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Social Well-Being in Extra Care Housing: An Overview of the Literature

Lisa Callaghan

PSSRU Discussion Paper 2528
March 2008

The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** undertakes social and health care research, supported mainly by the United Kingdom Department of Health, and focusing particularly on policy research and analysis of equity and efficiency in community care, long-term care and related areas—including services for elderly people, people with mental health problems and children in care. The PSSRU was established at the University of Kent at Canterbury in 1974, and from 1996 it has operated from three sites:

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Introduction

This literature review was carried out as the part of a Joseph Rowntree Foundation funded project investigating social well-being in extra care housing. An interim report from the project, describing the methodology and reporting some very early findings, is also available (Callaghan et al., 2008). The aim of the review was:

- To identify how social well-being has been defined in the literature
- To identify what factors affect social well-being
- To identify how social well-being could be measured in the present study

Another recent review by Evans and Valletly (2007a) explores the literature in greater depth, identifying best practice for promoting social well-being in extra care housing.

A number of themes were used to structure the review. First, the literature on well-being and quality of life in later life was reviewed and the definition of social well-being investigated. Social well-being is the area of overall well-being involving social relationships, social participation, social networks, and social support. Feelings of having a ‘social role’ or identity also play a part in this aspect of well-being. For the older people taking part in this project, social well-being is likely to be crucially influenced by moving to a housing–with–care setting. Therefore, the review focused on the effect of environmental characteristics (e.g. design, the philosophy of care) as well as both concrete and perceptual social factors (e.g. activity participation, social support, feelings of loneliness) on well-being.¹

In terms of environmental characteristics, we reviewed the literature in the areas of physical design, approach taken to activity provision within the housing/care setting, links with the local community, and staffing and care. The literature on social factors included friendships and social support, loneliness and isolation, social activity and participation, and social climate.

¹ Searches were conducted of a number of databases, including PsychInfo, IBSS, ISI Web of Science, BOPCAS, Cochrane, AgeInfo, Social Care Online, PubMed, and CommunityWISE. Internet searches were used to identify any additional material.

Overview of the Literature

Definitions

Social Well-Being

In reviewing the literature, it became apparent that there was no clear definition of social well-being, and few studies offered a theoretical basis for the concept. Traditionally, social well-being has often been seen as relating to a person's external social circumstances – their social economic status, life circumstances, and more widely the influence of the area that they live in or even their country of residence (Larson, 1993). England (1998) for example, in an article on the measurement of social well-being, takes an economic point of view and discusses the use of Gross National Product as an indicator of social well-being. However, using such proxies for social well-being runs the risk of ignoring social well-being from a personal, psychological perspective; in attempting to measure social well-being, it would seem important to capture aspects such as social support, social networks and friendships.

Larson (1993) does provide a framework for social well-being. Building on the work of McDowell and Newell (1987), social well-being is seen as being composed of two elements:

- *Social adjustment*: composed of satisfaction with relationships, performance in social roles (including social participation and social behaviour), and adjustment to one's environment.
- *Social support*: composed of the number of contacts in one's social network, and satisfaction with those contacts.

This definition seems useful, as it encompasses both subjective (e.g. satisfaction with relationships) and objective (e.g. number of contacts) aspects of social well-being.

Keyes (1998) is another author presenting a conceptual and theoretical base for social well-being. Working from a sociological and social psychological basis, Keyes (1998) proposes that well-being has a social foundation, and offers the following definition:

‘Social well-being is the appraisal of ones’ circumstance and function in society’
(p.122).

Based on existing theory and concepts, he goes on to suggest that individual social well-being is composed of the following five elements:

- *Social integration*: an individual's evaluation of the quality of their relationships to society and their community.
- *Social acceptance*: an individual's construal of society through the character and qualities of others; this is based on the idea that an individual who is socially accepting of others will hold favourable views of people in general, and will feel comfortable interacting with them.
- *Social contribution*: an individual's evaluation of their social value; the belief that they have something to give, and are valued by society as a whole.
- *Social actualisation*: belief in the evolution of society, and the conviction that there is hope and potential for society, which can be realised through its members and institutions.
- *Social coherence*: an individual's perception of the quality, organisation and operation of the social world; care for and understanding of the world they live in.

Keyes (1998) notes that the structural elements of a person's life will also affect their social well-being, and mentions in particular the influence of social stratification and aging. An individual's social well-being (as defined by Keyes) will naturally change throughout the life course, with getting older affecting a person's resources and perceptions. Interestingly, Keyes (1998) found that social integration, social acceptance, social contribution and social actualisation all increased with age. Social coherence on the other hand was found to decrease, which Keyes suggests may be attributable to the pervasiveness of 'youth culture' in modern society.

Of interest to the current project is the influence of old age on social well-being, but also the influence of moving to a new community (an extra care housing scheme) which will affect the individual's resources, both instrumental and social. Some of the five elements outlined by Keyes (1998) may be applicable to the extra care housing setting.

The conceptions of social well-being proposed by Larson and Keyes do seem helpful. Both cover a range of factors, and will be useful in informing the areas that we could cover when looking at social well-being in extra care housing (ECH). However, neither seems an entirely complete definition of social well-being. For example, Keyes does not cover the issue of social support, while Larson, although including adjustment to the environment as an element of social well-being, does not really take into account the

individual's role in wider society in the same way as Keyes. Many other studies use social networks, social support or levels of isolation alone as proxies which, whilst highlighting important aspects contributing to social well-being, do not necessarily reveal the complete picture. In the extra care housing setting, it is also important to consider aspects of the scheme – such as physical design, and links with the local community – when attempting to measure social well-being.

Quality of Life and Well-Being

The area of quality of life and general well-being is extremely broad, and there is a vast amount of literature even when looking at only that involving older people. One of the main issues is that of definition – there is little agreement among researchers as to how quality of life and well-being should be defined and measured, and this has differed according to discipline (Rapley, 2003). Nonetheless, it is important to recognise that social well-being is just one aspect of the wider concepts of overall well-being and quality of life (Bowling, Gabriel, Dykes, et al., 2003).

In research on quality of life and well-being in older people, social aspects have emerged as particularly important (e.g. Age Concern, 2003; Bowling et al., 2003; Gabriel and Bowling, 2004). Older people themselves indicate that having good social relationships, having a 'social role', and taking part in social activities are crucial to their quality of life.

So, social well-being can be seen as the area of overall well-being involving social relationships, social participation, social networks, and social support. Feelings of having a 'social role' or identity may also play a part in this aspect of well-being. For the older people taking part in this project, social well-being is likely to be crucially influenced by moving to a housing with care setting. Therefore, our literature review focussed on the effect of environmental characteristics (e.g. design, the philosophy of care) as well as both concrete and perceptual social factors (e.g. activity provision, social support, feelings of loneliness).

Scheme Characteristics

When older people move to an extra care scheme, they are moving into a new environment. Even if residents move to the scheme from existing sheltered housing, they are nonetheless entering a place which may be different in many ways to their previous accommodation. Each scheme will be different in some way, whether in its

design, its population characteristics, or the way in which it is run. We expect these different features to affect an individual's wellbeing through their effect on the social climate of the scheme, the type, rate and quality of social activities, and on various social aspects as perceived by the individual.

Design

Brawley (2001, p.77) suggests that 'Good design directly impacts quality of life', and it is likely that the way in which an extra care scheme is designed will have an effect on well-being through its effect on social aspects. For example, if a scheme has a number of well-designed communal areas which are welcoming and accessible by all, social interaction may be encouraged. In fact, Riseborough and Fletcher (2003) state that one of the 'main ingredients' of extra care housing is that its design allows for a range of social activities to take place.

Design features have been found to have an affect on social interaction. For example, Zaff and Devlin (1998), in a study of four public housing complexes for the elderly in the USA, found that social interaction was more likely to occur in those sites where there was more semi-public space. These spaces helped in the development of social networks, and also added to residents' sense of belonging. Sugihara and Evans (2000), in a study of Continuing Care Retirement Communities (CCRCs) in the USA, found that various design features (walking distances from individual homes to the main activity centre of the CCRC, likelihood of unplanned social encounters near one's home, and location of gardening areas) were linked to the development of social networks and also a sense of attachment to the CCRC. In Britain, Percival (2000) found that communal lounges in sheltered housing schemes were used for formal social activities, but because of the way they were designed (for example, their large size) were not places where people tended to meet informally.

An important way in which the physical environment of a building can impact upon well-being is through *control*. The way a building is designed can affect the amount of actual or perceived control an individual feels they have over their environment, which is in turn related to psychological distress (and therefore has a negative effect on well-being). Evans and McCoy (1998), in an article discussing how buildings affect human health, suggest that the built environment may have an effect on an individual's health through the effect on psychological stress. They propose five dimensions of architectural design that may have an effect on health via stress, one of which is control, defined as 'the ability to either alter the physical environment or regulate exposure to

one's surroundings.' (p.88). Indeed, an important issue in housing for the elderly is that of choice and control (Parker et al., 2004). Parker et al., (2004) found that well-being among older people living in residential or nursing homes was associated with design which provided choice and control (for example, in access to indoor and outdoor spaces and facilities). Oldman (2000), reviewing two extra care schemes in York, found that compared to when living in their previous accommodation, residents were now more able to carry out activities such as cooking for themselves due to the design of their living space, which in turn affected their well-being. Similarly, it has been found that the ability to maintain a well-kept home is important to many older people's sense of well-being (Clark et al., 1998).

Privacy is an important aspect of control; in fact, it has been found to be the most important aspect of the environment for some older people (Morgan and Stewart, 1998), and has also been linked with quality of life (Ball et al., 2000). Duffy et al., (1986), in a study of nursing home design, found that residents preferred designs which afforded more privacy, leading the authors to suggest that if residents felt that they had more privacy, they may be more inclined to interact socially – they would make the choice to do so. An individual needs to have some 'defensible space', an issue which is met in extra care housing through the idea of having 'your own front door' with individual flats seen as an individual's home (Riseborough and Fletcher, 2003). Evaluations of extra care housing schemes to date have indicated that this feature has been particularly praised by residents (e.g. Bartholomeou, 1999; Brooks et al., 2003).

Linked to this is the idea of progressive privacy, where the building is designed so that different areas are private, semi-private, or semi-public, ideally to ensure that residents feel a sense of control through this. For example, there should be areas in which people from outside the scheme can enter only if invited in – so that, for example, an individual can entertain guests without needing to invite them into their own room/flat unless they wish, or groups from the community can come in to provide entertainment or a service (Baker, 2002; Barnes, 2002). Again, Riseborough and Fletcher (2003) cite progressive privacy as an important aspect in the design of extra care housing.

Oldman (2000) points out that the different providers of extra care housing have different views regarding the ratio of communal space to private space; some provide a small number of communal facilities in order to create a more domestic feel, while others provide a large number of communal facilities and areas with the aim of promoting social interaction and creating a lively community. A particular issue lies in the provision of communal dining rooms; there is some evidence that they are important

in providing a forum for developing friendships (see Croucher et al., 2006), and have been described as the ‘social hub’ of a retirement community (Williams, 2000). On the other hand, others have suggested that they can make a facility feel ‘institutional’, and should therefore be avoided. A recent study of remodelling sheltered housing and residential care homes for extra care housing recommended that meals in this setting should preferably be provided in a communal dining room to provide opportunities to socialise (Tinker et al., 2007).

Bernard et al., (2004) in an evaluation of Berryhill, a large retirement village with a large number of communal facilities including a gym, craft rooms and computer rooms, found that many of these facilities were under used. However, Croucher et al., (2003), in a study of a British CCRC, found that:

‘The range of amenities and facilities at Hartrigg Oaks was widely praised and seen to be key in promoting the development of social networks ... the opportunity to take part in on-site activities was greatly valued’ (p. 35).

Along with the overall building design and the design of inside space, the design of *outside* space may also have an affect on well-being, in part via social aspects. As mentioned above, an aspect of control in housing for older people may be having the choice to go outside. Additionally, the way in which outside spaces are designed is important; there would be little point in having a garden if it was not user friendly, and indeed it has been found that outdoor spaces in care settings are often under-used (Cohen-Mansfield and Werner, 1999). Barnes (2002) suggests that:

‘Outside spaces are often added to care homes as decorative features without thought being given to their therapeutic benefit. Well-conceived external environments can provide older people with spaces for privacy, activity and stimulation, all of which can contribute to an improved quality of life (Brawley, 2001, p.782).

Similarly, another dimension of design proposed by Evans and McCoy (1998) as potentially affecting health via stress is *restorative*, meaning ‘... the potential of design elements to function therapeutically, reducing cognitive fatigue and other sources of stress.’ (p. 90).

Two design elements relating to this are *retreat* and *exposure to nature*. Having a garden in the scheme could meet needs in both of these areas by offering the individual

a way of ‘escape’ from the inner world of the scheme, and by also affording direct contact with the natural world. As noted above, if an individual has opportunities for privacy and solitude, they may be more likely to wish to interact socially. The presence of a well-designed garden in an extra care scheme may also have a more obvious effect on social well-being by providing a common interest for some people (and thus a talking-point), and by being another area for social interaction, either via a gardening club or as an informal meeting place. To sum up, Chalfont (2005) suggests that ‘Activities involving communal gardening spaces impact wellbeing both personally (the person individually) and socially (the person within their social network)’ (p. 7).

Approach to Activity

The approach taken to social activity may vary between each scheme. The approach taken is likely influence the type of activity available, levels of participation (which we expect to have a knock-on effect on an individual’s perceptions of social support, friendships and isolation), as well as overall social climate – all things which we can expect to influence overall well-being.

Given the current emphasis on user involvement in current Government programmes and policy statements (Carter and Beresford, 2000), it would seem particularly important to look at what taking a user-led approach to activity actually means. In practice, a user-led approach could evolve in a variety of ways, each of which could face particular problems, for example:

- Social activity could start off as being led by the manager or staff (e.g. activities coordinator) with the aim of gradually being handed over to residents. A potential problem here is that the hand-over does not work properly, meaning that activity is not determined by residents in any way.
- Staff may nominate or ask for volunteers to form an initial group of residents to lead and set up social activities, with the aim of expanding this smaller group to the residents as a whole. A potential problem here is that this may not happen, meaning that some residents’ views regarding social activities available are not heard. Further, this may encourage the development of ‘cliques’, or could lead to resentment among those residents not initially involved.
- The social side of life in the scheme may be left entirely to the residents with no input from staff at the initial stage. However, in practice, it may be that nothing is set up, potentially leading to isolation and loneliness (which is of course something which the concept of extra care seeks to avoid). Alternatively, some

residents may take the lead but run the risk of creating resentment among other residents; cliques could occur anyway.

In their report on models of involvement for older people, Carter and Beresford (2000) suggest that a user-led approach can have various strengths and weaknesses. A strength particularly applicable to social activities in extra care is that, if users are involved, the outcome is more likely to reflect their preferences and provide what they want. This is important if people are to feel satisfied with social aspects of the scheme – one resident of Runnymede Court (Baker, 2002) commented that ‘They have entertainment, but when they do it’s ... singing ‘Daisy, Daisy’ and that’s not me’ (p. 22).

In their review of extra care schemes in Britain, Croucher et al., (2006) found that many of the schemes were keen to promote a user-led approach to activities in order to prevent the schemes from taking on an institutional feel. This approach seemed popular with residents. For example, Croucher et al., (2003) found that Hartrigg Oaks had a large number of social activity groups, all set up and run by residents; this approach seems to have worked due in part to the presence of younger residents (in their seventies) and to the shared professional backgrounds of many of the residents. However, Croucher et al., (2006) also note that residents who were older and less active would have been glad of organised activities (Bartholomeou, 1999; Croucher et al., 2003; Bernard et al., 2004). Bartholomeou (1999), for example, found that some residents had expected social activities to be organised each day and were disappointed when this turned out not to be the case.

Links with Local Community

It has been argued that age-segregated housing runs the risk of alienating older people from the wider community in which they live (Osgood, 1982). Although socially there are obvious benefits due to the increased opportunity for social interaction and developing friendships along with the social activities that often take place, some older people may still feel isolated and cut off from the outside world.

Extra care schemes are likely to vary in the extent to which they are involved with their local community. This can be affected by the design of the building and its location, by the philosophy of the scheme – whether they see themselves as separate from or part of the wider community – and also by the attitudes of staff and residents. Again, this can affect various social factors such as a resident’s social network, their perception of

connection to the 'outside world' and of making a contribution, and the wider social climate in the scheme.

Residents of a scheme can be linked to the local community in a variety of ways – for example, through maintaining links with friends and family in the community, by using the local amenities, or via people coming into the scheme, either to provide a service (e.g. entertainment) or to use the facilities (Brooks et al., 2003). Turning first to issues surrounding an individual's links with family and friends outside of their housing, a study of social support in an American retirement community (Potts, 1997) indicated that although the quantity of social support was higher among friends within the retirement community, the perceived quality of social support and the closeness of relationships was higher for friends outside of the retirement community, and in fact predicted lower levels of depression. Similarly, Stacey-Konnert and Pynoos (1992) found that, although residents living in a CCRC relied primarily on other residents for regular social activity and contact, approximately half of those interviewed also mentioned people outside the CCRC as being part of their social network. The authors state that they found no evidence that the CCRC had become isolated from the wider world.

Having (and maintaining) links with friends in the wider community has also been shown to be important for residents of extra care housing in Britain. Many of the residents of Hartrigg Oaks indicated that their social networks outside of the village were as important as or more so than those within (Croucher et al., 2003). Similarly, most of the residents interviewed from Berryhill maintained their outside friendships and links with family members; even if they were unable to get out to see people, they kept in touch via telephone. Families often visit, and the presence of children in the village (for example, on school visits) was mentioned as something that was very much enjoyed (Bernard et al., 2004).

Second, links can be maintained by residents going out into the community to use local amenities, or take part in social activities. This also seems to be important to residents; Croucher et al., (2003) found that many residents '...talked about the importance of having a 'life outside of Hartrigg Oaks' and being able to leave the community regularly on day trips and holidays', and that the majority of residents left the retirement community on a fairly frequent basis. However, there are various potential barriers to getting out – Bernard et al., (2004) note that transport and security are issues of particular importance. Even if an individual wishes to remain involved in the wider community, they may have mobility and transportation problems, or may not feel safe

away from the scheme. Research has shown that having access to suitable transport can play a part in the quality of life of older people (Gilhooly, Hamilton, O'Neill et al., 2003; Gabriel and Bowling, 2004).

Although it has been found that residents often want to maintain links to the outside world through friends, family and 'getting out', there can sometimes be a less favourable attitude to people (other than friends and family) coming *in* to the scheme. It is the policy of some schemes to make facilities available to the local community for use – the Extra Care Charitable Trust villages, for example, make their facilities available to 'Friends' of the scheme who are aged over 55. However, when it was suggested to residents of Hartrigg Oaks that people living in the nearby village could be allowed to use the restaurant or coffee shop, or to join in with some of the social activities, some residents were unhappy with the idea of sharing facilities for which they had paid a substantial amount of money (Croucher et al., 2003). Still, this may not be the case in all schemes; Hartrigg Oaks, in comparison to the DH funded schemes of our evaluation, is financed through an insurance-based model, in which residents pay an initial capital sum and then an annual fee regardless of their level of care needs.

Some evaluations of ECH schemes have pointed towards a negative attitude towards the presence of day centres in the scheme to be used by non-residents (e.g. Baker, 2002; Oldman, 2000). Concerns included the fear that having a day centre could take away from the sense of community in a scheme (Oldman, 2000). In Runnymede Court (Baker, 2002), a luncheon club had relocated to the scheme from its previous home in a day-centre, causing one resident to suggest that having 'day centre activities' at the scheme could create a more institutional feel. There can be a feeling, as expressed by this resident, that '... this is our home, it's not a home' (Baker, 2002, p. 23).

Finally, the local community can benefit from having an ECH scheme. In Making the Case for Retirement Villages, Croucher (2006) points out that a survey of private sheltered housing (McLaren and Hakim, 2004) indicated that 62 per cent of residents chose to shop in the local community, over one-third on a daily basis. It is also noted that a retirement community can be the focus for community projects such as adult learning and that residents themselves can bring much to the local community through for example being parish councillors, or school governors.

Staffing and Care

A defining feature of extra care housing is the provision of 24 hour care on-site. The care provided is domiciliary, not residential care, and is delivered to residents via an individual care plan (or care and support plan) in their own homes (Garwood and King, 2005). However, there are likely to be differences in how care is delivered across the schemes, which will have differing effects on overall quality of life and well-being, and social well-being.

Research has indicated that the quality of care in care settings can impact upon individuals' quality of life. In reviewing the literature, Reed (2007) suggests that although separate, quality of life and quality of care are often interlinked, such that care of a high standard can encourage and maintain quality of life. More specifically, care can also have an impact in the domain of social well-being. For example, Grau, Chandler and Saunders (1995) found that, for nursing home residents in their sample, the quality of their interpersonal relationships with care staff was the most influential aspect over quality of care. Additionally, Bowers et al., (2001), in in-depth interviews again with a nursing home sample, found that for some residents, quality care was described as that which demonstrated friendship and allowed reciprocity with carers. Furthermore, friendship development within long-term care settings has been found to be related to the nature of the care routine in those settings (McKee et al., 1999).

It is worth noting, however, that this research was carried out in nursing and residential care homes, and that the nature of care delivery in extra care housing is different. As noted above, care in extra care housing follows the domiciliary model, with an emphasis on supporting independence, enabling people to do things for themselves rather than doing things for them. Garwood and King (2005) suggest that, although research is limited, the culture of an extra care scheme in terms of its staff and care provision has an influence on residents' well-being and quality of life.

Recent work from the PSSRU (Towers, 2008) comparing residents' experiences of control and well-being in extra care housing and care homes has indicated that care may have an influence on well-being. Residents of extra care schemes perceived their health to be worse and had lower well-being than care home residents, a finding which was not easily explained by the data. However, qualitative material indicated that there were issues with the quality of care in some of the extra care schemes, leading the author to query whether it could have been this which was affecting residents' well-being and self-rated health. This work will be followed up using a care home sample, to

investigate further the effect of quality of care on control, well-being, and self-rated health.

Other recent research investigating social well-being in extra care housing (Evans and Vallely, 2007) suggests that quality of care can have an impact on well-being in general, and can also directly impact extra care residents' social lives. For example, it was found that for some tenants, interaction with their carers was their main source of social interaction, and the authors suggest that a key-worker system should be in place to encourage these relationships to develop. Lower levels of staffing in the evenings and over the weekends meant that some residents with restricted mobility were unable to move about their scheme and engage in social activities. Similarly, it was found that a task-centred approach to care provision could limit the capacity of carers to support residents in getting to activities and facilities both within and outside of the scheme. The authors advocate a person-centred approach in order to maximise social well-being.

So, it seems that the nature of care provided in the schemes will be important to residents' social life; indeed, it could be argued that for some residents, their care will be integral to their quality of life and social well-being. Garwood and King, (2005) suggest, 'The best Extra Care Housing schemes will see social and leisure activities, encouraging independence, healthy living and lifestyles all as part of an overall approach to care and what good care really means' (p.10).

Social Factors

There are a wide range of personal social factors (e.g. social support and isolation) which are likely to be affected by moving into extra care housing, which are interrelated and involved in an individuals' overall well-being. These social factors are outlined in the following sections.

Friendships and Social Support

The importance of friendships and social support to older peoples' lives has been well documented. Bowling (1994) defines social support as 'the interactive process in which emotional, instrumental, or financial aid is obtained from one's social network' (p. 41). Friendships can be one source of social support, and although instrumental and financial support is most likely to come from relatives (Greenblatt et al., 1982; Seeman and Berkman, 1988), close friends (along with close relatives) often provide emotional support (e.g. Lee, 1985). Phillipson (1997) suggests that, although family support is

often crucial in old age, ‘...the search for meaning and fulfilment in later life is closely bound up with the ability to create and sustain social relationships of other kinds’ (p. 509) and that friendships are crucial to a sense of well-being in later life.

In a review of the literature on social networks and social support, Bowling (1994) concludes that, despite some contradictions in the literature, there is fairly positive evidence linking social networks and social support to health status (including mortality), whilst noting that such a relationship can be difficult to interpret. Similarly, Wenger (1997) found that the structure of older people’s social networks was associated with different levels of health, loneliness, and depression. Some network types are more beneficial than others; higher levels of social participation and therefore social support reduce the likelihood of social isolation, loneliness and depression. Research applying Wenger’s network typology to older people living in sheltered housing also indicated that network type was related to activity limitation and loneliness, although not in this case with depression (Field et al., 2002).

Similarly, different types of relationship can have different effects on well-being. In general, research suggests that it is the closer, more emotionally supportive relationships which are most important for well-being in later life (Strain and Chappel, 1982; Croucher et al., 2006; Duner and Nordstrom, 2007). For example, Potts (1997) found that although levels of social support among residents of a retirement community were high, this did not have an effect on depression. On the other hand, lower levels of depression were consistently related to social support from friends living outside the retirement community, with whom they had longer-standing and more intimate relationships. Likewise, Stacey-Konnert and Pynoos (1992) found that while the majority of residents in a CCRC relied on other residents for regular social activity, family members remained their confidants.

It is likely that moving into a housing with care setting will affect an individual’s levels of friendships and social support. The size and structure of their social networks may change – there is more opportunity for social interaction and the formation of new friendships, coupled with the challenges involved in maintaining old ties. As Potts (1997) suggests, although close relationships are important, it is the more casual relationships within a retirement community which provide regular interaction and companionship. Further, Sugihara and Evans (2000) suggest that ‘The development of socially supportive relationships among new members of a retirement community would seem paramount in facilitating good adjustment.’ (p.401).

Research carried out in a number of assisted living facilities in America found that social relationships within the facility (measured as friendships with other residents and positive feelings towards staff), were the most significant predictor of well-being (Street et al., 2007). Interestingly (and in contradiction to other research) contact with family and friends outside of the facility was not related to well-being in this study, which led the authors to suggest that individuals are able to form new support networks after moving to an assisted living facility, and that these relationships become more important to their well-being than the continuation of past relationships. This has implications for the current research, as it may be that although the move to an extra care scheme causes changes to an individual's social network structure, this may not necessarily have a negative impact on well-being.

Another feature of housing with care settings is that they may encourage mutual support and reciprocity among residents; indeed much 'neighbourliness' has been found to exist in different types of retirement communities (e.g. McDonald, 1996). Investigating the coping processes among residents of a CCRC, Lawrence and Schiller-Schigelone (2002) describe this kind of neighbourly behaviour as 'communal support', and suggest such support helps to buffer common stressors of ageing in the areas of health and well-being. It was found in this CCRC that a community existed in which residents often worked together to help those suffering from such age-related problems; even if an individual did not receive reciprocal support from the individual to whom they provided support (due to differing degrees of dependency), they could feel assured that, should they need it, support would be provided from others within the community.

The literature also highlights the impact of declining health on social support, an issue which is of potential importance in the context of extra care. Research in a CCRC in America suggested that those residents less likely to participate socially were those who had health problems, were cognitively impaired, were older, caregivers, or widows (Stacey-Konnert and Pynoos, 1992). This is in line with findings amongst nursing home residents that indicated that residents with problems with speech, cognition, hearing or mobility had fewer friendships (Retsinas and Garrity, 1985; Bitzan and Kruzich, 1990). However, research into friendships in long-term care settings has suggested that physical and cognitive problems can, in some cases (depending on how the dependency is dealt with by the home), be facilitative of caring friendships between these residents and others who are less dependent (McKee et al., 1999).

Social Isolation and Loneliness

Social isolation or loneliness has been described as the opposite of social support, with social support at the positive end of the spectrum and loneliness and isolation at the opposite, negative end (Andersson, 1998; Cattan et al., 2005). Andersson points out that research in these two areas has often been somewhat separate, with research on social support focussing on social networks (see above), and that on loneliness focussing on personal relationships; it is important, however, to be aware that the two notions have considerable overlap. Loneliness has been described as an important indicator of social well-being (De Jong Gierveld and Van Tilberg, 2006).

Victor and colleagues (Victor et al., 2002; Victor et al., 2005) make an important point regarding the definition of loneliness. 'Loneliness' refers to how individuals evaluate their overall level of social interaction; 'Social isolation' relates to an individual's actual level of integration in the social environment. Loneliness is the subjective experience, whilst social isolation can be measured objectively, as reflected in the distinction drawn by Andersson (1998). Research indicates that the two concepts are related, but that the relationship is modest, and distinctions are not always clear-cut, suggesting that it is important to measure both concepts (Wenger et al., 1996; Hughes et al., 2004).

Loneliness can impact upon quality of life and well-being. Much research into loneliness has sought to investigate variables associated with, and risk factors for loneliness. For example, Victor et al., (2005) identified various social and health factors which could be seen as risk factors for loneliness. Interestingly, there was no association between levels of social contact or proximity to family and friends. However, lack of a confiding relationship was related to loneliness, leading the authors to suggest that it is not the number of social contacts, but their quality that is important (a finding which echoes other research on social support, see above).

Research by De Jong Gierveld and colleagues has indicated that older individuals without an 'intimate partner' experience higher levels of levels of loneliness, and that having an intimate partner can in fact be protective against loneliness (Dykstra et al., 2005; De Jong Gierveld and Van Tilberg, 2006). The authors distinguish between emotional loneliness (absence of an intimate relationship or close emotional attachment) and social loneliness (absence of a wider social network).

The evidence for the success of interventions to reduce loneliness among older people is mixed (Findlay, 2003; Cattan et al., 2005). However, it seems that interventions based

around social group activities involving an educational or support element are most successful (Cattan et al., 2005), which has important implications for the facilitation of social well-being (and the targeting of loneliness) in extra care housing.

Social Activity and Participation

Social activity is important to the lives of many older people in housing with care settings in part because it can provide an opportunity for interaction. Indeed, research indicates that social activity is closely linked to levels of social support. For example, the Health Survey for England 2000 indicated that social participation among older people in care homes was associated with perceived social support. Men (but not women) who felt they had lower levels of social support took part in fewer activities than those with higher perceived levels of support (Tait and Fuller, 2002). McKee et al., (1999) found that those with more friendships had higher levels of social activity, although this was also clearly related to the home they lived in, and influenced in particular by the care regime.

The focus in this part of the review was on social activity rather than physical activity, apart from when the benefits of physical activity were discussed in relation to social participation/ social well-being. As pointed out in the New Ambition for Older Age report, ‘Activities such as exercise classes and dancing, promote not only health and independence, but also increase social interaction leading to improved emotional well-being’ (Department of Health, 2006). Similarly, Stathi et al., (2002) suggest that physical activity helps respondents maintain social networks and remain fit enough to do the things they ‘want to do’, as well as enabling them to meet different people with similar interests.

Activity has long been established as being important in later life. One of the most prominent theoretical explanations for this is activity theory. Activity theory states that an individual’s well-being is related to their involvement in activity through the frequency of activity engagement, and the degree of intimacy involved (Lemon et al., 1972). More specifically, engagement in activity offers opportunities for social role support and for positive feedback on role performance, which in turn enhances self-esteem, which contributes to well-being (Reitzes et al., 1995). The theory suggests that the role losses experienced by many in older age (e.g. occupational, parental) are replaced by the development of new roles and activities, resulting in the maintenance of well-being (Havighurst and Albrecht, 1953).

According to Lemon and colleagues, activity can be divided into informal, formal and solitary activity. They suggested that, because informal activity is characterised by interactions with family and friends, it generates the most role support; indeed, it was found that informal activity with friends was related to life satisfaction, while other types of informal activity, and formal and solitary activity, were not. This finding has supported by other studies of activity theory (e.g. Knapp, 1977; Longino and Kart, 1982; Harlow and Cantor, 1996), and indeed seems to be the only consistent finding among studies into activity theory (Everard, 1999).

Litwin and colleagues (Litwin, 2000; Litwin and Shiovitz-Ezra, 2006) sought to examine in greater detail the association between well-being and activity in older adults, particularly focusing on social relationship factors. In two studies, it was found that it was the quality of social ties and the supportiveness of the social network associated with older adults' participation in informal activities that accounted for the relationship of informal activity to well-being rather than frequency of participation or any other factor associated with the activity. (Litwin, 2000; Litwin and Shiovitz-Ezra, 2006). In other words, 'well-being in later life is less a result of what older people do, but rather of who with and how they feel about them' (Litwin and Shiovitz-Ezra, 2006, p.237). Activities involving a link with the local community, such as volunteering, charity work and church involvement, have also been found to be related to life satisfaction and well-being (Harlow and Cantor, 1996; Morrow-Howell et al., 2003; Warr et al., 2004).

Other research examining the association between activity and well-being has highlighted other factors in the relationship. For example, Ritchey et al., (2001) found that not all types of activity were related to well-being, but those that were were activities that reflected a healthy, independent lifestyle which afforded older people a sense of control, such as frequency of visits with friends (informal activity), working in the garden, taking walks (solitary activity), attendance at religious services and hours worked per week (formal activity). Everard (1999) investigated the hypothesis that individuals' reasons for engaging in activity moderate the relationship with well-being. It was found that activities engaged in for social reasons were positively related to well-being, in line with the findings above highlighting the importance of the social aspect of activity. Activities engaged in for fun and mental stimulation were also positively related to well-being. Finally, Warr et al., (2004) suggest that activity could influence well-being for a number of reasons. For example, activity is often accompanied by the achievement of personal goals, and the setting and achievement of goals are important components of good mental health. Linked to this, activities often offer rewarding outcomes. Additionally, activity may have other beneficial outcomes beyond those

inherent in the activity, and these outcomes may influence well-being; for example, going to church may have social benefits as well as spiritual ones.

It seems, therefore, that activities can have a positive effect on well-being, particularly those activities which have a social aspect. However, Warr et al., (2004) make another important point – that as well as the potential effect of activity on well-being, the reverse may also apply, such that individuals with higher levels of well-being may be more likely to have more social involvement and higher levels of activity.

Activities may be particularly important in housing with care settings, as they can provide an opportunity for friendship development and social interaction, and activities do seem to be valued by older people in these settings. (e.g. Bernard et al., 2004). However, it can be difficult for residents who were frail or disabled to take part in social activities, for reasons including sensory impairment and wheelchair use (Croucher et al., 2003; Croucher et al., 2006). Another note of caution is the finding in one study that that social activities for older people designed as interventions to reduce loneliness and social isolation, were in fact seldom targeted to the needs of those people (Cattan et al., 2005).

Suffering from dementia can also be a barrier to social activity participation, although the Health Survey for England 2000 (Tait and Fuller, 2002) indicated that, among care home residents, older people with cognitive impairment were more likely to take part in a larger number of activities than those with no cognitive impairment. Activities are particularly important for the frailer older people, and can significantly enhance their quality of life. (Croucher et al., 2006). Age has also been found to be negatively related with activity participation; older people participate less than younger ones (e.g. Tait and Fuller, 2002; Croucher et al., 2003).

Social Climate

Moos and Lemke (1996) in describing the concept of social climate state that:

‘The social climate perspective assumes that each individual environment has a unique ‘personality’ that gives it unity and coherence. Like some people, some social environments are friendlier than others. Just as people regulate their behavior, settings influence the behavior of the people in them’ (p.110).

The Social Care Environment Scale (SCES; Moos and Lemke, 1996), developed in the USA, measures the social climate of a care facility, reflecting the degree to which care environments (including congregate housing) are seen as cohesive, supportive and fostering independence, levels of conflict and resident influence (see Table 1). In the UK, the SCES has been used in a number of studies to describe and evaluate a variety of care environments for older people (Benjamin and Spector, 1990; Netten, 1993; Schneider and Mann, 1997; Mozely et al., 1998; Netten, et al., 2001).

Table 1: The Sheltered Care Environment Scale: Subscale and Dimension Descriptions

<i>Relationship dimensions</i>	
1. Cohesion	How helpful and supportive staff members are towards residents, and how involved and supportive residents are with each other
2. Conflict	The extent to which residents express anger and are critical of each other and of the facility
<i>Personal Growth Dimensions</i>	
3. Independence	How self-sufficient residents are encouraged to be in their personal affairs and how much responsibility and self-direction they exercise
4. Self-disclosure	The extent to which residents openly express their feelings and personal concerns
<i>System Maintenance and Change Dimensions</i>	
5. Organization	How important order and organization are in the facility, the extent to which residents know what to expect in their daily routine, and the clarity of rules and procedures
6. Resident Influence	The extent to which residents can influence the rules and policies of the facility and are free from restrictive regulations
7. Physical Comfort	The extent to which comfort, privacy, pleasant décor, and sensory satisfaction are provided by the physical environment

Source: Moos and Lemke (1996)

In general, however, studies do not seem to have investigated the links between social climate and social well-being. Nonetheless, it seems likely that the social climate of an extra care scheme will have an impact on individual residents' well-being, for example through the effect on type of activities available and how residents feel about

participating among other things. Likewise, the approach to activity taken in a scheme may have an effect on the social climate:

‘...a judgement of friendliness might stem from whether residents greet each other in the lounge, help each other, participate in activities, and so on’ (Moos and Lemke, 1996, p. 110).

Conclusion

This literature review aimed to identify definitions of and factors influencing social well-being for older people, and to inform the design of materials for a project investigating social well-being in extra care housing. Overall, the literature indicated a number of areas which are involved in, or are likely to influence, the social well-being of an older person moving into an extra care housing scheme.

The findings influenced the design of the project in a variety of ways. For example, control over the environment emerged as an important aspect in design, so objective control over immediate environment and daily life was reflected in our instruments in addition to perceived control. Links with the local community emerged as an important theme and are explored at initially at scheme level and later at the individual level in terms of perceived involvement and potential barriers. Focus is on the community coming in to the scheme, as well as on residents going out of the scheme.

Type, frequency and amount of social activity engaged in are measured in a survey to all residents. To supplement this, a follow-up interview with a smaller sample investigates the perceived enjoyment and benefits of activity (e.g. friendship, mental stimulation), as the literature indicated that it is not always activities per se that are important to well-being but features associated with those activities. The importance of social support to well-being in older age and the influence of this on social participation, social networks and perceived social support were identified as key and are measured in both the survey and interview, in different ways. The presence or otherwise of a confidante is also established, drawing on indications in the literature that emotionally supportive relationships are particularly important.

At the time of writing, the project is over halfway through the data collection phase. An interim report has been produced, outlining the methodology and presenting some early findings (Callaghan et al., 2008). An initial report from the PSSRU’s ongoing

evaluation of the first round of the Department of Health's Extra Care Housing Funding Initiative (2004-2006) is also available (Darton et al., 2008).

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