in TI)) or (((retirement place*) in

AB)or((retirement place*) in TI))) in the database(s) PsycINFO Weekly 2004/06 Week 1, PsycINFO Weekly 2004/05 Week 4, PsycINFO Weekly 2004/05 Week 3, PsycINFO Weekly 2004/05 Week 2, PsycINFO Weekly 2004/05 Week 1, PsycINFO 2004/01–2004/04, PsycINFO 2003/07–2003/12, PsycINFO 2003/01–2003/06, PsycINFO 2002/08–2002/12, PsycINFO 2002/01–2002/07, PsycINFO 2001, Part A, PsycINFO 2001, Part B, PsycINFO 2000, PsycINFO 1999, PsycINFO 1998, PsycINFO 1996–1997, PsycINFO 1993–1995, PsycINFO 1990–1992, PsycINFO 1988–1989, PsycINFO 1985–1987, PsycINFO 1978–1984, PsycINFO 1967–1977, PsycINFO 1872–1966

738 records were downloaded into the Endnote Library

SIGLE (1980–2003/12 searched 08/06/04)

((((retired or retirement) in AB)or((retired or retirement) in TI)) or (((retired or retirement) in AB)or((retired or retirement) in TI)) or (((OAP* or old* age) in AB)or((OAP* or old* age) in TI)) or (((pensioner* or senior citizen*) in AB)or((pensioner* or senior citizen*) in TI)) or (((old* people or old*-people) in TI)or((old* people or old*-people) in AB)) or (((elderly) in AB)or((elderly) in TI)) or (((old* men or old* women) in AB)or((old* men or old* women) in TI)) or (((senior or seniors) in AB)or((senior or seniors) in TI)) or (((fourth age) in AB)or((fourth age) in TI)) or (((third age) in AB)or((third age) in TI)) or (((laterlife or later life) in AB)or((laterlife or later life) in TI))) and ((((retirement village*) in AB)or((retirement village*) in TI)) or (((retirement communit*) in AB)or((retirement communit*) in TI)) or ((hous*) in TI) or (((residential care) in AB)or((residential care) in TI)) or (((residential care) in AB)or((residential care) in TI)) or (((sheltered hous*) in AB)or((sheltered hous*) in TI)) or (((independent living) in AB)or((independent living) in TI)) or (((retirement place*) in AB)or((retirement place*) in TI))) in the database(s) SIGLE 1980–2003/12

272 records were downloaded into the Endnote Library

((((communal living) in AB)or((communal living) in TI)) or ((((lifetime home*) in AB)or((lifetime home*) in TI)) or (((intermediate care) in AB)or((intermediate care) in TI)) or (((extracare or extra care) in AB)or((extracare or extra care) in TI)) or (((housing care) in AB)or((housing care) in TI)) or (((grouped hous*) in AB)or((grouped hous*) in TI)) or (((collaborative living) in AB)or((collaborative living) in TI)) or (((hous* adj3 model*) in AB)or((hous* adj3 model*) in TI)) or (((CoHousing or co-housing or co housing) in AB)or((CoHousing or co-housing or co housing) in TI)) or (((inclusive hous*) in AB)or((inclusive hous*) in TI))) and ((((retired or retirement) in AB)or((retired or retirement) in TI)) or (((retired or retirement) in AB)or((retired or retirement) in TI)) or (((OAP* or old* age) in AB)or((OAP* or old* age) in TI)) or (((pensioner* or senior citizen*) in AB)or((pensioner* or senior citizen*) in TI)) or (((old* people or old*-people) in TI)or((old* people or old*-people) in AB)) or (((elderly) in AB)or((elderly) in TI)) or (((old* men or old* women) in AB)or((old* men or old* women) in TI)) or (((senior or seniors) in AB)or((senior or seniors) in TI)) or (((fourth age) in AB)or((fourth age) in TI)) or (((third age) in AB)or((third age) in TI)) or (((laterlife or later life) in AB)or((laterlife or later life) in TI))) in the database(s) SIGLE 1980–2003/12
1 record was downloaded into the Endnote Library

(((((model* near (home or hous*) near care)) in AB)or(((model* near (home or hous*) near care)) in TI)) or (((supported hous*) in AB)or((supported hous*) in TI)) or (((housing association*) in AB)or((housing association*) in TI)) or (((Abbeyfields or Anchor or Housing 21 or Beld or Hanover or Guiness trust) in AB)or((Abbeyfields or Anchor or Housing 21 or Beld or Hanover or Guiness trust) in TI)) or (((almshous*) in AB)or((almshous*) in TI)) or (((continuing care) in AB)or((continuing care) in TI)) or

((((assisted living near hous*)) in AB)or(((assisted living near hous*)) in TI))) and ((((retired or retirement) in AB)or((retired or retirement) in TI)) or (((retired or retirement) in AB)or((retired or retirement) in TI)) or (((OAP* or old* age) in AB)or((OAP* or old* age) in TI)) or (((pensioner* or senior citizen*) in AB)or((pensioner* or senior citizen*) in TI)) or (((old* people or old*-people) in TI)or((old* people or old*-people) in AB)) or (((elderly) in AB)or((elderly) in TI)) or (((old* men or old* women) in AB)or((old* men or old* women) in TI)) or (((senior or seniors) in AB)or((senior or seniors) in TI)) or (((fourth age) in AB)or((fourth age) in TI)) or (((third age) in AB)or((third age) in TI)) or (((laterlife or later life) in AB)or((laterlife or later life) in TI))) in the database(s) SIGLE 1980–2003/12
19 records downloaded into the Endnote Library

Social Science Citation Index (MIMAS searched 30/06/04)

TS=(retirement communit*) OR TI=(retirement communit*)
TS=(retirement village*) OR TI=(retirement village*)
TS=(retirement place*) OR TI=(retirement place*)
TS=(independent living) or TI=(independent living) AND TS=(elderly or elder or older or senior or pensioner or retir*) or TI=(elderly or elder or older or senior or pensioner or retir*) (limit to English language)
TS=(sheltered hous*) or TI=(sheltered hous*)
TS=(residential care) or TI=(residential care) AND TS=(elderly or elder or older or senior or pensioner or retir*) or TI=(elderly or elder or older or senior or pensioner or retir*)
TS=(co housing) or TI=(co housing)
TS=(collaborative living) or TI=(collaborative living)
TS=(grouped hous*) or TI=(grouped hous*)

TI=(elderly or elder or older or senior or pensioner or retir*) or TS=(elderly or elder or older or senior or pensioner or retir*) AND TI=(housing SAME care) or TS=(housing SAME care)

TS=(extra care) or TI=(extra care)

TS=(intermediate care) or TI=(intermediate care) AND TI=(elderly or elder or older or senior or pensioner or retir*) or TS=(elderly or elder or older or senior or pensioner or retir*)

TS=(lifetime home*) or TI=(lifetime home*)

TS=(communal living or communal housing) or TI=(communal living or communal housing)

TS=(assisted living SAME hous*) or TI=(assisted living SAME hous*)

TS=(continuing care) OR TI=(continuing care) AND TI=(elderly or elder or older or senior or pensioner or retir*) or TS=(elderly or elder or older or senior or pensioner or retir*)

TI=(almshous*) or TS=(almshous*)

TS=(Abbeyfields or Anchor or Housing 21 or Beld or Hanover or Guiness) or TI=(Abbeyfields or Anchor or Housing 21 or Beld or Hanover or Guiness)

TI=(supported hous*) or TS=(supported hous*) AND TI=(elderly or elder or older or senior or pensioner or retir*) or TS=(elderly or elder or older or senior or pensioner or retir*)

1288 records downloaded into a Reference Manager Library

Social Science Humanities Index

TS=(retirement communit*) OR TI=(retirement communit*)

TS=(retirement village*) OR TI=(retirement village*)

TS=(retirement place*) OR TI=(retirement place*)

TS=(independent living) or TI=(independent living) AND TS=(elderly or elder or older or senior or pensioner or retir*) or TI=(elderly or elder or older or senior or pensioner or retir*) (limit to English language)

TS=(sheltered hous*) or TI=(sheltered hous*)

TS=(residential care) or TI=(residential care) AND TS=(elderly or elder or older or senior or pensioner or retir*) or TI=(elderly or elder or older or senior or pensioner or retir*)

TS=(co housing) or TI=(co housing)

TS=(collaborative living) or TI=(collaborative living)

TS=(grouped hous*) or TI=(grouped hous*)

TI=(elderly or elder or older or senior or pensioner or retir*) or TS=(elderly or elder or older or senior or pensioner or retir*) AND TI=(housing SAME care) or TS=(housing SAME care)

TS=(extra care) or TI=(extra care)

TS=(intermediate care) or TI=(intermediate care) AND TI=(elderly or elder or older or senior or pensioner or retir*) or TS=(elderly or elder or older or senior or pensioner or retir*)

TS=(lifetime home*) or TI=(lifetime home*)

TS=(communal living or communal housing) or TI=(communal living or communal housing)

TS=(assisted living SAME hous*) or TI=(assisted living SAME hous*)

TS=(continuing care) OR TI=(continuing care) AND TI=(elderly or elder or older or senior or pensioner or retir*) or TS=(elderly or elder or older or senior or pensioner or retir*)

TI=(almshous*) or TS=(almshous*)

TS=(Abbeyfields or Anchor or Housing 21 or Beld or Hanover or Guiness) or TI=(Abbeyfields or Anchor or Housing 21 or Beld or Hanover or Guiness)

TI=(supported hous*) or TS=(supported hous*) AND TI=(elderly or elder or older or senior or pensioner or retir*) or TS=(elderly or elder or older or senior or pensioner or retir*)

1288 records were downloaded into a Reference Manager Library

Sociological Abstracts (1969–2004/06 searched 07/07/04)

#44 #42 and #43

#43 #32 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41

#42 #22 or #31(

#41 ((senior or seniors) in AB)or((senior or seniors) in TI)

#40 ((fourth age) in AB)or((fourth age) in TI)

#39 ((third age) in AB)or((third age) in TI)

#38 ((laterlife or later life) in AB)or((laterlife or later life) in TI)

#37 ((retired or retirement) in AB)or((retired or retirement) in TI)

#36 ((OAP* or old* age) in AB)or((OAP* or old* age) in TI)

#35 ((pensioner* or senior citizen*) in AB)or((pensioner* or senior citizen*) in TI)

#34 ((elderly or elderly-people) in AB)or((elderly or elderly-people) in TI)

#33 ((old* men or old* women) in AB)or((old* men or old* women) in TI)

#32 ((old* people) in AB)or((old* people) in TI)

#31 #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30

#30 ((supported hous*) in AB)or((supported hous*) in TI)

#29 ((housing association*) in AB)or((housing association*) in TI)

#28 (((Guiness near hous*)) in AB)and(((Guiness near hous*)) in TI)

#27 (((Hanover near hous*)) in AB)or(((Hanover near hous*)) in TI)

#26 ((Beld) in AB)or((Beld) in TI)

#25 ((Housing 21) in AB)or((Housing 21) in TI)

#24 (((Anchor near hous*)) in AB)or(((Anchor near hous*)) in TI)

#23 ((Abbeyfields) in AB)or((Abbeyfields) in TI)

#22 #10 or #21

#21 #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20

#20 ((almshous*) in AB)or((almshous*) in TI)

#19 ((continuing care) in AB)or((continuing care) in TI)(81 records)

#18 (((assisted living near hous*)) in AB)or(((assisted living near hous*)) in TI)

#17 ((communal living or communal housing) in AB)or((communal living or communal housing) in TI)

#16 ((lifetime home*) in AB)or((lifetime home*) in TI)

#15 (intermediate care)or(intermediate care)

#14 ((extra care) in AB)or((extra care) in TI)

#13 ((housing care) in AB)or((housing care) in TI)

#12 ((grouped hous*) in AB)or((grouped hous*) in TI)

#11 ((collaborative living) in AB)or((collaborative living) in TI)

#10 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9

#9 ((inclusive hous*) in AB)or((inclusive hous*) in TI)

#8 ((co housing) in AB)or((co housing) in TI)

#7 (residential care) in AB

#6 (residential care) in TI

#5 ((sheltered hous*) in AB)or((sheltered hous*) in TI)

#4 ((independent living) in AB)or((independent living) in TI)

#3 ((retirement place*) in AB)or((retirement place*) in TI)

#2 ((retirement village*) in AB)or((retirement village*) in TI)

#1 ((retirement communit*) in AB)or((retirement communit*) in TI)

358 records downloaded into the Endnote Library.

APPENDIX 2: DATABASES SEARCHED

Table A2.1 Databases searched

Database	Version/service	No. of hits
AgeInfo	www	861
ASSIA	CSA	358
Caredata	www	193
Dissertation Abstracts	www	1
EconLit	ARC2	36
International Bibliography of the Social Sciences 1951–2004	BIDS	22
Medline 1966–May week 4 2004	Ovid	1,252
PAIS	ARC2	101
Planex	www	186
PsycINFO		738
Sigle	ARC2	283
Social Science Citation Index	MIMAS	1,288
Social Science Humanities Index 1990–2004	MIMAS	21
Sociological Abstracts 1969–2004/06	ARC2	358

Appendix 3: List of contacts

Academic

Centre for Policy on Ageing
Centre for Sheltered Housing Studies
ESRC, Press Enquiries and Publications
Professor Mary Maynard, University of York
Dr Sheila Peace, School of Health and Social Welfare, The Open University
Dr Kevin McKee, Sheffield Institute for Studies on Ageing, University of Sheffield
Maria Evandrou, Institute of Gerontology, King's College London
Dr Elizabeth Breeze, Centre for Ageing and Public Health, London School of Hygiene and Tropical Medicine
Dr Kate Davidson, Centre for Research on Ageing and Gender, University of Surrey
Dr Thomas Scharf, Centre for Social Gerontology, University of Keele
Professor Mary Gilhooy, Centre for Gerontology and Health Studies, University of Paisley
Institute of Gerontology, King's College London
International Institute of Health and Ageing
Rose Gilroy, Institute for Ageing and Health, Housing for Older People Research Group, University of Newcastle
Sue Jackson, University of Newcastle, Institute for Ageing and Health
Housing for Older People Research Group

Sheffield Institute Studies on Ageing
Ian Shaw, University of York
Miriam Bernard, Professor of Social Gerontology, Keele University
Maria Brenton, School for Policy Studies, University of Bristol
Malcolm J. Fisk, Director of Insight Social Research
Julienne Hanson, Reader in Architectural and Urban Morphology, Bartlett School of Graduate Studies
Caroline Holland, School of Health and Social Welfare, The Open University
Leonie Kellaher, Director of the Centre for Environmental and Social Studies in Ageing, University of North London
Ruth Madigan, University of Glasgow
Mary Marshall, Dementia Services Development Centre, University of Stirling
Professor Judith Phillips, School of Social Relations, Keele University

Government

Audit Commission
Department of Health
Office of the Deputy Prime Minister
Scottish Executive
Welsh Assembly

Housing Associations

Abbeyfield Society
Almshouse Association
Bield Housing Association Limited
Fifty5plus.com
Guinness Trust Group

Hanover Housing Trust
Housing 21

Other

Alzheimer's Society
Association of Retirement Housing Managers
Better Government for Older People
Help the Aged
Chartered Institute of Housing
Emerging Role of Sheltered Housing Chair
Housing Corporation
Kendal Corporation, Philadelphia

APPENDIX 4: WEBSITES SEARCHED

Abbeyfield Houses Society of Canada, www.abbeyfield.ca
Abbeyfield Society, www.abbeyfield.com
ACH Group (Australia), www.ach.org.au
Age Concern, www.ageconcern.org.uk
Aged and Community Services Australia, www.agedcare.org.au
Alzheimer's Society, www.alzheimers.org.uk
Anchor Trust, www.anchor.org.uk
Audit Commission, www.audit-commission.gov.uk
Australian Government Department of Health and Ageing, www.health.gov.au
Australian Housing and Urban Research Institute, www.ahuri.edu.au
Bield, www.bield.co.uk
Canada Mortgage and Housing Corporation (CMHC), http://cmhc.ca
Canadian Association on Gerontology, http://ww.cagacg.ca
Canadian government website, http://canada.gc.ca/main_e.html
Centre for Policy on Ageing, www.cpa.org.uk
Centre for Sheltered Housing Studies, www.cshs.co.uk
Communities Scotland, www.communitiesscotland.gov.uk
Department of Health, www.dh.gov.uk
Department of Housing and Urban Development (USA), www.hud.gov/
Emerging Role of Sheltered Housing, www.shelteredhousing.org/erosh/index.aspx

Engineering and Physical Science Research Council, www.epsrc.org.uk

EQUAL (Extending Quality of Life), www.equal.ac.uk

ESRC, www.esrc.ac.uk

Europa (English language version) – ageing and later life, http://europa.eu.int/

The ExtraCare Charitable Trust, www.extracare.org.uk

Fifty5plus.com, www.fifty5plus.com

Growing Older: ESRC Research Programme on Extending Quality of Life, www.shef.ac.uk/uni/projects/gop/index.htm

Guinness Trust Group, www.guinnesstrust.org.uk

Hammond Care Group (Australia), http://hammond.com.au

Hanover Housing Trust, www.hanover.org.uk

Help the Aged, www.helptheaged.org.uk

Housing 21, www.housing21.co.uk

Housing Corporation, www.housingcorp.gov.uk

Institute of Gerontology, King's College London, www.kcl.ac.uk/kis/schools/life_sciences/health/gerontology/index.php

It's Your Life, www.itsyourlife.com.au

Joseph Rowntree Foundation, www.jrf.org.uk/home.asp

National Housing Research Committee (Canada), http://www.nhrc-cnrl.ca/cmhc/

Office of the Deputy Prime Minister, www.odpm.gov.uk

Scottish Executive, www.scotland.gov.uk

Sheffield Institute for Studies on Ageing, www.shef.ac.uk/sisa/

Simon Fraser University Gerontology Research Centre (Canada), www.sfu.ca/rgrc

Social Gerontology Group (Sweden), www.soc.uu.se/research/gerontology

Stimulating Social Policy in an Ageing Society Research Group, LSE, www.lse.ac.uk/Depts/sage/

United States Department of Health and Human Services (US equivalent of DH and DWP), www.hhs.gov/

US government websites, www.fedworld.gov/
US National Institute on Aging, www.nia.nih.gov/
Welsh Assembly, www.wales.gov.uk