Best practice in promoting social well-being in extra care housing

A literature review

Simon Evans and Sarah Vallelly

This review explores the literature on best practice in promoting well-being in a range of housing and care settings.

The review highlights some key factors in promoting social well-being for older people, including:

- the availability of inclusive and diverse activities, both social and creative
- the provision of a range of facilities as venues for social interaction, particularly a shop, a restaurant and a garden
- imaginative and accessible design that promotes a sense of community
- access to social networks beyond the housing scheme
- opportunities for service users to be involved in decisions about care delivery and service development
- and a person-centred approach to care provision.

It also identifies groups of older people who are particularly at risk of social isolation.

This study will be of interest to commissioners, providers and practitioners across a range of housing and care settings.

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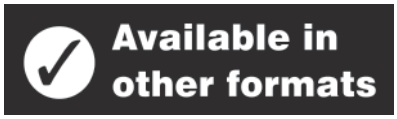

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1 Introduction

This literature review was undertaken as part of a research project exploring social well-being in extra care housing. The study was funded by Joseph Rowntree Foundation (JRF) and carried out by researchers at the University of the West of England, Bristol and Housing 21, London. The main aim of this review is to set the context for the research project and provide an overview of the literature concerning best practice in promoting social well-being for frail older people in extra care housing. The research report can also be accessed via the JRF website.

Literature review rationale and methodology

An electronic search was performed in September 2006 using a range of databases, as listed in the Appendix. This search was restricted to publications with English language abstracts that had been published over the past ten years. In addition, an internet search was carried out in order to identify reports and other relevant information. The main broad research areas covered were social well-being, older people, housing and care. The following table shows the full range of research terms employed in a number of combinations.

Table 1 The full range of research terms used in the literature search

Person	Quality of life	Setting
Older*	Quality of life	Housing
Elder*	Well-being	Extra care
Age*	Wellbeing	Long term
Retire*	Satisfaction	Residential
		Domiciliary
		Care home
		Retirement

The majority of the literature reviewed here comes from peer reviewed journals, research reports from key agencies with long-standing reputations in the field of older people, and UK government policy and strategy documents. The review literature is based largely on qualitative studies. This reflects an increasing recognition that concepts such as quality of life and well-being should be viewed in terms of the 'lived experience', which is best captured through in-depth methodologies. Such qualitative approaches are now widely used in studies that explore the needs and experiences of older people who have chosen living environments, such as extra care housing, which provide care and support. However, reference is also made to

some quantitative research, particularly in relation to standardised quality of life and well-being measures. These are included because they have made an important contribution to the evidence base in terms of cross-cultural generalisability and comparison around the care and support of older people. A further body of evidence from quantitative studies into the association between physical health and quality of life is included, largely because this is one area of well-being in which randomised controlled trials have been carried out.

The literature review included peer reviewed journal articles, reports of research studies, literature reviews and a range of grey literature. Quality criteria included an explicit methodology that outlined how data were collected, a description of the sample and a defined outcome measure/indicator. An initial scoping exercise found little literature that focused specifically on well-being for older people in relation to extra care housing. This is partly because extra care is a relatively new form of provision. There are still less than 30,000 units of extra care accommodation in England and this covers many different models. Extending the review to all housing with care settings led to a slightly improved success rate. However, this was not sufficient to produce a substantial and useful review. This review is therefore based on a broader search, which explored well-being and quality of life for older people across a broad spectrum of housing, health and social care. This reflects the diverse and interrelated nature of the factors that are believed to impact on social well-being. A significant proportion of the literature included in this review comes from outside the United Kingdom and includes work from the USA, Canada, Europe and Israel. This has been included in order to cover a broad range of service provision, while acknowledging the possible difficulties associated with cross-cultural comparisons. This broader approach to reviewing the literature aims to highlight good practice for promoting social well-being for older people that is transferable to a range of housing and care settings, particularly in terms of the underpinning values and philosophies of service providers.

Electronic and manual search strategies were used in September 2006. Information produced by key agencies was identified through general searching on the internet, following up any leads and also using broad research terms. Key articles and other documents were identified and all relevant references from those articles were followed up until saturation had been achieved. Review of abstracts and summaries appropriate to this search strategy resulted in identification of 141 relevant publications, all of which were included in the review. These are listed in the references.

Terminologies

Definitions are problematic in the area of quality of life and well-being. Measures abound, each with a different focus in terms of what constitutes quality of life. Common approaches adopted are needs based, satisfaction based and psychosocial models. A key issue is that different people may value different aspects of their life to different extents, and therefore quality of life means different things to different people and at different times in the life course. There is now a growing consensus that any meaningful measure must take firmly into account what is important to the people to whom it is being applied (Bowling, 1997; Owen, 2006). An example of this approach is found in the JRF-funded workbook (Riseborough and Jones, 2005), which uses a range of domains based on research with older people to assess quality of life in specialist housing and residential care. Another example, the Schedule for the Evaluation of Individual Quality of Life (SEIQoL), allows individuals to nominate, weigh and assess those domains of greatest relevance to their own quality of life (Browne *et al*., 1994). There are also questions about the extent to which such measures take into account physical and cognitive capacity (Boldy *et al*., 2006). Some writers make a useful distinction between general quality of life and health-related quality of life. This is supported by research carried out by Spiro and Bossé (2000), who conclude that these two notions are characterised by distinct and separate factors, despite being conceptually related.

The World Health Organization Quality of Life Group produced the following broad and comprehensive definition, which is now widely used:

> … an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, and standards and concerns. It is a broad-ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, and their relationships to salient features of their environment.
> (World Health Organization, 1993)

The term 'well-being' is widely used in the research literature, often interchangeably with 'quality of life' and sometimes with 'life satisfaction', but often without any attempt at a definition. Where definitions are discussed, they tend to focus on four aspects of lifestyle: physical, emotional, social and financial. Social well-being, the subject of this review, can be seen as a sub-set of general well-being and is slightly easier to define. At a basic level it is that aspect of overall well-being that relates to social interaction and engagement. However, much of the relevant literature includes social well-being as part of a wider concept of well-being, sometimes explicitly but more

often by implication. Discussions of social well-being in the literature tend to focus on factors such as social relations, social interaction, relationships, friendship networks and social support.

Similarly, the word 'frailty' is used widely throughout the literature in relation to older people, but here again there is a lack of consensus about its meaning and use. Often the term is used with minimal consideration of its precise meaning, but when definitions are included they are predominantly medical/biological in nature. These identify a range of chronic conditions that lead to body-wide deteriorations and a decline in physical activity (Hamerman, 1999). This can lead to an assumption that to be old is inevitably to be frail and that the older you are the more frail you become. Indeed, some writers assert that the state of frailty is largely inseparable from the ageing process (Bortz, 2002). In health prevention work a range of lifestyle factors are presented as increasing the likelihood of frailty, including smoking, depression and obesity (Woods *et al.*, 2005). Social gerontologists reject this construction of frail older people as 'a target population in the health and social care sectors' (Barrett, 2006). Instead, they propose a social model whereby the concept of frailty moves beyond purely physical conditions and is an outcome of the relationship between the individual and his or her environment. In this model, formal and informal support networks mediate the experience of frailty for the individual.

Financial and economic well-being is beyond the scope of this review, although the authors do recognise its importance and have included some examples of where specific financial considerations impact on social well-being, largely in terms of older people's ability to exercise choice and control on their environment, life quality and social interactions. Broader links between economic and social well-being have been widely discussed in the research literature (e.g. Burholt and Windle, 2006; Palmer *et al.*, 2006; Walker *et al.*, 2006).

In summary, in reviewing the literature it is difficult to separate the range of concepts that are discussed in terms of social well-being and quality of life. Therefore, although this review has a focus on social well-being, in order to provide a comprehensive and useful overview it will include literature relating to the broader concepts of well-being and quality of life. Irrespective of how 'frailty' is defined, it is likely to be an important factor in social well-being in housing with care settings. However, difficulties of definition and a paucity of literature that specifically focuses on frailty and well-being have led us to use the broader strategy outlined above.

Background

The promotion of mental health and well-being in later life has been the least visible area of activity in older people's care services (Age Concern, 2006). However, there is a growing research evidence base that highlights the importance of developing strategies for promoting well-being (Joseph Rowntree Foundation, 2004), which is reflected in recent government policy. For example, the adult social care Green Paper *Independence, Well-being and Choice* (Department of Health, 2005) identifies many potential benefits of promoting well-being for older people, including maintaining their social and economic contributions, minimising the costs of care and improving quality of life. A range of other government documents confirm the importance of the link between well-being, independence and choice (Department of Work and Pensions, 2005; Commission for Healthcare Audit and Inspection, 2006). It is interesting to note, therefore, that the concepts of independence and choice are also central to the philosophy of extra care housing.

Themes from the literature

Although there is considerable ambiguity around the use of the terms 'well-being' and 'quality of life' in the literature, there is far more consensus as to what are the main factors that promote them. For example, a UK survey of people aged 65 or over found that the most important factors in quality of life included having good social relationships, help and support and maintaining social activities. Similarly, a Swedish study asked older people which of eight categories were most important to their quality of life. The most frequent response was social relations, followed by health, activities, functional ability, well-being, personal beliefs and attitudes, living in their own home and personal finances. In addition, they were asked to choose three items that they regarded as important to quality of life. The authors concluded that social relations, functional ability and activities influenced the quality of life of older people as much as health status (Wilhelmson *et al*., 2005).

A recent Age Concern (2006) report, *Promoting Mental Health and Well-being in Later Life*, identifies five key areas that influence mental health and well-being in later life: discrimination, participation in meaningful activity, physical health, poverty and relationships (family, friends, pets, spiritual faith and belief).

In addition, social isolation (absence of meaningful relationships, lack of social contacts) is identified as a strong risk factor for poor mental health, which is experienced by a million older people in the UK. This work also emphasises the importance of intergenerational contact and identifies the need to encourage and

support older people to take advantage of opportunities for meaningful activity, social interaction and physical activity.

Marital status and aspects of people's living situations were shown to be important for well-being, while age, gender, race, and employment showed no consistent independent relationship. Exclusion is often identified as a barrier to social well-being. *A Sure Start to Later Life* (ODPM, 2006) suggests a range of factors that can contribute towards exclusion for older people, including the difficulties of escaping from mid-life exclusion, the impact of key life events such as bereavement and the impact of age discrimination on aspirations and the environment. A recent study carried out in Sweden and based on data from the European Study of Ageing Well (Borg and Blomqvist, 2006) concluded that life satisfaction in older people with reduced self-care capacity is determined by an interaction between social, physical, mental and financial factors.

There is increasing support for a preventative approach to promoting well-being. Godfrey *et al*. (2004) suggest the need to focus on opportunities for personal development and growth, adjustment to the experience of loss, engagement in social life, involvement in activities, intimacy/companionship, stimulation and social and practical support. Wistow *et al*. (2003) argue that well-being is an important component of successful ageing and call for a greater focus on promoting older people's quality of life and their engagement in the community.

The literature search on social well-being for older people as carried out for this review reveals a range of evidence and information. Much of this covers a broad range of overlapping themes, but for the purpose of providing a structured review it will be described under the following six headings:

- social interaction
- gender, marital status and parenthood
- the environment and well-being
- purpose, religion and spirituality
- exercise, activity and well-being
- the philosophy of care.

This review will now explore the literature under each of these headings in more detail, including a description of the evidence and discussion of the implications for good practice.

2 Social interaction

Much has been written about the social networks of older people (e.g. Phillipson, 1997) and there is widespread agreement on the role of social interaction in promoting well-being for older people across a range of settings. For example, a study of older people in three Canadian hospitals found that patients with higher social engagement scores also tended to have higher levels of well-being, particularly among those with more stable physical health (Gilbart and Hirdes, 2000). Similarly, Sugisawa *et al*. (2002) found that having a greater number of social contacts was associated with lower rates of depressive symptoms and Godfrey *et al*. (2004) concluded that interdependent relationships were the essence of 'ageing well' because of the way in which they met older people's needs for intimacy, comfort, support, companionship and fun. Some research literature even goes as far as suggesting that higher levels of social engagement are associated with lower mortality rates (Flacker and Kiely, 2003) and decreased risk of dementia (Sugisawa *et al*., 2002). A range of explanations have been suggested for the association between social interaction and well-being. For example, a study by Berkman *et al*. (2000) concluded that social engagement can provide older people with a meaningful social role and thereby promotes a sense of purpose and attachment. Wiggins *et al*. (2004) suggested that the negative impact of past events and experiences, as well as that of the immediate environment, can be ameliorated by the quality of the social contact that older people experience and how close they feel to people around them.

Some writers have distinguished between different types of relationships and their impact on well-being. For example, Litwin and Shiovitz-Ezra (2006) report that the quality of social ties matters more than activity participation per se as a predictor of a 'good' old age among Israeli retirees. Similarly, Granovetter (1983) suggests that weak ties between acquaintances contribute to social networks between groups, while the stronger ties that exist between friends are much more localised.

This theme of different types of relationship fulfilling different functions in the lives of older people across a range of living environments is also found in a Japanese study. For Ho *et al*. (2003), relationships with friends were related to life satisfaction for community-dwelling older people in Japan, whereas relationships with family were more important for those living in residential care. However, a Canadian study of older people living in the community found that the quality of social relationships that was more important to well-being than the quantity (Fox and Gooding, 1998).

There is a growing body of research that focuses specifically on social interaction within housing with care settings. Some studies have found relatively low levels of social interaction in long-term care settings (Clark and Bowling, 1989), particularly among residents who are older, cognitively impaired, widows or care givers (Stacey-Konnert and Pynoos, 1992). McKee, (1999) found that non-intimate friendships were more common than close friendships in these settings and that those with more friendships had higher levels of social activity. In their review of housing with care for later life, Croucher *et al*. (2006) concluded that more intimate and confiding relationships are most important in terms of maintaining a sense of well-being, although many of those reported by residents were with family and friends from outside their housing setting (Potts, 1997). Interestingly, Croucher *et al*. (2006) also reported that, while housing with care settings may be conducive to friendship and community formation for some, for others they could be alienating. This view is supported by Percival (2001), who identified the importance of social interaction but also acknowledged the potential challenge that it posed for older people in age-segregated settings. For example Nolan *et al*. (1995) reported that long-stay patients in continuing care units spent most of their time disengaged and isolated from human contact, while staff tended to interact with the more socially adept residents.

Social activities emerge from the literature as important in long-term care settings, largely because they provide one of the main opportunities for social interaction, particularly for residents in poorer health (Croucher *et al*., 2006). Findlay (2003) reviewed the empirical literature published over the last 20 years on the effectiveness of interventions that target social isolation among older people and concluded that, although numerous interventions have been implemented worldwide, there is very little evidence to show their effectiveness. A review by Cattan *et al*. (2005) found that educational and social activity group interventions targeted at specific groups are more effective than one-to-one interventions in terms of alleviating social isolation and loneliness among older people. There is evidence that some specific activities can be effective. For example, Chao *et al*. (2006) found that one-hour weekly sessions of group reminiscence therapy significantly improved self-esteem for nursing home residents and could enhance older people's social interaction with one another. An American study by White *et al*. (2002) found that new opportunities for communication provided by the internet can help reduce social isolation for older people in housing with care settings, although the figures for this trend were not statistically significant. However, it is important to recognise that social interaction does not necessarily equate with well-being and that some residents seek solitude (McKee, 1999; Vallelly *et al*., 2006).

O'Malley and Croucher (2005) identified a lack of research evidence in relation to the integration and segregation of people with dementia, particularly in mixed housing

settings where it is assumed that older people with different levels of need can live in close proximity. One such study has been carried out by Streib and Metsch (2002), who reported that people with cognitive impairments or mental health problems living in retirement communities are more likely to be socially isolated and possibly subject to resentment and hostility.

A wide range of literature identifies minimising isolation and exclusion as a way of promoting well-being. De Jong Gierveld and Van Tilburg (2006) found that having a small number of relationships is one possible factor in loneliness; other factors included the presence or absence of an intimate partner, family relationships, participation in clubs/church/etc., personality traits, gender and health. This led them to differentiate between emotional loneliness (missing an intimate relationship) and social loneliness (missing a wider social network).

Although much of the literature on social interaction in housing with care settings focuses on activities and relationships between residents, it is also important to recognise the value of social networks beyond the immediate environment. *My Home Life* (Owen, 2006), a report into quality of life in care homes, reported that activities that connect residents to the outside community are highly valued.

3 Gender, marital status and parenthood

Several studies have explored the impact of gender and marital status on well-being, with mixed results. For example, a study carried out in Thailand (Sobieszczyk *et al.*, 2003) found no significant gender differences between the oldest groups in terms of psychosocial indicators of well-being. However, reporting on a study of gender differences in physical health and psychosocial well-being among four age groups of older people in Israel, Carmel and Bernstein (2003) conclude that decline in health status and other losses experienced with ageing have a more significant effect on men's sense of control over life and therefore have a more deleterious effect on men's well-being than on that of women. Research carried out in American assisted-living facilities found that gender was an important factor in well-being for residents, with women reporting higher levels of life satisfaction and lower levels of depression than men (Cummings, 2002). Other important factors were identified, including functional impairment, perceived social support and participation in activities.

There is stronger evidence of an association between marital status and well-being for the population as a whole. Coombs (1991) reviewed over 150 empirical studies and found that married men and women were generally happier and less stressed than the unmarried, largely because of the role of partners in providing companionship and psychological support. This association appears to be particularly strong for older people. A study of older adults carried out in Holland by Peters and Liefbroer (1997) found that the loss or lack of a partner was more detrimental to males than females, irrespective of age, health and social network size. A Norwegian study reported lower levels of support and psychological well-being among widows and widowers compared to married individuals (Thuen *et al.*, 1997). There were also some indications that the perceived social support had a buffering effect on the psychological well-being of the respondents. A study by Bernard *et al.* (2004) of a retirement village in England found higher levels of loneliness among those living alone.

Parenthood is another factor that can impact on well-being for older people. Yamaguchi and Silverstein (2003) reported that weaker filial responsibilities and stronger affection for children predicted greater overall satisfaction with children, which in turn was positively associated with the older person's life satisfaction and a subsequent reduction in depressive symptoms among Japanese-Americans in a retirement residence. However, one North American study found no statistical evidence that childlessness increases loneliness and depression for divorced, widowed and never married older people (Zhang and Hayward, 2001). This study,

however, shows how complex the relationship between gender, marital status and parenthood may be. While gender did alter how childlessness and marital status influenced psychological well-being, divorced, widowed and never married men who were childless had significantly higher rates of loneliness compared with women in comparable circumstances. Divorced and widowed men who were childless also had significantly higher rates of depression than divorced or widowed women.

4 The environment and well-being

The built environment is important to all of us but particularly for people living in extra care housing and other similar environments, who are likely to spend considerable amounts of time within the housing scheme and which they may rely on to compensate for their physical or cognitive impairments (Day *et al*., 2000). The role of design in quality of life in such settings has been widely studied. For example, Parker *et al*. (2004) identified several areas of living through which design features can impact on well-being and quality of life, for both tenants and staff. These included choice and control, community, normalness, comfort and personalisation. They also suggested that stringent health and safety regulations in such environments could have a negative effect on the well-being of tenants by, for example, discouraging staff from allowing free access to outdoor spaces for fear of injury. A study of older Americans living in the community (Evans *et al*., 2002) reported that housing quality was associated with positive affect. Moreover, this association was mediated by place attachment, whereby older residents of higher quality homes felt more attached to their home, independent of multiple socio-demographic factors such as income and gender. Linked to this is the finding that keeping a well-maintained house is central to many older people's sense of well-being (Clark *et al*., 1998). For those older individuals who seek alternative accommodation because of isolation or loneliness, relocation to congregate-style accommodation may increase their social contacts and have a positive impact on their well-being (Buys, 2001). Croucher *et al*. (2006) conclude that, while housing with care offers opportunities for companionship and mutual support, there is consistent evidence of marginalised groups, particularly residents who are frail and/or cognitively impaired.

The Health Survey for England (Department of Health, 2002) found that men were more likely than women to perceive themselves as having a severe lack of social support and this self-perception was also more common in care homes than in private households. Men and women in private households were more likely to report a severe lack of social support if they had a serious disability than if they had no disability, while the reverse was true for men in care homes. Men who had been resident in a care home for more than a year were more likely to have a severe lack of social support than those who had been resident for less time, while no such association was seen for women.

Vallelly *et al*. (2006) suggest that design is an important factor in promoting social well-being for extra care housing tenants with cognitive impairment. In particular, they identify the provision of adequate facilities for shopping, communal eating and day centres as important to well-being, both as places for tenants to interact with

each other and people from the wider community and as sources of support for independence. The importance of dining rooms as the main social hub and their significance for friendship development was also highlighted by Williams (2000) in his study of a USA retirement community. However, he also concluded that they can lead to specific problems such as particular eating habits that lead to social exclusion.

There is a growing recognition of the role of outdoor spaces in promoting quality of life and well-being for older people (Chalfont, 2005; Owen, 2006). Specific benefits that have been identified include opportunities for exercise, provision of a different social environment, sensory stimulation, access to plants and wildlife, and therapeutic gardening. The importance of the outdoor environment in general is demonstrated by Ward-Thompson and Sugiyama (2006), who conclude that supportive outdoor spaces can encourage life satisfaction and health for older people by promoting a more active lifestyle. Similarly, a study carried out in Ireland by Leyden (2003) reported that pedestrian-friendly neighbourhoods that provide greater opportunities for walking can encourage social interaction. In addition, living near the main activity centre and sharing enclosed outdoor spaces can increase the likelihood of unplanned encounters and lead to greater 'place attachment' (Sugihara and Evans, 2000).

5 Purpose, religion and spirituality

There is a considerable literature regarding the potential benefits of spirituality, religion and a sense of purpose for older people. One American study found that older people with a strong sense of God-mediated control tend to have greater life satisfaction, more optimism, a higher sense of self-worth and lower levels of death anxiety (Krause, 2005). Crowther *et al*. (2002) emphasise the importance of including spirituality as a factor in successful ageing and present evidence to suggest that the addition of spirituality to interventions focused on health promotion has been received positively by older people. A British study of warden-controlled retirement housing found that spirituality was a significant predictor of psychological well-being and moderated the negative effects of frailty (Kirby *et al*., 2004). A similar study in Canada concluded that personal meaning, religiosity and spirituality contributed more significantly to well-being than demographic variables or other traditional measures such as social resources, physical health or negative life events, particularly for institutionalised older people (Fry, 2000).

However, Ardelt (2003) found that purpose in life rather than extrinsic or intrinsic religious orientation was positively related to community-dwelling older people's subjective well-being and negatively associated with fear of death and death avoidance. Pinquart (2002) suggested that maintaining high levels of purpose in life may become more difficult in older age because of increasing losses such as widowhood and retirement. His meta-analysis of findings from 70 studies found a small age-associated decline of purpose in life, which was stronger in older age groups. Purpose in life showed a strong association with social integration, psychological well-being and low levels of depressive symptom. Herzog *et al*. (1998) found some evidence to support their model in which well-being for older individuals is enhanced by the extent to which they see themselves as active, hard-working and competitive. Windle (2004) concluded that psychological resources are important in coping with change and well-being, particularly 'a sense of control'. This may be particularly significant for people moving into housing with care settings in later life.

6 Exercise, activity and well-being

In reviewing the extensive literature on activity and well-being, this report will look first at the impact of physical exercise before considering more general activities such as social events and activities.

Physical exercise

There is a considerable amount of evidence that physical exercise is effective in increasing muscle strength in older people, but the effects on quality of life are less clear (Chandler *et al.*, 1998). A study by Morgan and Bath (1998) found some support for the hypothesis that physical activity contributes to psychological well-being in later life, although they concluded that the contribution is extremely modest. However, physical activity interventions focusing on balance and resistance training can improve physical functions and prevent falls and disabilities in daily living (Kato *et al.*, 2006), which in turn can improve quality of life. Multiple-element interventions (e.g. advice as well as strategies to increase self-efficacy and motivation, and to eliminate barriers to participation) tailored to individual activity preferences were likely to be more successful than more prescriptive single-focus interventions. A Japanese study concluded that a physical therapy programme could successfully enhance the independence of older people. Overall, it seems likely that the benefits of physical exercise are greater for those who are physically frail than for healthy older people (Judge *et al.*, 1994), and may increase their ability to perform activities of daily living. Reduced ability to perform everyday tasks has in turn been associated with worsening life satisfaction, particularly among those aged 85 and over (Bowling *et al.*, 1997). This is supported by a study of people over 65 in Australia, which found that major illness in itself did not necessarily lead to low scores for well-being (Kendig *et al.*, 2000). Crucially, it was the effect of poor health in terms of limiting the opportunities for activity that often led to lowered well-being. The benefits of therapeutic exercise have been demonstrated for people with a range of physical frailties including those who have had a stroke (Duncan *et al.*, 2003).

The role of activities across the broad spectrum of physical functioning, social interaction and well-being has been recognised by the Government (Social Exclusion Unit, 2005), the College of Occupational Therapists and the National Association of Providers of Activity for Older People. The latter aim to produce a joint benchmark document that addresses the national standards. These relate to the provision and inspection of activities and meaningful occupation for older people, particularly those

living in residential and nursing home settings. Older people represent a high-risk group for depressive symptoms and depression is recognised as one of the most frequent mental health problems among older people (Blazer, 2003). This makes the potential benefits of activity particularly important. In a review of over 90 studies, Gauvin and Spence (1996) found a consistent association between physical activity and psychological well-being, although the underlying mechanisms are seldom defined.

Singh *et al*. (2000) suggest that exercise is an effective alternative treatment for major depressive illness, while a literature review by Scully *et al*. (1998) concluded that physical activity had a positive impact on depression, anxiety and general mood. However, a study carried out in the Netherlands concluded that neither strength training nor all-round, functional training of moderate intensity is effective in improving quality of life, vitality or depression of older people living in long-term care facilities (Marijke *et al*., 2004). Menec (2003) found that higher activity levels for older people are associated with greater well-being (life satisfaction and happiness), particularly for creative and social activities. A randomised controlled trial carried out in the USA found that a physical exercise programme can lead to improvements in terms of esteem and self-image for older people (McAuley *et al*., 2000a). Another study by the same researcher (McAuley *et al*., 2000b) found that physical activity interventions can have a positive effect on subjective well-being and social relations among older people living in the wider community.

There is a growing amount of research into the impact of rehabilitative activities on people with cognitive impairment (Jorm, 1994). This is particularly important for settings such as extra care housing where a significant proportion of tenants have dementia and other forms of cognitive impairment at a level that can interfere with daily living. A Cochrane review published in 2003 (Clare *et al*., 2003) found a lack of strong support for the use of cognitive training interventions for people with early stage dementia, but concluded that there is an insufficient body of evidence from random controlled trials to reach a definitive conclusion. Studies using other methodologies have found support for the benefits of rehabilitation for memory problems (Clare, 2001) and the performance of activities of daily living (Rogers *et al*., 1999). There is also convincing evidence from randomised trials that exercise training increases fitness, physical function, cognitive function and positive behaviour in people with dementia and related cognitive impairments (Heyn *et al*., 2004).

Social activities and occupation

A common characteristic of housing with care settings is the provision of some element of social and occupational activity for residents. The Health Survey for England 2000 (Tait and Fuller, 2002) provided some interesting statistics on the involvement of older people in activities. Women in care homes took part in more activities than men, while those over 80 participated less than those from 65 to 79. Women and men with high General Health Questionnaire scores had similar levels of social participation but, among those with lower scores, women were twice as likely as men to take part in five or more activities. Older people with severe cognitive impairment were more likely to take part in five or more activities than those with no impairment.

Vallelly *et al*. (2006) found that activities were received positively by older people with dementia living in extra care housing. However, there were considerable differences between housing schemes in the number and range of activities provided, partly because of different staffing and funding arrangements. Similarly, Perrin (1997) identified a dearth of occupational provision for people with dementia in specialist care units, with most spending the majority of their time unoccupied, supported by staff who failed to interact in a meaningful way. Another UK study of people between the ages of 50 and 74 found that overall activity level was associated positively with well-being and life satisfaction (Warr *et al*., 2004). In particular, activities in the family and social sphere and the church and charity domains were found to be important. In contrast, a study of active older people living in the community in the USA found that engaging in more activities does not necessarily enhance well-being (Everard, 1999). The type of activity was more important and activities engaged in for social reasons were more closely linked to well-being than other activities. As with physical exercise, there is some evidence that the impact of social activities may be greatest for people with physical frailties. An American study (Atchley, 1998) found that, for older people with functional limitations, maintaining a stable activity level by increasing participation in activities that remained to offset declines or losses in other activities (consolidation) resulted in higher levels of morale compared with those who did not consolidate.

A number of studies have looked at specific types of social activity in terms of their impact on well-being. One Scottish study found that older people who took part in community singing experienced physical, emotional, social and cultural benefits as well as increased social well-being (Hillman, 2002). Activities that involve humour have also been shown to improve well-being and quality of life for older people in residential settings (Houston, 1998). In this UK study, residents who participated in a humorous activity were found to have significantly reduced levels of anxiety, as

measured by the General Health Questionnaire, and significantly reduced levels of anxiety and depression, as measured by the Hospital Anxiety and Depression Scale, when compared to residents who received no intervention.

This review has already discussed the importance for older people of access to gardens and other outdoor environments as social spaces. Gardens have other potential benefits in housing with care settings. A study by Heliker *et al*. (2000) found that a structured gardening intervention could have psychological and spiritual benefits for older adults, which transcend socio-economic, educational and cultural boundaries. They concluded that such an activity is a cost-effective therapeutic option. Similarly, Midden and Barnicle (2003) reported that horticultural activities may have a beneficial effect on the current psychological well-being of older people in a long-term care facility and Bertera (2003) identified the potential benefits of outdoor activities such as gardening and walking in terms of increased social contact.

Analysis of data from the American's Changing Lives study found that older adults who volunteer and who engage in more hours of volunteering report higher levels of well-being (Morrow-Howell *et al*., 2003). This finding has been replicated in Canada, where Narushima (2005) found that the self-help and transformative mechanisms embedded in community volunteering provide opportunities for retirees to sustain their self-esteem and sense of well-being.

In addition, music has been shown to have a wide-reaching impact on the well-being of older people across a range of settings. Hays and Minichiello (2005) reported that, for older Australians living in the community, music contributes to positive ageing by providing ways for people to maintain positive self-esteem, feel competent and independent, and avoid feelings of isolation or loneliness. A range of specific therapeutic benefits of music therapy have been identified in research, including effective treatment of a range of dementia symptoms (Koger *et al*., 1999; Brotons and Koger, 2000), and there is a growing body of robust quantitative research on the impact of music in a variety of health-care settings for adolescents (Gold *et al*., 2004), oncology patients (Pothoulaki *et al*., 2005) and more widely (Vink and Bruinsma, 2003). An Australian study found that music provides older people with a number of potential benefits (Hays and Minichiello, 2005). These include ways of understanding and developing their self-identity, connecting with other people, maintaining well-being, and experiencing and expressing spirituality. It can also provide strong associations with and memories of a person's life, and is used as a source of entertainment as well as a forum to share and interact with others. Music was described as a personal experience to which people assigned meaning and emotions. The informants also described how music allowed them to engage in imaginative play and to escape from some of the hardships experienced in later life.

7 The philosophy of care

There is a body of literature highlighting the general impact of the overall philosophy of care provision on well-being in housing with care settings.

Armstrong-Esther *et al*. (1994) identify a general lack of stimulation and low levels of staff–patient interaction for older patients in nursing care settings. This is supported by a review carried out by Nolan *et al*. (2004), who conclude that the picture is particularly bleak in long-stay and continuing care environments, largely because activity tends to be centred on the provision of personal care and the meeting of minimal universal needs. As an alternative approach, they suggest that relationship-centred care offers significant advantages in terms of quality of life for older people. Drawing on 'The Senses Framework', they identify six dimensions of care: a sense of security; a sense of continuity; a sense of belonging; a sense of purpose; a sense of fulfilment; and a sense of significance. They call for care environments that initiate interaction with even the most dependent of patient populations to provide meaningful activities that meet the needs of disparate patient groups, while simultaneously allowing patients not to participate if that is their wish. Finally, they echo the conclusions of Crump (1991), that a failure to provide for such needs among older people is tantamount to abuse. Similar concerns are raised by Dewing (2004) who explores a range of relationship-based nursing frameworks and concludes that the concept of personhood needs further clarification. Issues of person-centred care are also raised by Evans and Means (2006), who advocate the use of person-centred risk assessment strategies in order to maximise independence for people with dementia in extra care housing. Another aspect of person-centred care is the opportunity for service users to be involved in decisions about care delivery and service development on an ongoing basis. This approach is increasingly promoted as central to a sense of well-being for frail older people (Audit Commission, 2004), and specifically in housing with care settings (Owen, 2006). However, a recent study (Abbott *et al*., 2000) found that older people in a range of residential settings did not participate in decision making, and identified a need to change both attitudes and practice to enable older people to participate more fully.

The social environment has already been identified as crucial to well-being in housing with care settings. Timko and Moos (1990) found that the overall philosophy of care and staffing levels were the main factors in determining which social environment existed. Their study of group residential facilities in the USA identified a number of types of social climate, ranging from 'supportive, self-directed' to 'unresponsive'. The social climate was associated with opportunities for residents to develop friendships, levels of well-being, the extent to which activities were self-initiated and the degree of use of health services.

8 Summary and conclusions

This review aimed to examine the literature concerning best practice in promoting social well-being for frail older people in housing with care. The nature of the literature as revealed by a scoping search led to the need to broaden the search to include wider definitions of well-being/quality of life and a range of long-term care settings. Within these parameters, the following six key themes have been identified: social interaction; gender, marital status and parenthood; the environment; purpose, religion and spirituality; exercise and activity; and the philosophy of care.

There is widespread consensus concerning the importance of social networks and social interaction to quality of life and psychological and social well-being. The impact of social interaction comes through its role in meeting older people's needs for intimacy, comfort, support, companionship and fun. By contributing to a sense of purpose and attachment, social interaction can also ameliorate the negative impact of past events and experiences. The logical conclusion of this literature is that interventions that minimise social isolation can help increase social well-being.

There is mixed evidence regarding levels of social interaction in residential care settings compared with that for older people generally. Overall, it seems that people in such settings who are physically frail and/or cognitively impaired have lower levels of social interaction than other residents. The literature examines different types of social interaction in housing with care settings and concludes that there are more non-intimate relationships than intimate ones in these settings. However, it is the intimate relationships that are most important in terms of sense of well-being and, crucially, many of these are with family and friends from outside their housing setting. The importance of connections and networks in the wider community outside housing with care settings is a recurring theme in the literature. It is also important to note that, while housing with care settings may be conducive in terms of friendship for some, they can be more challenging for less socially adept residents, including people with cognitive impairment and mental health problems.

Organised activities provide the main opportunity for social interaction in housing with care settings, particularly for long-term residents in poor health who may have problems getting out. Some specific activities have been shown to have an impact in certain settings. For example, regular reminiscence groups can increase self-esteem in nursing homes and access to the internet can increase social interaction. A range of specific interventions have been implemented to target social isolation but there is little evidence of what works. Not surprisingly, group activities appear to be more effective than those that operate on a one-to-one basis. Another key finding is that

some residents seek solitude rather than social interaction; the important thing is to have the opportunity and choice to interact or not.

There is contradictory evidence from the literature regarding the association between gender and well-being in older age. This can be explained partly by the different nature of male and female social networks and the reluctance of older men to take part in organised social events. Some studies have suggested that significant negative life events such as widowhood have a more damaging effect on men's psychological and social well-being than on that of women.

For the population as a whole, married men and women report greater levels of happiness and lower levels of stress than the unmarried and this trend appears to be particularly strong for older people. The role of partners in providing social and psychological support seems to be important in terms of well-being.

There is little research evidence regarding parenthood and well-being for older people and what does exist is inconclusive. This may be largely because of the seemingly complex relationship between gender, marital status and parenthood as factors. There is considerable evidence that family carers provide extremely high levels of support to many people in a range of housing with care settings. It would seem logical therefore that those without such support might have lower levels of well-being, but this review found no studies that specifically explored this issue.

There is a broad literature that acknowledges the importance of the built environment, particularly for people in long-term care settings who may rely on it to compensate for physical and cognitive impairments. Some studies have linked the design of housing with care settings with quality of life and a range of factors have been identified as important, including choice and control, a sense of community, normalness, comfort and personalisation. It has also been suggested that stringent implementation of health and safety regulations in such environments can have a negative effect on the well-being of tenants, particularly those with physical and cognitive impairments. For example, the fear of injury can discourage staff from allowing free access to outdoor spaces.

Facilities play an important role in providing venues and opportunities for social interaction and the development of friendships. The provision of communal eating areas is of particular importance, although some writers have suggested that they can also have a negative impact by contributing towards the feeling of an institutional environment. Access to gardens and other outdoor spaces is increasingly seen as important in the literature. The benefits of these include opportunities for exercise, provision of a different social environment, sensory stimulation, access to plants and wildlife, and the therapeutic effects of gardening.

There is a wide range of research literature that identifies the potential benefits of promoting purpose, religion and spirituality for older people, particularly in long-term care settings. These include greater life satisfaction, higher levels of optimism, a greater sense of self-worth and lower levels of death anxiety. One study found that spirituality was a significant predictor of psychological well-being and moderated the negative effects of frailty. Personal meaning, religiosity and spirituality contributed more significantly to well-being than demographic variables or other traditional measures such as social resources, physical health or negative life events, particularly for institutionalised older people. However, another study found that purpose in life rather than extrinsic or intrinsic religious orientation was positively related to community-dwelling older people's subjective well-being.

Purpose in life also has a strong association with social integration, psychological well-being and low levels of depressive symptom. However, there is some evidence that a feeling of purpose in life may be reduced in older age because of increasing losses such as widowhood and retirement.

The link between physical exercise and well-being/quality of life is unclear. Any positive effects appear to be fairly modest but may be greatest for those who are physically frail. There is, however, some evidence that moderate physical activity such as walking can prevent cognitive impairment and dementia. Also, physical activity interventions focusing on balance and resistance training can improve physical functions and prevent falls and disabilities in daily living. Reduced ability to perform everyday tasks has in turn been associated with lower life satisfaction, particularly among those aged 85 and over. Crucially, it appears to be the effect of poor health in terms of limiting the opportunities for physical activity that often leads to lowered well-being.

The importance of a range of organised activities in long-term care settings has been widely recognised by Government and health organisations. Research has shown that women in care homes take part in more organised activities than men and younger residents take part in more activities than those aged 80 or over. Overall, activity level is positively associated with well-being and life satisfaction for people between the ages of 50 and 74. Activities engaged in for social reasons are more closely linked to well-being than other types of organised activity. As with physical exercise, there is some evidence that the impact of social activities may be greatest for people with physical frailties. There is some evidence for the benefits of specific activities. For example, singing can improve social and emotional well-being; activities involving humour have been found to reduce anxiety and depression; gardening has therapeutic benefits and increases social contact; and volunteering has a positive impact on self-esteem.

There are considerable differences between housing with care schemes in the number and range of activities available and a dearth of occupational provision for people with dementia in specialist care units. Most of the latter spend the majority of their time unoccupied and there is little meaningful interaction between staff and this client group.

The overall philosophy of care in an organisation and within specific housing with care settings can impact greatly on the social environment and therefore on levels of well-being. Activities in many long-term care settings tend to focus on the provision of personal care and the meeting of minimal universal needs. This can lead to a lack of stimulation for residents and low levels of staff–patient interaction. Attitudes to health and safety and risk can also be barriers to social interaction. Some authors have suggested that relationship-centred care offers significant advantages in terms of quality of life for older people.

Opportunities for service users to be involved in decisions about care delivery and service development on an ongoing basis are increasingly seen as central to a sense of well-being. However, older people in a range of residential settings appear to have relatively low levels of participation in such decision making.

Overall, this review has identified some key factors in promoting social well-being for older people. Although the literature relates to a wide range of environments, it is likely that much of the best practice highlighted is relevant to extra care and other housing with care settings. The review has also revealed the complex nature of the interaction between a range of factors in promoting well-being. For example, access to good food through an on-site restaurant or dining room can be important to nutrition, which has been shown to be associated with high levels of well-being. Issues of terminology were discussed, focusing on the lack of clear definitions in the literature of ‘well-being’ and ‘frailty’. Finally, this review has concluded that there are considerable gaps in the research literature in the area of social well-being for older people in housing with care settings.

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Appendix: Literature sources

Electronic databases

AgeInfo
ASSIA CSA
British Library Direct
Caredata
Cochrane
Humanities Index 1990–2004
International Bibliography of the Social Sciences 1951–2004
ISI web of knowledge – covers web of science databases ISI proceedings and Journal Citation Reports Index
Medline Ovid 1966–May week 4 2004
PAIS ARC2
Planex
PsycINFO
Sigle ARC2
Social Science MIMAS
Sociological Abstracts 1969–2004/06 ARC2

Websites

Abbeyfield Houses Society of Canada http://www.abbeyfield.ca
Abbeyfield Society http://www.abbeyfield.com
ACH Group (Australia) http://www.ach.org.au
Age Concern http://www.ageconcern.org.uk
Aged and Community Services Australia http://www.agedcare.org.au
Alzheimer's Society http://www.alzheimers.org.uk
Anchor Trust http://www.anchor.org.uk
Audit Commission http://www.audit-commission.gov.uk
Australian Government Department of Health and Ageing http://www.health.gov.au
Australian Housing and Urban Research Institute http://www.ahuri.edu.au
Bield http://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 http://www.cpa.org.uk

Centre for Sheltered Housing Studies http://www.cshs.co.uk
Communities Scotland http://www.communitiesscotland.gov.uk
Department of Health http://www.dh.gov.uk
Department of Housing and Urban Development (USA) http://www.hud.gov/
Emerging Role of Sheltered Housing http://www.shelteredhousing.org/
Engineering and Physical Science Research Council http://www.epsrc.org.uk
EQUAL (Extending Quality of Life) http://www.equal.ac.uk
ESRC http://www.esrc.ac.uk
Europa (English language version) – ageing and later life http://europa.eu.int/
(The) ExtraCare Charitable Trust http://www.extracare.org.uk
Fifty5plus.com http://www.fifty5plus.com
Growing Older: ESRC Research Programme on Extending Quality of Life
http://www.shef.ac.uk/uni/projects/gop/index.htm
Guinness Trust Group http://www.guinnesstrust.org.uk
Hammond Care Group (Australia) http://hammond.com.au
Hanover Housing Trust http://www.hanover.org.uk
Help the Aged http://www.helptheaged.org.uk
Housing Corporation http://www.housingcorp.gov.uk
Housing 21 http://www.housing21.co.uk
Institute of Gerontology, King's College London
http://www.kcl.ac.uk/ kis/schools/life_sciences/health/gerontology/index.php
It's Your Life http://www.itsyourlife.com.au
Joseph Rowntree Foundation http://www.jrf.org.uk/home.asp
National Housing Research Committee (Canada) http://www.nhrc-cnrl.ca/cmhc/
Office of the Deputy Prime Minister (ODPM) http://www.odpm.gov.uk
Scottish Executive http://www.scotland.gov.uk
Sheffield Institute for Studies on Ageing http://www.shef.ac.uk/sisa/
Simon Fraser University Gerontology Research Centre (Canada)
http://www.sfu.ca/rgrc
Social Care Institute for Excellence http://www.scie.org.uk
Social Gerontology Group (Sweden) http://www.soc.uu.se/research/gerontology
Stimulating Social Policy in an Ageing Society Research Group, LSE
http://www.lse.ac.uk/Depts/sage/
US Department of Health and Human Services (US equivalent of Department of
Health and Department of Work and Pensions) http://www.hhs.gov/
US government websites http://www.fedworld.gov/
US National Institute on Aging http://www.nia.nih.gov/
Welsh Assembly http://www.wales.gov.uk