Our Home East York: the OHEY Project

# Age friendly societies in our time?

## A literature review

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## About this review

This review has been prepared for a specific community research project: the OHEY ('Our Home East York') project in Toronto, Canada. The city's population is ageing rapidly and this has a significant impact on the housing provision (CMHC, 2008) with many more older people living alone. The demographic change is not trivial:

> Over the past decade, households aged 25-39 years, a group typically responsible for a large share of new household formation, decreased by 12% whereas households 40 to 59 years grew by 25% and those 75 years of age and older increased by 40%. Between 1996 and 2006, the two fastest growing age groups were the 80 to 84 year olds and those 85 years and older, which grew by 42% and 37% respectively. (City of Toronto Planning Division, 2012)

The implications of these changes are of course social as well as structural, focusing minds in the community sector as well as those responsible for formal services including health, social services, police, and fire and safety services. There are justifiable concerns that damaging levels of isolation could arise, with enormous social costs, and not enough is known about quite how this happens nor what can be done by way of amelioration.

The OHEY project therefore sought to gain an understanding of the state and breadth of knowledge about *the social isolation of older people in urban areas, with particular attention paid to housing form, and formal and informal care*. The coverage is of international material in English; with items emanating from or relating to Canada generally, being of particular interest. This is an overview rather than a systematic literature review.

The various literatures that have been used as resources for this review are substantial: in particular, those on loneliness and isolation, social support, neighbourhood characteristics, health, well-being and quality of life, and social capital. Other areas, such as the burgeoning literature on dementia, could not be explored without more time and resources. A collection of more than 450 items was accumulated with comparatively little effort. But this rich flow of material can be deceptive because it makes it less easy to identify key, seminal items.

In compiling this review it has not been possible to assess the various methodologies in any of the research reported. Thus when findings are re-presented here, they come with the same trust-based assumptions that are due to the publishers, scholars and peer-reviewers who make up the social science system. Nor has it been possible to examine every item in full, and there has necessarily been a degree of dependency on published abstracts.

A feature of the literature as a whole is the inevitable and surely unintended impression it gives that older people are a homogeneous group. The key point to be aware of is that different pieces of research refer to different age groups – from the questionably-useful 'over-50s' to the relatively specific 'centenarians'. These often nebulous categories disguise groups of older people with very different physical and mental abilities, experiences and resources. It has not been possible systematically to distinguish these, although some noteworthy instances are mentioned.

The British spelling 'ageing' is used in the narrative.

Finally, this is an opportunity to note two characteristics of the literature that have been most striking. The first is the stark invisibility of lesbian, gay, bisexual and transgender older people in any content that is not specifically about them. This material is distributed across several sections of the literature review as appropriate, not collected as if to accentuate the categorisation. The second is the number of calls that are made for increased participation of older people in decision making processes, alongside comparatively few *accounts* of such involvement. This is one very clear pointer for the future.

# 1

# Introduction

**The social context of ageing: 'apocalyptic demography' and the 'burden discourse'**

During the 1980s and 1990s it was recognised that the proportion of older people in the world's population was increasing at a rate that required a policy response. Awareness of the implications of this trend – described questionably in one case as a 'demographic tsunami' (Miller *et al*, 2007) – led some writers to address the morality of ageing policy and 'the obligations one generation has to another' (Johnson 1995). Robertson (1997) adds to this an early awareness of the politics of the post-welfare context. She directly challenges 'catastrophic projections of the burden to society of an increasing ageing population' which she sees as an 'apocalyptic demography.' Her approach to ageing policy calls for a focus on obligations and reciprocity, noting that

> Older people are often caught between a social ethic of independence on the one hand, and, on the other, a service ethic which constructs them as dependent.

Robertson proposes 'a moral economy of interdependence', which depends on the recognition that 'not all human exchanges can be entered into cost-benefit equations.' This is not just academic theorising. Among the practical steps that might be taken she lists the following:

> supporting the development of community health centres run by community boards; providing funds to families who care for a dependent family member rather than to institutions or professionals; integrating community centres and community activities through existing neighbourhood centres like schools and community centres, rather than segregating people by age groups into day care centres, seniors' activity centres, teen centres etc; reversing the ghettoisation of old people by encouraging the development of smaller care facilities like group homes in local neighbourhoods or multigenerational housing initiatives. Whatever the form such actions take, '*what matters at this stage is the construction of local forms of community*. (Robertson, 1997, original emphasis)

Other researchers have also challenged the discourse of 'old-people-as-burden'. Wiles and Jayasinha (2013) for example, use it as a starting point

to explore the local contribution of older people in caring for their neighbourhood. Schwanen and colleagues (2012), in reviewing studies of independence, argue that independent mobility is related to 'the enactment of particular forms of embodiment and ageist subject positions for older people.' They go on to suggest that 'older adults are inadvertently complicit in the perpetuation of the connotations of dependency in later life with passivity, burden and undesirability.'

Various commentators have also challenged the representation of old age. Godfrey, Townsend and Denby argue that

> Ageing and old age have been subjected to negative and positive stereotyping. The first – or 'deficit' model – views old age as an unremitting period of loss, decline and social withdrawal. The second – or 'heroic' model – considers 'active' or 'successful' ageing in terms of being fit, healthy and happy. Both are problematic. The deficit model not only denies the accomplishments of ageing, but reinforces the devaluing of older people and the view of them as passive recipients of services. The heroic model implies that to experience loss – of health or abilities – is to age 'badly'. (Godfrey et al, 2004)

If the dominant experience of old age is seen as being one of isolation and limited association or sociality, this is challenged by Sophie Watson (2006), who argues that the notion is a consequence of older people's relative invisibility. For Watson, this invisibility is rooted in two sources: the bodies of older people being strongly differentiated from norms of attractiveness and therefore not being used in media to represent the pleasures of sociality; and the shift in older people's social relations into spaces that are publicly obscured. Nonetheless, whether or not it is exaggerated in the popular representation of ageing, the isolation of older people is extensive and can be deadly, as plenty of research emphasises.

The 'packaging' of ageing is inescapably political, as a number of writers make clear. A review of the literature can help to clarify the sense that there are notions and schemes in any society's attitude towards older people that have political salience at certain times. It is for this reason – as discussed in the sections below on housing and ageing in place – that it may be as well to question widespread movements that appear to be ideal solutions at the time, but which ultimately might come to resemble tired fashions. A global economic recession coupled with an acknowledged demographic shift would seem like a good time to be better-informed but sceptical about politically-desirable approaches to the care and support of vulnerable people.

# 2

# In the neighbourhood: the built and green environment

> Theories of environmental aging suggest that as people age and their mobility declines, their residential neighborhood environment may become more relevant to their health and well-being. Yet the existing research does not consistently support this model.
>
> (Yen *et al*, 2009)

Various characteristics of the built and green environment will have direct or indirect influences on the well-being of all residents. Thus the importance of supportive, barrier-free environments for older adults, particularly those who are more vulnerable because of disability or failing health, is emphasised (*e.g.* Clarke and Nieuwenhuijsen, 2009). The International Longevity Centre UK has argued that poor design of neighbourhoods should be grounds for rejection at the planning stage. The Commission for Architecture and the Built Environment established a framework for poorly designed homes[1] and it is argued that 'a similar standard for poorly designed neighbourhoods should also be established' (Kneale and Sinclair, 2011).

The more negative the factors, the greater the likelihood that an older person may succumb to isolation and its negative consequences. Reviewing research evidence of environmental influences (broadly interpreted) on older adult health and activity participation, Annear and colleagues (2012) catalogue the following personal influences:

> ethnicity and cultural norms, energy and motivation, sex, age, education, genetic heritage, self-efficacy, and personal financial circumstances;

- together with the following environmental influences:

> climate, level of pollution, street lighting, traffic conditions, accessibility and appropriateness of services and facilities, socio-economic conditions, aesthetics, pedestrian infrastructure, community life, exposure to antisocial behaviour, social network participation, environmental degradation, level of urbanism, exposure to natural settings, familiarity with local environment and others.

[1] http://is.gd/kpBWvd

There is, then, a significant challenge in knowing which factors have most influence, how they interact in combination, and to what extent they are susceptible to change.

## 2.1 Environmental press

The theory of 'environmental press,' developed by M. Powell Lawton, describes the way an individual's behaviour is limited by features of their environment, and the necessary adaptations that they may make or need to make. Lawton (1989) describes environmental press as 'the strength with which the environment demands a response from the person.' The theory notes that a degree of press (*e.g.* the need to get up to change television channels or make a drink) is desirable to maintain health. The theory helps to demonstrate the close relationship between residential well-being and social and psychological well-being (Lawton, 1989). Other commentators have referred to it in proposing design principles:

> If social capital can be defined as a neighborhood high in trust, stability, and willingness and ability to exercise control in the neighborhood, many reasons exist to suppose a neighborhood high in social capital might be an environment low in environmental press and high in environmental buoying. (Glass and Balfour, 2003)

Garvin and colleagues studied the context of a northern, winter city in Canada to understand how older people cope with the environmental adversity of severe weather. They found that 'winter weather was the dominating concept for discussion of the environment regardless of the time of year.' They note that the research participants 'almost unanimously spoke to the need to make individual adaptations in order to navigate their environments as their mobility decreased. In other words, instead of expecting environmental adaptations to meet their changing needs, seniors accepted and individually managed – to the best of their ability – the ongoing challenges' (Garvin *et al*, 2012).

In a study of environmental press in relation to residential satisfaction in the home and neighbourhood, Byrnes and colleagues found that

> Respondents who reported the lowest levels of mental and physical functioning also reported the lowest levels of residential satisfaction and faced the greatest environmental challenges. The results suggest that older adults occupying disadvantaged social locations may be overlooked in current practice definitions of aging in place. (Byrnes *et al*, 2006)

## 2.2 Neighbourhood characteristics

> Environmentally-based interventions in the form of community development, planned housing, favorable neighborhood location, and crime control may significantly enhance well-being, and in many instances have more widespread effectiveness than time-consuming attempts to change the individual.
>
> (Lawton *et al*, 1980)

Can your neighbourhood make you feel better or worse than you would otherwise? According to one study, social networks and loneliness among older people are 'hardly influenced' by the characteristics of neighbourhoods (Moorer and Suurmeijer, 2001). Yen and colleagues (2009) reviewed research evidence of neighbourhood effects on the health of older people. It is widely accepted that health is negatively affected by stressful local environments, but they found that the evidence is mixed:

> Neighborhood problems were significantly associated with self-rated health and symptoms, but results for physical function and mental health were mixed. There was no evidence of an association between neighborhood problems and physical activity in cross-sectional studies or in a longitudinal study.

Nonetheless, significantly, the authors did see evidence that negative features of neighbourhoods 'may influence health through psychosocial mechanisms (*e.g.* stress and lack of social support).' In a systematic assessment of quality of life indicators among older people in deprived areas, Smith and colleagues (2004) conclude that 'variables that described characteristics of the urban environment had limited direct influence on the quality of life.' Further, the notion of culturally-neutral measures of neighbourhood quality may be spurious: a UK study (Bajekal *et al*, 2004) found that residents from different ethnic minority groups tended to have a more positive perception of their area than was rated by conventional measures of area deprivation such as the *Index of Deprivation*. South Asian older immigrants in Canada were reported to be mostly 'satisfied with their living arrangements, housing, and perceived safety at home and in their neighbourhood' (Ng *et al*, 2010). But while surveys might indicate that a comfortable majority of older people are content with their neighbourhood, a minority could be identifying all the negatives and be highly vulnerable as a consequence (Windsor *et al*, 2012).

In a study of the relation between self-reported health and neighbourhood characteristics in New Haven, Connecticut, Subramanian and colleagues (2006) confirmed that neighbourhood characteristics (reflected through

measures of poverty, residential stability, and age-based demographic concentration) predict the health of older people. Notably, the study also took account of neighbourhood 'services' – encompassing agencies that promote social organisation, such as faith groups; services that promote social interaction (beauty parlors, cafés, libraries); those that are directly health related (such as clinics and hospitals); and those that may be said to affect the reputation of neighbourhoods adversely, or promote deleterious health behaviours ('*e.g.* liquor stores, pawnbrokers, tattoo parlors, fast food outlets'). The researchers report that the density of these services at neighbourhood level did not appear to have an independent effect on the self-rated health of older residents.

The importance of a range of accessible services for older people is echoed strongly in a major UK study of older people in socially deprived areas (Scharf *et al*, 2002). Gauvin and colleagues (2012) point to the significance of having amenities at neighbourhood level: in their study,

> Closer proximity to services and amenities was associated with greater likelihood of frequent walking.

Similarly, an Australian study concluded that

> the type of bridging social contact which appears to be so crucial to increasing social capital does not just come about because of the agency of people, but also because of the characteristics of the places in which they live. (Baum and Palmer, 2002)

Health professionals working with older people described facilities such as libraries and social groups as important because they give 'a sense of belonging and encourage socialisation' (Giummarra *et al*, 2007). (Social aspects of local amenities are discussed further in section 4.5.2).

The consistent association of the built environment with well-being is confirmed by Burton and colleagues (2011) who used a range of 14 well-being constructs and found that each of them was associated with at least one built environment measure. In piloting and testing their Neighbourhood Design Characteristics Checklist they found that:

> The built environment measures found to have the greatest number of significant associations were: type of housing; residential location on the urban-rural spectrum; built-up density; and number of junctions / intersections within 300 m radius. No associations were found for extent of 'eyes on the street' or motorised traffic level on participant's street.

While objective assessment of neighbourhood quality is important, it is not going to be sufficient. In a large interview sample of 1,185 respondents,

Gory and colleagues (1985) looked at neighbourhood satisfaction as a combination of three factors: objective qualities in the neighbourhood, the psychological and physical state of the person making the evaluation, and the individual's own subjective definitions of the neighbourhood. While all three general factors are significant, they conclude that 'mental portraits of the neighborhood are the most significant source of neighborhood satisfaction.'

A pioneering study by Lawton and colleagues used a national (US) sample of over 3,000 tenants based in 153 planned housing environments to explore the association of neighbourhood characteristics and well-being in older residents. They found that

> In general, quiet neighborhoods in small or middle sized communities where the risk of crime was low were conducive to active and satisfying lives for older people. Well-being tended to be higher in segregated buildings even with other factors such as exposure to crime controlled. (Lawton *et al*, 1980)

The relationship between the local environment and depressive mood is unclear, according to a review of the research evidence (Julien *et al*, 2012); but the authors did find support for the notion that 'selected neighborhood variables, especially those related to poverty and material deprivation, are associated with worse mental health.' They also report mixed evidence regarding the mental health benefits of *a concentration of older persons in the neighbourhood*, although planners are often called on to design for this and it is argued that it contributes to more efficient service provision.

## 2.3 Housing and housing form

In 2002 the Joseph Rowntree Foundation in the UK published a paper on housing policy for older people, which suggested that 'where they choose to live will increasingly be influenced by their lifestyle choices' (Appleton, 2002). Five years later a US study (Fisher *et al*, 2007) suggested that Americans' 'housing consumption' (housing assets and housing-related consumption) remains largely stable between the years of 60 and 80.

Since these papers were published, western nations have experienced severe economic recession and these assumptions may need reviewing. The proportion of older people for whom 'lifestyle' is increasingly constrained and the choices are few, has undoubtedly increased sharply. Many of these people are 'vulnerably housed' - which in Canada means that within the past year, they have either been homeless or have moved at least twice. Holton and colleagues (2010) have described the crisis of the 'vulnerably

housed' as 'Canada's hidden emergency.' According to Means (2007) 'it can be argued that the crunch issue for many older people is not that they are vulnerable *per se* but that they live in vulnerable housing situations.' Housing inequality as it affects older people in the UK has been reviewed by Adams (2009), who emphasises lifetime homes and neighbourhoods.

The literature on older people and housing is extensive, although not many commentators get to grips with the politics of housing in relation to the institutionalisation of ageing. Every shift in policy over the years is likely to have at least some macro-economic justification that is politically promoted for reasons which may have little to do with the aspirations of older people: is it entirely unfair to associate the rise of 'ageing in place,' for example, with the belated political recognition of the prospective economic implications of an ageing population? As Luken and Vaughan (2003) argue, 'housing regimes are the work of those involved: ordinary people, builders, developers, bankers, psychologists, gerontologists, social workers, foundations, federal employees, demographers, and magazine publishers.' For Luken and Vaughan, the action of this regime makes the knowledge and experience of older women in particular 'invisible.' In this light, there may be questions to be asked about whether what always seem like ideal solutions at the time – co-housing, say, or the principle of 'age-friendly places' – will come to be seen as flawed ambitions ultimately resembling tired fashions; and, worse, what unintended damage might they cause?

The range of housing accommodation may seem daunting: Giarchi (2002) has published a typology of 21 forms across Europe, using a matrix covering 'exclusive sector provision' and 'alternative mixed sector provision' (public, private, voluntary etc); against three categories – unassisted housing; assisted 'support in housing;' and assisted 'supported housing.' These forms of *provision* can be integrated with *structural* forms – such as bungalows or tower blocks for instance; and can accommodate different *household* forms, from living alone to extra care.

Further, these different forms belong in a neighbourhood context, from which in most cases they are inseparable. In a review of housing with care, for example, Garwood (2013) places emphasis on 'promoting supportive and positive relationships'; and in a resource pack for 'planning, designing and delivering housing that older people want,' Bligh and Kerslake (2011) include a section on 'reviewing neighbourhoods.' Moore (2013) has identified a range of ways in which the quality of life of older people in care homes can be improved. Sometimes the findings of research into particular housing forms can be counter-intuitive. One study of older people living in high-rise apartments in Taiwan (Cheng *et al*, 2014) found that the

environment 'does not decrease physical activity and may promote overall quality of life.'

It has been argued that inappropriate and poorly located housing can contribute to or exacerbate social isolation, 'by narrowing social circles and cutting off opportunities to socialise with people of different ages' -

> Some older people fear social isolation but dislike the prospect of living in age-segregated 'ghettos' – a term they attach to some retirement housing. (Bazalgette and Salter, 2013)

Bazalgette and Salter describe pioneering models such as cohousing and home-sharing as 'sociable housing' and argue that they offer older people 'a more socially connected home environment' - although they do require greater support from local authorities and housing associations.

It's fair to say that traditional options for housing older people – ageing in place at home, with family, or in a care home – have been extended over the past two decades with a number of alternatives emerging such as retirement communes (Baars and Thomése, 1994), 'villages' (Grant, 2006; McDonough and Davitt, 2011), modern almshouses, naturally occurring retirement communities ('NORCs') and age-specific co-housing. Their significance is that these are initiatives which 'seek to provide both services and meaningful connections among members' (Bookman, 2008).

This gradually increasing variety reflects general appreciation that there is no 'one-size-fits-all' solution. Thus for example a study of the design of extra-care housing (Barnes *et al*, 2012) reports that

> while the design of extra-care housing meets the needs of residents who are relatively fit and healthy, those with physical frailties and/or cognitive impairment can find the building restrictive resulting in marginalisation.

The variety is also reflected in a number of more specific findings, some of which (including those referring to NORCs and co-housing) are summarised below.

A number of studies of housing form suggest lessons for the design of age-friendly places. An early study by Lawton and colleagues (1975) found that

> greater height of building was associated with lower housing satisfaction and less neighborhood motility.

The researchers also report that tenants in smaller communities had 'higher friendship scores, greater housing satisfaction, and greater activity participation.'

A previous study (Lawton and Simon, 1968) had illustrated the significance for older people of housing design that permits ‘casual contacts which lead to exploratory conversations as the basis for viable friendships.’ Proximity proved to be of great importance in the creation of social connections: in some apartments 'the open door was literally an invitation to social interaction.'

Older people’s right to self-determination has not always been valued in the provision of housing. The theme of disempowerment emerges strongly in the sheltered housing context as for example UK and Swedish studies show (Churchill *et al*, 1997; Hellstrom and Sarvimaki, 2007).

Lee and colleagues (2011) describe a design process for an apartment complex for older dementia patients in South Korea. They conclude:

> The findings illustrate the vision for the shared space community, a community home for the dementia elderly, with appropriate scale for easy management and being connected with local community and with affluent green environment for healing and natural environment that would ease local residents’ aversion towards elderly housing.

In a strikingly different context but with not dissimilar results, Tyvimaa (2011) looked at connections between well-being and the built environment in two housing settings in Finland, one of them a co-housing initiative. The article highlights the importance of *common areas* which can serve to activate residents and create social contacts:

> When well-designed common areas exist, a higher level of engagement can be achieved by getting residents involved in the planning and running of activities.

The significance of co-housing is that it uses both design and formal social structures to encourage social interaction in neighbourhoods (Williams, 2005). It’s worth noting that this is manageable but guaranteed social contact. Williams argues that

> informal social factors and personal characteristics of those living in cohousing communities predispose them to social interaction. Thus, cohousing is a housing form with optimal conditions for social interaction. Cohousing also provides a unique opportunity to study these variables in one setting to determine the relative importance of each and how social and personal factors may help to enhance the outcomes of design.

The literature on co-housing is accumulating steadily and much of it reflects on the benefits for older people (*e.g.* Bamford, 2005; Brenton, 2001; Brenton, 2013). Some co-housing options are ‘intentional’ communities

reserved for older people: Glass (2009) offers a case study from the United States. With a focus on the contribution that local authorities can make, Brenton (2008) offers Dutch and UK case studies.

NORCs (naturally occurring retirement communities) are described as ‘communities where individuals either remain or move when they retire’ and it is argued that, compared to the provision of additional medical or social services, ‘healthy NORCs are a low-cost community-level approach to facilitating healthy aging’ (Masotti *et al*, 2006).

The principle of ‘lifetime homes’ has more to do with architectural design and the sustainability of buildings. According to Kelly (2001)

> While not aimed at any particular age or client group, lifetime homes address the different needs of families and households by house design that creates accessible homes, which will adapt to the changing needs of all the people who live in them as they age and change, and to meet the varying needs of different occupiers of that same house.

Most of these housing schemes imply the partial or complete segregation of older people, although the principle is not often questioned and can be over-simplified. One investigation explored preferences for planned retirement housing among older lesbians and gay men. A large majority indicated an interest in housing specifically sensitive to their needs, with support for a continuum of services (Lucco, 1987). In a members' survey the Opening Doors project in London found that 78 per cent of respondents 'feared the prospect of moving into sheltered housing or a care home, in case they were discriminated against'; but a similar proportion would 'feel comfortable to answer questions about [their] sexuality as part of an assessment for health or social services'. The project also found that older lesbian women preferred to participate with older project workers (Knocker *et al*, 2012).

Research in Melbourne with older people in high rise public housing (and a control group) confirmed that ‘age-segregated housing in an inner city location appears to facilitate friendships, particularly for people rendered vulnerable in old age’ (Davidson *et al*, 2001). Occasionally, there are also insights from focus group participants – Weeks and LeBlanc (2010) for instance report that a group of older aboriginals ‘did want to live where multiple generations could interact as a community.’ But as in most of the literature implying segregation of older people, the question that is not asked is *what is the impact on the rest of society of rendering older people comparatively invisible?*

The effect of NORCs on psychological well-being has been questioned, although in a project working with older Black residents it was found that an informal recreational intervention was beneficial (Lyons and Magai, 2001).

One well-established if less well-known approach that addresses isolation and provides for low level needs of older people is home-sharing, whereby older people with room to spare in their homes share their housing with others, either for rent or in exchange for services (Howe, 1985; Danigelis and Fengler, 1990; O'Shea, 2012; Suen, 2012). This approach offers a distinctive intergenerational component coupled with flexibility in relation to service provision.[2]

Among the more practical challenges for new housing settlement forms, Bookman (2008) notes the need to ensure access for older people on low incomes, accommodating diverse cultural and linguistic backgrounds, and ensuring the participation of older residents in aspects of governance. The study by Weeks and LeBlanc (2010) took as a basis the Canadian Mortgage and Housing Corporation's three standards of core housing need - 'affordability, adequacy, and suitability'[3] - and identified additional concerns among vulnerable older adults, including 'cultural appropriateness, availability, accessibility, and safety.' In similar vein, Greenfield and colleagues (2012) offer a framework for future development which covers 'civic engagement and empowerment activities; social relationship building activities; services to enhance access to resources.' There is, then, still much to be done if housing is genuinely to meet the needs of older people.

## 2.4 Ageing in place

The principle of 'ageing in place' is generally understood to resonate with the preferred wishes of most older people. It can be seen as a reaction against creeping institutionalisation and to have emerged from the tradition of community care and client-centred care (Kendig *et al*, 2012). In a review of social capital and ageing, Cannuscio and colleagues (2003) suggest that as more older people choose to age in place, this will in turn create NORCs.

The ambition to remain living in one's own home as long as one is physically able to do so, is supported by 'increased home equity, greater financial resources, and stronger ties to the community' according to a US study: at the same time, 'increases in property taxes and utility costs, changes in family composition, and diminished physical well-being,' were negatively

[2] See Homeshare International, http://homeshare.org/resources/

[3] http://cmhc.beyond2020.com/HiCOFAQs_EN.html#_What_is_core_housing_need?

associated with ageing in place (Sabia, 2008). A Swedish study has shown how older people's views of independence 'changed from being independent in activity performance without help from others, to experiencing independence in being able to make autonomous decisions concerning daily life at home' (Haak *et al*, 2007).

The challenge is about the extent to which policy promotes ageing in place beyond what works for those older people who are vulnerably housed. Environmental press plays a part. One commentator observes that

> Older people who rent may have an enormously strong attachment to their rented property built up over many years, but equally they might be being bullied in a multi-occupancy house, bereft of privacy and afraid for their security. Some older people with dementia may achieve a higher quality of life by moving into more specialist accommodation – 'ageing in place' should be seen as one option rather than the only option...
>
> A more sophisticated approach is needed than one in which it is assumed that attachment to place means that all older people should stay put. Older people are themselves only too aware of the potential limitations of staying put and the need to make constant re-adjustments between themselves and their environment. (Means, 2007)

Another UK study notes that the home in old age can be

> a place of negative experiences, such as isolation and loneliness and there are often significant weaknesses in terms of informal support, physical environment of the home and neighbourhood and social network, which undermine the person's ability to live independently. (Sixsmith and Sixsmith, 2008)

Ageing in place depends heavily on highly sensitive delivery of services in the home: outreach, as one Canadian report emphasises (Mark Holmgren Consulting, 2010), is crucial. Research by Tang and Lee (2010) suggests that it may be possible to predict older people's ability to age at home from their use of services. The issues raised in the provision of home care are extensive and may be steeped in complex meaning, covering for example 'issues of territory and boundary, control and cooperation, the symbolic significance of home and the negotiating of contingent relationships when public services are provided in the private sphere of home' (Martin-Matthews, 2007).

There may be a need for services that help the younger old to plan for the future: one group of people aged 55 years and older were found to favour ageing in place but most were not making plans to do so (Wagnild, 2001).

Various commentators (*e.g.* Dalrymple, 2005; Knapp, 2008) stress that the notion of 'ageing in place' needs to be understood to cover more than the home and its internal arrangement and meaning. Dalrymple's (2005) paper belongs with a number of public and community sector blueprints or strategic reports for 'liveable communities' that systematically accommodate the ageing population, or that seek to assess and address barriers. This theme is discussed further in the section on age-friendly places below. A community engagement project based in Toronto, which explored ageing in place in the context of accelerating gentrification (Janes, 2008), identified 'three thematic clusters where greater accessibility is critical: in their housing, neighbourhoods and local health and social service agencies.'

Finally we should note the situation recently reported in Sweden - a country known for its commitment to supportive welfare programmes. In an interview for the European Urban Knowledge Network, researcher Cecilia Henning observed:

> What is interesting in the Swedish example is that we have had a very decisive policy towards ageing in place, but we have found that we have gone too far… we have closed a lot of residential facilities… because the politicians and the municipalities think that we should not have so much residential care, we should have ageing in place. So instead, we give home care in people's homes. But at a certain point old people want to go to residential care units because they feel insecure and lonely. (European Urban Knowledge Network, n.d.)

Does this suggest that formal and informal care provided in the home to older people in the interests of ageing in place has 'crowded out' the state's provision of residential facilities? In a conference paper Henning and her co-researcher report that

> After cutbacks and changed priorities concerning Home Help the public sector have focused more on helping people with 'heavier' tasks involving personal care (e.g. dressing, bathing, feeding, using the toilet). This development have most likely led to that informal caregivers and volunteers commonly carries out 'lighter' tasks for someone who is a relative but might also be a neighbour or a friend. (Jegermalm and Henning, 2013)

We find ourselves coming round again to the broader social politics of elder care, and questions about the long term social effects of centrally-funded welfare. The 'crowding out' hypothesis is an economic theory which in this context suggests that over time, people's readiness to provide informal and voluntary care for others is reduced as the state crowds them out. Although widely questioned (Motel-Klingebiel *et al*, 2005; van Oorschot and Arts,

2005), politically the argument is extended to justify reduced state funding of welfare. The Swedish revelation may be potent because of the suggestion that

> From the studies of unpaid activities in Sweden, we see that there may be more of a 'crowding in' effect on social care instead of informal helpgivers and volunteers 'crowding out' the government programs. (Jegermalm and Henning, 2013)

In practice this appears to be an example of 'reverse crowding out,' a phenomenon in which 'private provision of a public good replaces existing tax-supported provision of the public good' (Isaac and Norton, 2013). What is clear is that ageing in place is inescapably political.

## 2.5 Age friendly places

The Public Health Agency of Canada[4] describes age friendly places as follows:

> In an age-friendly community, the policies, services and structures related to the physical and social environment are designed to help seniors "age actively." In other words, the community is set up to help seniors live safely, enjoy good health and stay involved.

A more academic definition is offered by Liddle and colleagues (2013):

> underpinned by a commitment to respect and social inclusion, an age-friendly community is engaged in a strategic and ongoing process to facilitate active ageing by optimising the community's physical and social environments and its supporting infrastructure.

It is worth noting that both definitions refer to 'structure' as well as encapsulating a sense of an ongoing process, rather than of an age-friendly place as an end in itself. The breadth of intent is apparent in the World Health Organization's *Checklist of essential features of age-friendly cities,* which covers the following:

> Outdoor spaces and buildings; Transportation; Housing; Social participation; Respect and social inclusion; Civic participation and employment; Communication and information; and Community and health services. (WHO, 2007)

A comprehensive review of the growing international literature on age-friendly communities published in 2009 (Lui *et al*, 2009) suggests that there

[4] Age-Friendly Communities, http://www.phac-aspc.gc.ca/seniors-aines/afc-caa-eng.php#sec1

are two main characteristics to the ideal of age-friendly places: 'an integrated physical and social environment, and a model of participatory, collaborative governance.'

Various pieces of work preceded (*e.g.* Feldman and Oberlink, 2003) or have augmented the WHO general list. A recent Canadian study (Novek and Menec, 2013) offers three additional 'contextual factors':

> community history and identity, ageing in urban, rural and remote communities, and environmental conditions

- together with three cross-cutting themes: independence, affordability and accessibility.

Canadian practice appears to be at the forefront of this global movement, exemplified by a resource-rich website.[5] In 2007 Miller and colleagues were calling for the focus of government research on aging to be broadened 'beyond just the delivery of healthcare'. A subsequent review of Canadian initiatives notes that:

> With variations across states, policy actions have included the following: declaring the initiative as an official policy direction; establishing model cities to be emulated by other cities; funding community projects; implementing consistent methodology; evaluating implementation, enhancing public visibility, and aligning age-friendly community policy with other state-level policy directions. To stimulate knowledge development and exchange, Canadian efforts have included the creation of a community of practice and of a research and policy network to encourage the development and translation of scientific evidence on aging-supportive communities. These activities are expected to result in a strong and durable integration of older persons' views, aspirations, rights and needs in municipal, as well as state, planning and policy. (Plouffe and Kalache, 2011)

A follow-up paper (Plouffe *et al*, 2013) argues that 'the engagement of municipalities in creative and comprehensive community development with and for seniors' has been one of the critical ingredients of success so far.

Two recent studies exemplify the kinds of detail we can begin to expect as practice becomes established. Young and colleagues (2012) set out to test whether residents' impressions of age-friendliness in a given place differ by age. They found that both older and younger adults were relatively consistent in their ranking of 15 age-friendly characteristics in St. Johns, the capital city of the Canadian province of Newfoundland and Labrador, thus reinforcing the argument that age friendly places benefit all citizens.

[5] The Age-Friendly Communities Hub, http://afc-hub.ca/

Also in Canada, an architect's approach is described in a Master's thesis by Long (2010), exploring the age-friendliness of local environments in the Metro Vancouver area based on the perceptions of residents over the age of 65. The researcher reports that:

> The key informants' perceptions support the literature on the importance of walkable neighbourhoods, adequate transit service, aging in place, autonomy, and prevention of social isolation.

Liddle and colleagues (2013) looked at age-friendliness as an attribute of retirement communities in England, identifying unfulfilled potential: they suggest such communities 'might better involve residents in a regular cycle of planning, implementation, evaluation and continual improvement if they are to facilitate active ageing.'

In the USA, Howe (2001) argues that American land use planning and regulations, public investments, private financing, and dominant societal values, have created communities that present significant obstacles to the continued independence of older adults. Howe describes various initiatives and notes that the key themes include:

> the recognition that healthy environments for older people are good for all ages; credible, locally-specific information is essential; values are important in defining preferred alternatives and appropriate courses of action; and it is necessary to bring together relevant stakeholders.

It's apparent that 'joined-up government' is essential to lasting success: Howe (2001) in particular calls for policy leadership in the USA, while CARP (2010) has published recommendations for an age-friendly Toronto, including:

1. Age-mindful governance (political will and civic values)
2. Universally accessible built form (public spaces and buildings)
3. Universal mobility in the public space (transit, co-located services, and community hubs).

The key message for policy makers, according to a recent review of progress across European cities, is that

> by applying healthy ageing strategies to programmes and plans in many sectors, city governments can potentially compress the fourth age of 'decrepitude and dependence' and expand the third age of 'achievement and independence' with more older people contributing to the social and economic life of a city. (Green, 2013)

The Canadian Urban Institute has called for age friendly communities to be brought 'into the mainstream of planning-related discourse' (Miller and Annesley, 2011). Practical support has also been published, for example the ‘community implementation guide’ (PHAC, 2012). This practical turn should go some way to alleviating the concerns of Mahmood and Keating (2012) that concepts like ‘universal design, visitability and age-friendliness’ are valuable but that there is a need ‘to look beyond the ideal city or neighbourhood design.’

Finally, there is benefit to be gained from returning to the overlooked, well-articulated concept of ‘lifetime neighbourhoods,’ promoting places that ‘provide all residents with the best possible chance of health, wellbeing and social inclusion, particularly as they grow older’ (Harding, 2007; Adams, 2009). The concept was developed by the International Longevity Centre UK in collaboration with the Department for Communities and Local Government (Communities and Local Government (UK), 2008), but was arguably the victim of abrupt policy changes consequent on a change of government. It emphasised the role of residents as active participants in their neighbourhoods, and the importance of a balance of services and support through social networks (Bevan and Croucher, 2011). The idea was adopted by the charity Help the Aged, which published a manifesto, developing proposals for age-friendly cities and challenging the way ageism is often designed-in:

> The manifesto for lifetime neighbourhoods includes a call to build lifetime homes; for greater involvement of older people in local decision-making processes; and an emphasis on the importance of local places and opportunities to meet. (Help the Aged, 2008)

## 2.6 Density and walkability

Received wisdom may favour dense urban environments for older people, but Burton and colleagues (2011) found that ‘older people reported positive feedback in both high- and low-density neighbourhoods and negative feedback in moderate-density neighbourhoods.' This adds force to long-resonating questions over the desirability of the traditional suburban environment for older people.

In low-income neighbourhoods, there may be health advantages conferred from density of ethnic populations. Research among older Mexican Americans in the south western United States found that the higher the levels of poverty at neighbourhood level, the greater the levels of

depression; but that this was reversed when there was a high proportion of Mexican Americans in the neighbourhood (Ostir *et al*, 2003).

There are a number of facets to the desirability of walkable neighbourhoods, to do with health, safety, access to services, social connection, social participation and so on. Connolly's (2003) study of the issue for older and disabled Londoners focused on the increased distances required to reach facilities; the sense of disempowerment in relation to change that affected them; and the ways in which a degraded street environment undermined their quality of life.

The assumption that walkable neighbourhoods are more sociable places to live may be misplaced. Two Australian studies offer only weak evidence in this respect. Du Toit and colleagues (2007) were 'unable to demonstrate that pedestrian-friendly urban forms play a significant role in encouraging strong social ties between neighbours.' Despite a large sample, the researchers could find only 'a weak positive relationship' between walkability and sense of community. Wood and colleagues (2008) looked at the walkability of suburbs as determined by street network design and the mix of land uses. While their research did not focus specifically on older people, they found that the built environment had

> a significant but small effect on social capital and feelings of safety, particularly in relation to the number and perceived adequacy of destinations. A high level of neighbourhood upkeep was associated with both higher social capital and feelings of safety.

Using data from eight neighbourhoods in two cities in the Pacific Northwest of North America, Chaudhury and colleagues (2012) confirm that traffic hazards and personal safety are of more concern to older residents in higher density neighbourhoods compared to lower density areas. A further report from the same programme of work (Mahmood *et al*, 2012) refers to the value of diverse destinations in the neighbourhood:

> Our findings suggest that beyond the intention to become or to stay physically active, the potential of interacting with others may play an equally motivating (if not a stronger) factor for older adults to get out of their homes and participate in a physical activity oriented event.

Various studies address specific features in the urban built environment that relate to the experiences of older people. Researchers working in low income areas in Florida measured the impact of architectural features which might be said to suggest social interactions and the possibility of social support, or otherwise to affect mental health in older Hispanics. They found that

> features of the front entrance such as porches that promote visibility from a building's exterior were positively associated with perceived social support. In contrast, architectural features such as window areas that promote visibility from a building's interior were negatively associated with perceived social support. (Brown *et al*, 2009)

This assumes of course that the environment is walkable for older people in the first place. Another study raises important design questions for the public realm on the grounds that 'most older adults either cannot walk eight feet safely or cannot walk fast enough to use a pedestrian crossing in the UK' (Asher *et al*, 2012).

## 2.7 Being active in the neighbourhood

> The positive association between physical environment, perceived or objective, and physical activity behavior was fairly consistent.
>
> (Yen et al., 2009)

The literature on walkability is extensive and much of it confirms the positive association of walkable environments with older people's physical and mental well-being. The review carried out by Yen and colleagues (2009) confirms the consistency of the evidence regarding accessible neighbourhood design. The examples that follow have been selected to illustrate the range of research and insights.

The work of Prince and others (2011; 2012) in the Ottawa Neighbourhood Study, although not distinguishing older people from the rest of the adult population studied, found that more green space was associated with a *reduced* likelihood of physical activity and increased odds of being overweight *in men*, and *decreased* odds of being overweight *in women*. As might be expected, the researchers confirmed that physical activity was affected by the seasons: the odds of leisure-time activity in winter months were half that of summer months (Prince *et al*, 2012). Never mind the seasons, dogs make a difference: Rogers and colleagues (1993) found that 'Dog owners reported taking twice as many daily walks as non-owners.'

Clearly, environmental quality does make a difference. A focus group exercise with older people in Portland, Oregon, concluded that

> For older adults, maximizing the attractiveness or safety of a walking path is more important than minimizing the distance to a destination. Safety emerged as the biggest concern that limits walking for everyday activities as well as exercise. Primary safety concerns were busy, trafficked streets and unsafe street crossings. Traffic lights that provide exclusively

> pedestrian access and adequate time to cross were high priorities. (Michael *et al*, 2006)

Another study in the same area found no association between built environment and the likelihood of walking or not walking. However,

> among those participants who reported some degree of walking activity, average time spent walking per week was significantly associated with amount of automobile traffic and number of commercial establishments in their local neighborhood. These findings suggest that built environment may not play a significant role in whether older adults walk, but, among those who do walk, it is associated with increased levels of activity. (Nagel *et al*, 2008)

The association between perceived traffic safety and walking is echoed in a study of walking patterns among older people in Bogota (Gómez *et al*, 2010). The researchers found 'negative association between street connectivity and walking for at least 60 minutes'. This is attributed to the compactness of the city, with 'a high connectivity level' and more intersections and pedestrian crosswalks, 'which could be associated with a perception of higher risk of traffic accidents among older adults.'

The association between depression and the combined effects of social participation and walking has been studied in a population of older Canadians. The results show that

> individuals who do not walk outside their home report more depressive symptoms or a greater likelihood of possible clinical depression. (Julien *et al*, 2013)

## 2.8 The green environment

Research confirms that living in urban areas with walkable green spaces can positively influence the longevity of older people independent of their age, sex, marital status, baseline functional status, and socioeconomic status. A study in Tokyo found that

> walkable green streets and spaces near the residence showed significant predictive value for the survival of the urban senior citizens over the following five years. (Takano *et al*, 2002)

Green residential environments do not only have an influence on individual health and well-being (Wells and Laquatra, 2010). Another study (Kweon *et al*, 1998) found that the use of green outdoor common spaces predicted both the strength of local social ties and the 'sense of community.' The authors argue that

> spending time in nearby common spaces with trees and grass fosters older adults' informal face-to-face contacts with their neighbors and in doing so supports the development of meaningful relationships among acquaintances and neighbors.

The benefits to older people of the availability and use of gardens appears to be under-researched. A study based in northern England suggests that communal gardening on allotment sites

> creates inclusionary spaces in which older people benefit from gardening activity in a mutually supportive environment that combats social isolation and contributes to the development of their social networks. (Milligan *et al*, 2004)

Alves and Sugiyama (2006) offer a short review of literature on the benefits of access to outdoor environments for older people, emphasising the links between physical activity and social networks.

## 2.9 Place attachment

The percentage of people who express a sense of belonging to their neighbourhood tends to increase with age. In the UK it increases from 69 per cent of those aged 50 to 54, to 84 per cent of those aged 70 and over (Lofts, 2013). Allison Smith notes in her (2009) study of place attachment and social exclusion that the research evidence on attachment in urban areas is equivocal. People living in an environment characterised by disorder and uncertain security may only abandon their association with a place with the greatest reluctance, especially if they have lived there a long time. It is not inconsistent to express a sense of bewilderment and disempowerment along with an affirmed sense of belonging. And as all community workers know, adversity can stimulate allegiance.

The power of place attachment is starkly illustrated by Susan Saegert (1989) in her study of older women who showed leadership as residents of limited equity co-ops in landlord-abandoned buildings in New York City. Saegert describes how

> The elderly leaders' tendency to stay at home seems to have contributed positively to the functioning of the co-ops as they socialized, watched out for children, screened strangers, peered over workmen's shoulders, and otherwise looked after the interests of the co-op.

She goes on to report that

> Positive identification with place depended on individual and collective memories of the past and visions of the future woven together by durable, multifaceted social ties and activities centred in the neighborhood. Such attachment coexists with recognition of the problems in an area.

This resonates with Taylor's (2001) assessment of the life stories of older African Americans in a small town in the mid-western United States. Taylor highlights a positive attachment to place which contrasts with assumptions of the negative impact of lifelong experiences of injustice and inequality.

In a study of older people in Rotterdam neighbourhoods, Blokland (2001) has shown how the collective production of memories is part of the way they 'format the neighbourhood symbolically.' The presence or absence of neighbourhood resources, and their cultural or age-related appropriateness, will influence people's collective capacity to assemble the ingredients of such local identity. Eby illustrates in her (2012) study of single women's experiences of local 'gathering places' in Hamilton, Ontario, how sense of place can be influenced strongly by the nature of local spaces:

> The older women in particular noted that their age group, especially those who are single, have a hard time finding places to go to meet people, since many programs cater to mothers of young children.

There are practical ways of demonstrating place attachment. Work in Aotearoa New Zealand (Wiles *et al*, 2009; Wiles and Jayasinha, 2013), has focused on 'the varied and active ways many older people are involved in and contribute to their neighbourhoods.' The concept of 'care for place' is used here to encapsulate the different forms of older people's care for place, including volunteering, activism, advocacy, and nurturing. (This touches on the theme of the barely-visible and rarely-acknowledged contributions of older people to the lives of each other and of other generations, which is reviewed in section 4.6.4). It has also been shown that age-specific research tools on environmental factors such as collective efficacy can be developed (Galinsky *et al*, 2012).

## 2.10 Social exclusion and neighbourhoods

While the effects of specific neighbourhood characteristics may be hard to pin down, given the range of variables, it is acknowledged that there are negative effects associated with living in an area where most of those around you experience exclusion. According to the research review carried out by Yen and colleagues, socio-economic status at the neighbourhood

level ‘was the strongest and most consistent predictor of a variety of health outcomes’ (Yen *et al*, 2009).

Andreas Hoff’s (2008) review of European approaches to tackling social exclusion among older people offers two findings of value in the present context. First, that almost universally throughout Europe, local community or day-care centres can be found, that take care of older people’s needs in daily living, ranging from advice on rights and entitlements, to the provision of social care and socialising opportunities. Secondly, Hoff notes ‘the frequent occurrence of the intergenerational theme in various small-scale but very innovative projects on pooling the resources of the old and the young generations even in the absence of kinship ties.’

A number of UK studies (*e.g.* Smith *et al*, 2004; Demakakos, 2008; Centre for Social Justice, 2010) responded to the urgency of early 21st century policy concerns about social exclusion. The benchmark was set by Scharf and colleagues (2002) who investigated the impact of social exclusion on older people living in some of England’s most deprived urban areas. The key findings include the following:

- Older people living in deprived areas of England are at least twice as likely to experience poverty as those in Britain as a whole.
- Not only are older people in deprived areas fearful of crime but the research suggests that they are justified in many of their anxieties.
- Older people are particularly concerned about the physical appearance of their neighbourhoods, the social problems that accompany profound socio-economic change and the absence of amenities and services that can meet their needs. Nevertheless, older people display a considerable degree of attachment to their local areas.
- There is potentially a relationship between the characteristics of deprived urban areas (in England) and the incidence of loneliness among older people.

Evidence of this kind was augmented by the Centre for Social Justice in 2010, with a working party report that used observation visits and witness contribution sessions as well as published material. While much attention is paid to housing, pensions and care services, there is recognition of the significance of ‘relational well-being’. A study in Scotland has shown ‘direct associations of objectively and comprehensively determined neighbourhood deprivation with self-perceived quality of life in physical and environmental domains, but not in psychological or social relationship domains’ (Mõttus *et al*, 2012).

Comparing evidence from interviews with older people in deprived inner-city neighbourhoods in England and Belgium, Buffel and colleagues (2012) draw attention to four common overarching issues:

- experiences of community change;
- feelings of security and safety;
- the management of urban space; and
- strategies of control.

These themes, taken together with the points by Scharf and colleagues (2002) enumerated above, suggest a narrative of disempowerment and the sense of sometimes vague but persistent threat, in the experiences of older people in such areas. This narrative is among the themes explored by Smith (2009) using empirical research with older people in Vancouver and Manchester, seeking to explain the ways in which older people in marginalised neighbourhoods negotiate their private and public spaces.

Where you live can also make a difference if there is a perceived imbalance of socio-economic status. People who live in conditions of high income inequality tend to exhibit low levels of trust (Ichida *et al*, 2009). Deeg and Thomése (2005) looked at discrepancies between income and relative affluence of neighbourhood among older people in the Netherlands, in relation to health indicators. They found that low-income older adults who lived in 'high-status' neighbourhoods had poorer physical functioning, more functional limitations, worse self-rated health, worse cognitive ability, and were more lonely than low-income adults who lived in low-status neighbourhoods. In New Zealand, researchers looked at the living conditions of older people and suggest that lower income levels and wealth, less secure housing, limited mobility, and less frequent social contact are all associated with a higher prevalence of frailty among older people:

> Disadvantage in these areas reduces the ability of the older person to adjust to their living environment, affecting the potential for recovery and the maintenance of wellbeing. (Barrett *et al*, 2006)

Krause (1993) proposed a logic model based on the combination of low levels of trust, education and financial resources, arguing that:

> older adults with low levels of educational attainment are more likely to experience financial problems and that elderly people who are confronted by financial difficulties are more likely to reside in dilapidated neighborhoods. The model further predicts that deteriorated neighborhoods in turn tend to promote distrust of others and older adults who are more distrustful of others tend to be more socially isolated.

The model was developed by Thompson and Krause (1998) in an attempt to explain why 'anticipated support is lower among elders who live in deteriorated neighborhoods than among older adults who live in well-maintained neighborhoods.'

Marginalisation from economic productivity is a profound form of exclusion which can be emphatic for older people. This is most clearly illustrated in a UK study (Churchill *et al*, 1997) which discusses the ways in which sheltered housing works to restrict or deny older people any economic role – including as consumers or, for example, the fact that they can no longer perform an informal child care role to enable extended family to work:

> The resulting paucity of material resources is compounded by experiences of lack of worth, respect and self-esteem, all contributing to exclusion from social activity and relations and to little control over your own life.

A number of other writers touch on the context of social exclusion for older people. For example, studies of the experiences of women in poverty (Boneham and Sixsmith, 2006; Saegert, 1989) and of specific ethnic groups (Ostir *et al*, 2003).

## 2.11 Residential satisfaction

It is to be expected that older people's satisfaction with their housing and area will vary considerably, according to their expectations and background. Costa Font's (2012) study of older people and housing in Spain concluded that

> satisfaction with housing in old age is indeed independently associated with environmental influences. Although homeownership does improve well-being related to housing, home equity does not exhibit a significant and independent effect.

Reynolds and Beamish (2003) outlined the high expectations of residents in a private pay retirement facility. Residents valued 'good design and construction, friendly neighbors, privacy, efficient handling of maintenance concerns, and accessible management.' By contrast, Lawton (1980) in a study of public housing tenants found that

> residential satisfaction is incremental, depending on a large number of possible contributors to perceived quality, few of which are overwhelmingly stronger than others. Adequacy of heating was somewhat more important than other housing indicators and fear of crime somewhat more important than other neighborhood attributes.

It's apparent that people's expectations are central to their residential satisfaction, and this will influence psychological well-being. Research in Hong Kong (Phillips *et al*, 2005) found that older people's residential satisfaction was determined by assessment of both the interior environment and the exterior environment, but these were appraised differently: the interior environment had a greater impact on residential satisfaction than the exterior environment.

## 2.12 The home environment

> Take Ella's experience for example — her home was her safe haven, yet it was also the location of her loneliness and isolation.
>
> (Grenier, 2005)

Any project seeking to address social isolation has to come to terms with the tension between privacy and publicness: where older people are concerned, this can be associated closely with issues of dignity and independence. The home has been more or less sacrosanct as a symbol of privacy in western societies for the past several centuries, but Milligan (2009) argues that there is an 'increasing porosity of boundaries between formal and informal care and between home and institution.'

Homes have histories and histories have emotional power. As a society we may lack the tools to measure such power against other forces, but that is no reason to ignore it when assessing the emotional importance of the home for older people before and during the period when they may need to leave it. Research into the value of 'low level' domestic services (housework, gardening, laundry, home maintenance and repairs) for older people stressed that 'keeping a well-maintained house was central to many older people's sense of well-being and of being part of society, as well as to their confidence about coping at home.' The researchers conclude that

> services which enhance quality of life and social engagement have a central role in helping older people to remain in their own homes with dignity and independence. (Clark *et al*, 1998)

A study carried out in Australia (de Jonge *et al*, 2011) found that older people were interested in 'the capacity of the house to support their many and varied occupations, particularly their ability to care for others.' The researchers discuss the significance of history and emotional connection as well as social connections. In interviews with older women living in a congregate housing complex in the USA, Leith (2006) found that 'the meaning of home was manifested in (1) the autonomous decision to find a

place somewhere, (2) the deliberate resolve to feel in place anywhere, and (3) the ongoing effort to stay placed there.' Research by Seo and Mazumdar (2011) records the significance of cherished objects in the home and the emotional disruption of having to part with them under certain circumstances.

Two scholars in particular have explored the contemporary nature of home-based care. Wiles (2005) has drawn attention to the contrast between 'the home as a place full of meaning and emotion to those who live in it, compared with the home as a space which is convenient (or not) and cheaper for those providing formal care.' Milligan (2009) points to the growing complexity of the 'landscape of care' for frail older people, and Wiles (2011) has gone on to explore the concept of vulnerability in this context.

Related issues are covered in the discussions of environmental press and ageing in place (above) and relocation (below).

## 2.13 Relocation

There is a long history and continuing experience of older people being forced from their homes in the name of regeneration. This theme, documented by Dumbleton (2006), links back to the desirability of ageing in place even where conditions may be negative. Residential mobility has a negative effect on the relative size of older people's neighbouring networks (Thomese and Van Tilburg, 2000).

Loneliness and isolation can easily be exacerbated by relocation away from familiar surroundings and from extended family, especially adult children. Mulder (2007) has noted the need for research investigating the influence of the wider family context on residential choice. Older people's experience of relocation can have positive or negative effects on their sense of psychological well-being, because of a complex range of factors associated with the congruence between personal needs and what the new setting provides (Ryff and Essex, 1992). The effects need not be negative: a study published in 1974 by Lawton and Cohen suggested that older people who were re-housed 'were significantly better off than the community residents' on a number of dimensions, controlling for original state of wellbeing, demographic characteristics, and initial state of health.

A study of older people who moved to a new suburban (but not age-specific) residential development in Brisbane suggests that some residents found its heterogeneity problematic when it came to establishing new social

networks. There were low expectations of filial obligation, and 'the older residents displayed little propensity, or opportunity, to form these neighbourly relationships' (Walters and Bartlett, 2009).

Deciding on whether or not to relocate will often not be straightforward. Golant (2003) in discussing the notion of '*residential normalcy*' suggests that relocation is a coping strategy that 'requires the most strenuous adaptive efforts.' This is illustrated in some detail by Seo and Mazumdar (2011) who studied the relocations of older Korean immigrants to the USA and describe

> the complex and interwoven nature of the decision to move involving experiences, events, and nested mini-decisions, as well as the emotional disruptions, loss of sense of self, and detachments that occur.

On the basis of a qualitative study with older women in the USA, Leith (2006) suggests that successful relocation late in life 'depends less on concrete and/or external factors and more on social and/or intrinsic factors.' Research on an extensive U.S. scheme to promote mobility within the housing market in the 1960s and 1970s confirms the influence of social networks in discouraging relocation: unsurprisingly, those without family or friends in their neighbourhoods participated in the experiment 'at a higher rate than did the elderly who had access to other sources of assistance' (Walter, 1985).

A Canadian study (Weeks *et al*, 2005) has described the range of connections between family support currently provided and older people's future housing preferences. Caro and colleagues (2012) devised a 'vignette experiment' with older people and family members, examining five dimensions that might influence a decision to relocate to a retirement home. They found that the older person's functional status had the greatest impact on the decision. However, for adult children the prospect that the older person would experience social isolation proved as powerful as the issue of functional status:

> For older adults, the dimension (of social isolation) was much less important. It is possible that adult children are more likely than older adults to interpret knowing fewer people in the neighborhood as a sign of vulnerability because of lack of informal support from neighbors that contributes to reasons for relocating to a retirement community. Adult children may also interpret weak social networks in neighborhoods as a sign that more extensive support from them may be needed. (Caro *et al*, 2012)

Fisher's (1990) three-year study of retirement homes demonstrates how 'residents felt stigmatized' and claims that 'relocation to a retirement facility can have a detrimental effect on an older person's self-concept.'

At the societal level, a paper for the International Longevity Centre (UK) (Kneale *et al*, 2013) suggests that the concept of 'ageing in place' can be misinterpreted, encouraging older people to remain in properties that are too large and inappropriate for their needs. This context is complicated by the fact that retirement housing is seen as largely for those with existing care needs. Another recent paper in the UK reports that more than half (58 per cent) of people over 60 were interested in relocating; and more than half (57 per cent) of those interested in moving wanted to downsize by at least one bedroom, rising to 76 per cent among older people currently occupying three-, four- and five-bedroom homes. The author makes a telling point for housing policy:

> A lack of choice of suitable homes to downsize into is having a negative effect not just on older people's health and wellbeing, but on the rest of the housing chain, as 85 per cent of larger family homes owned by older people only become available when someone dies (Wood, 2013).

# 3

# Quality of life, health and well-being

## 3.1 Quality of life and well-being

> Models of quality of life range from identification of 'life satisfaction' or 'social wellbeing' to models based upon concepts of independence, control, and social and cognitive competence. However, regardless of how the concept of quality of life is defined, research has consistently demonstrated the importance of social and family relationships in the definition of a 'good quality of life.'
>
> (Victor *et al*, 2000)

Studies of quality of life among older people tend to discuss variations on the four main themes of *health*, *wealth*, *relationships* and *place*. A major UK study, based on 999 people aged 65 or more years living in private households (*i.e.* excluding those in care homes), adds two other factors to the list, the participatory and the psychological:

- engaging in hobbies and leisure activities (solo) as well as maintaining social activities and retaining a role in society;
- having a positive psychological outlook and acceptance of circumstances which cannot be changed. (Gabriel & Bowling, 2004)

The latter is also picked up in a report by Watson and Sinclair (2011) which divides it as follows:

- psychological factors such as a sense of optimism and realistic expectations; and
- having a sense of control over one's life.

If these approaches value the degree of agency in the individual's own quality of life, there are others that imply that quality of life largely comes down to the situation in which individuals find themselves. Thus a participatory study in seven Canadian cities (Bryant *et al*, 2004) comes up with a more pragmatic list: access to information, health care, housing, income security, safety and security, social contacts and networks, and

transportation. And hidden away in another Canadian report (Raphael *et al*, n.d.) another factor that influences quality of life is listed -

> political features of the community environment that directly affect the life of its citizens (*e.g.*, cutbacks to funding for needed services).

Occasionally there is additional insight in the specificity or nuanced language used. With reference to social relationships for instance, Netuveli and colleagues (2006) refer to 'lack of at least one trusting relationship;' and with reference to place at one point they use the phrase 'residence in an appreciated neighbourhood' as an indicator of positive quality of life.

Overall then, the significance of subjective factors is confirmed in several pieces of detailed research, with greater or lesser emphasis alongside objectively measureable factors like wealth or poverty, and health. A US study notes that

> poor overall self-reported health and poor financial resources in relation to needs had the strongest explanatory value. Also of significant importance were loneliness, the degree of reduced self-care capacity and feeling worried. (Borg *et al*, 2006)

There are important insights into differences relating to ethnicity and relative poverty. A study by Smith and colleagues (2004) of quality of life amongst older people in deprived neighbourhoods adopted two existing measures and developed a third, then tested them all to produce four key determinants: perception of own health, perceived ability to cope financially, perception of poverty over time, and loneliness. For this category of older people then, quality of life was less influenced by neighbourhood characteristics (see also sections 2.2 and 2.10).

Poor health, especially reduced ability to care for oneself, affects and is affected by other factors which in turn affect quality of life: these include the sense of loneliness and inadequate financial resources, but not gender or living conditions (Borg *et al*, 2006). In 'a large part of the elderly population,' poor quality of life is associated with combinations of social support deficits, loneliness, disability, and depression (Prince *et al*, 1997).

There are lessons to be learned from cross-cultural studies. Chappell in her (2003) comparison of ageing in Shanghai and Canada implies that, of the four key themes, finance and place are less important. She found that

> in both cultures it is social support and health that predict life satisfaction. The form that social support takes… and the particular physical health problems that one might suffer from differ across cultures but it is social

> support and health that appear to be universal in their (e)ffects on our subjective quality of life.

Three articles based on work in the UK and all published in the same year, draw attention to differences between ethnic groups in understandings of quality of life among older people. Moriarty and Butt (2004) found differences in health, income and social support among white British, Asian, Black Caribbean, Black African and Chinese people. Based on the same study, Butt and Moriarty (2004) suggest we may be seeing 'increasing convergence in household living arrangements between different ethnic groups' and that 'certain minority groups may be more, not less likely, to live on their own.' Meanwhile, in spite of the reported differences, it is striking that Bajekal and colleagues end up with four quality of life indicators in terms very similar to other studies that did not take ethnicity into account:

> quality of neighbourhood (availability of local amenities, and problems with crime and the physical environment); social networks and community participation (strength of family networks, and community participation); material conditions (income, wealth and housing conditions) and health. (Bajekal *et al*, 2004)

There is a fair degree of consensus then about the factors that make up quality of life for older people, with 'social connections' and 'health' apparently the most important, followed by neighbourhood and financial resources. Claims are also made for variations on the themes of material security, participatory agency and psychological resources. The following policy implications are proposed by Watson and Sinclair (2011):

> policies aimed at improving the quality of life of older people should focus on providing facilities that support neighbourliness and social interaction and help people to feel in control of their own lives.

Finally, consideration should be given to the quality of life benefits accruing to pet owners, and to those with dogs in particular: according to Rogers, Hart and Boltz (1993), dog owners reported 'significantly less dissatisfaction with their social, physical, and emotional states.' Another study found that pet ownership was positively associated with certain forms of social contact and interaction, and with perceptions of neighbourhood friendliness:

> After adjustment for demographic variables, pet owners scored higher on social capital and civic engagement scales. The results suggest that pet ownership provides potential opportunities for interactions between neighbours… (Wood *et al*, 2005)

### 3.1.1 Well-being

Quality of life can be seen as the generalised expression of the most positive prevailing context for ageing. By comparison, the related notion of 'well-being' seems to be understood as reflecting how individuals pursue that quality of life.

The four studies discussed here suggest that what characterises well-being in the context of ageing is an ongoing attempt at or achievement of equilibrium – for example in seeking social opportunities while managing functional decline. Sense of control, and valuing social relationships, are usually at the heart of this. Thus in their 2004 report for Joseph Rowntree Foundation, Godfrey, Townsend and Denby explored what older people understood by 'a good life' and how they enacted it. They suggest three factors that appeared necessary for people to sustain their sense of well-being:

- having the capacity and opportunity to be involved in different types of social, leisure and stimulating activities that connected them to people and places with whom they shared interests and experiences
- a continued enjoyment of mutually supportive, intimate and companionable relationships
- the ability to do things that brought pleasure and meaning. (Godfrey *et al*, 2004)

Similarly, in their work with older people in Aotearoa New Zealand, Wiles and colleagues discuss the notion of resilience as 'a useful concept framing how ageing well can incorporate multidimensional pathways including both vulnerability and flourishing.' The sense of well-being and resilience are not simply resources available to individual personalities in greater or lesser quantity, but reflect the *process* of ageing in a social, political and physical context:

> our participants illustrate that having a positive attitude or purpose in life is not merely an internal state, but is inextricably connected to relationships with others, to the resources available in a given community, and other opportunities such as employment or government services. (Wiles *et al*, 2012)

Hildon and colleagues (2009) define resilience as 'flourishing despite adversity,' although they go on to conclude that resilience will be promoted by 'policies that offer access to protection and help minimize adversity exposure' – which seems inconsistent. Their research identified indicators of

protective attributes, including good quality relationships, integration in the community, developmental coping, and adaptive coping styles.

The balancing of personal resourcefulness with a realistic appreciation of the ageing context, and minimising the loss of control, is reflected in research in Sweden reported by Hammarström and Torres (2012), which gave rise to a framework for understanding well-being in older people. Using four subjective categories ranging from 'well-being', 'well-being despite it all', 'well-being so far', to 'lack of well-being,' the researchers identified the three themes of 'acceptance, predictability, and control' which play across the categories. They note:

> subjective well-being among older people who receive help and support in their everyday lives is not only related to socio-contextual factors – such as physical and mental capability, activities and/or engagement in the outside world, the spatial and social consequences of physical limitations, social and emotional relations, as well as the social support they receive – but also to how they regard and handle these matters in terms of acceptance, predictability and control.

There are strong arguments then, for accounts of ageing that reflect the continual play of adjustment to circumstances and recognition of change in the light of accumulated experience. As Godfrey and colleagues argue,

> For older people in our study, ageing was not simply about decline. It was not even about holding on or maintaining an even keel. It was about actively managing the transitions and changes that occurred in their lives, opening out opportunities and expanding horizons. (Godfrey *et al*, 2004)

## 3.2 Elder abuse and neglect

Any community project concerned with the isolation of older people has to take account of issues of elder abuse and neglect. As Johannesen and LoGiudice (2013) conclude from a systematic literature review, abuse is the consequence of complex sets of circumstances which can include the personality and behaviour of the older person, the nature of the relationship, and the environment. Through interviews with professionals, Hickey and Douglass (1981) have suggested that abusive behaviour is 'primarily based in the flawed development of the perpetrator and in disordered family relationships' and is triggered by certain 'environmental contexts and situational problems'. There are grounds for fearing that relatively isolated older people are as likely as others to have been the victims of abuse or to be vulnerable to it.

In this respect, one study points to a particular role for local voluntary agencies:

> It was also notable that respondents had concerns about knowing where to go with a problem, about whether it was appropriate to approach statutory services with a problem and about the consequences of reporting. The research suggests the need for a nonthreatening, generic 'first port of call' for older people experiencing a wide range of problems. Such a facility would provide or signpost older people to relevant services and support and would remove anxiety about whether the experience of mistreatment or abuse was serious enough or appropriate to report to authorities. (Mowlem *et al* 2007)

'Abuse' can of course include exploitation and manipulation. Occasionally, stories about the effective 'kidnapping' of older people for their assets are found to be based in fact. One neighbour's account published in the *Guardian* (Johnson, 2007) describes how an elderly woman was taken over by another neighbour, brought into her house, and eventually her will was found to have been changed to favour her new 'carer'.[6]

[6] A follow up article, in the context of the Crown Prosecution Service's policy on crimes against older people, was published a year later at http://www.theguardian.com/society/2008/jul/30/longtermcare.law

## 3.3 Health

This section considers the literature on older people's health generally, in relation to the objectives of the OHEY project. Material concerned with depression and loneliness is reviewed in section 4.7.

The association of social networks with health benefits has been recognised at least since the publication of a nine-year 'follow-up' study by Berkman and Syme (1979). They reported that:

> Four sources of social relationships were examined: 1) marriage; 2) contacts with close friends and relatives; 3) church membership and 4) informal and formal group associations. In each instance, people with social ties and relationships had lower mortality rates than people without such ties. Each of the four sources was found to predict mortality independently of the other three; the more intimate ties of marriage and contact with friends and relatives were stronger predictors than were the ties of church and group membership.

They found that people who lacked social and community ties were 2-3 times more likely to die in the follow-up period than those with more extensive contacts. Subsequent studies in various parts of the world (*e.g.* Iwasaki 2002; Jerliu *et al*, 2013) have re-affirmed these messages. A recent review from the medical perspective concludes that

> The influence of social relationships on risk for mortality is comparable with well-established risk factors for mortality. (Holt-Lunstad *et al*, 2010)

Again, social disconnectedness and perceived isolation are independently associated with lower levels of self-rated physical health (Cornwell and Waite, 2009). It is subjective health, rather than objective health, which exerts a significant indirect effect on social loneliness (Heylen, 2010). An article based on the Seattle Longitudinal Study[7] grouped individuals (not necessarily older people) into clusters and found that those groups with greater health problems were more likely to be isolated, had the least social contact, and had lower levels of education and income (Bosworth and Schaie, 1997). Another study suggests that the key health-benefitting ingredients in social networks are 'elective relationships' and social participation; but not family connections (distance from and contact with relatives) which are not significantly associated with any health outcome (Golden *et al*, 2009). Social support, networks, participation and loneliness and isolation are reviewed in sections 4.4 – 4.7.

[7] http://www.uwpsychiatry.org/sls/index.htm

Nonetheless, there may be a risk that in over-emphasising social connectedness we lose sight of the importance of both self-management of health, and the role of formal care services. Focus group research with older people and health professionals (Giummarra *et al*, 2007) found that

> While health professionals tended to place the source of poor health on failures of social connectedness and poor service delivery, older people stressed the importance of taking ownership of one's own health and actively seeking out health promoting activities and services.

### 3.3.1 Use of health services

Coulton and Frost (1982) report that older people are not dissimilar to the general adult population in the factors affecting their use of health services. The variance that exists can be attributed largely to need.

As might be expected, those who lack networks are likely to make greater use of health services (Bosworth and Schaie, 1997). A large scale interview-based study in Manitoba (Penning, 1995) found differences in health service use depending upon the type of support (instrumental, emotional) and type of service (medical, hospital, home care) involved. A subsequent study in the same area (Hall and Havens, 1999) found strong correlations between health service use and loneliness among older women. Higher levels of loneliness were more likely for women who had:

- more admissions to hospital,
- longer stays in hospital,
- a greater number of physician visits
- higher number of pharmacare claims, and
- used home care services.

This appears to contrast with the findings from a study in British Columbia, which found that older people who were socially isolated ‘do not appear to be ‘over-using’ the health system' (Cloutier-Fisher *et al*, 2006) and ‘were not more inclined to overuse health services’ (Kobayashi *et al*, 2009).

Use of health services is positively influenced by illness, being female, and having insurance; but according to one study of a general adult population in Baltimore, ‘being aged’ is inversely related to service use (Kouzis and Eaton, 1998). This suggests confirmation for the assumption that older people tend to just get accustomed to declining health, although the true picture would need to take account of health provision in care homes.

The usefulness of self-rating health is asserted by Menec and Chipperfield (2010), who showed that, as might be expected, older Canadians who rated

their health as bad, poor or fair were more likely to be hospitalised than those who rated their health as excellent. In a study of older people's social networks in Israel, however, Litwin (1997) found that the greatest use of health services was made by the healthiest respondents with the most diversified support networks. Those with family-focused networks made the least use of services.

### 3.3.2 Decline in physical function

Decline in physical function is associated with increased self-neglect (Dong *et al*, 2009); but the relation between functional impairment and depression is not always straightforward. A study by Cummings and colleagues (2003) found that although older African Americans were more impaired in daily activities than older white Americans, they did not experience higher levels of depression. The researchers also reported higher levels of social support and religiosity among the Black sub-sample, reinforcing the association of social support with resistance to depression.

Physical function can be ameliorated by activity in many cases, and the value of non-exercise physical activity for older people, in terms of cardiovascular health and longevity, has recently been reasserted (Ekblom-Bak *et al*, 2013). A UK study claims that among the oldest old, having poor physical quality of life is not necessarily associated with poor mental quality of life (Grundy *et al*, 2007). Hirvensalo and colleagues (2000) categorised a sample of older people according to the extent to which they were mobile or impaired, and sedentary or active. The relative risk of death was two times greater in 'Impaired-Active' older people, and three times greater in 'Impaired-Sedentary' groups than it was among those who were 'Mobile-Active.' Different kinds of ill-health can have different effects on social connections. For example, Penninx and colleagues (1999) found that older people with lung disease or arthritis were more likely to experience loneliness, than those with other diseases or with none. They note also that arthritis patients reported giving significantly more emotional support to others 'when compared to persons with other chronic diseases and persons with no disease.'

In a study of the experience of decline and disability among older women in Montreal, Grenier (2005) calls for more attention to be paid to the ways in which context influences frailty:

> when faced with a change in the body, the context and social location become key to how older women experience disability and decline.

This seems to be confirmed in a research review by Beswick and colleagues (2010) who conclude that 'complex interventions' - including some social component - make a difference in health terms, reducing the number of nursing home admissions.

Research into the health status of Canadian immigrants suggests that their health tends to decline quickly after arrival, with a concomitant increase in use of health care services (Newbold, 2005). It is reasonable to suppose that this applies as much to older individuals. Recent UK research with refugee populations confirms that 'social connections have a clear impact on health' (Cheung and Phillimore, 2013).

### 3.3.3 Women and health

The role of women in taking responsibility for their own and others' health is highlighted in an interview-based study of older women (aged 55–78 years) in northern England:

> Their experiences of dealing with health matters, together with frequent health talk, gave the women confidence as lay health experts, enabling them to contest medical advice. (Boneham and Sixsmith, 2006)

Kawachi and Berkman (2001) point out that the protective effects of social ties on mental health are not uniform across all social groups. They note the higher prevalence of psychological distress among women compared to men, which may be attributed at least in part to gender differences in social support. They add:

> Social connections may paradoxically increase levels of mental illness symptoms among women with low resources, especially if such connections entail role strain associated with obligations to provide social support to others.

### 3.3.4 Key policy issues

In terms of policy issues at the national level, Edwards and Mawani (2006) list five issues to address health outcomes among older people in Canada: staying socially connected, increasing levels of physical activity, healthy eating, minimizing the risks of falls and not smoking. They identify barriers to progress on these themes and offer policy recommendations.

## 3.4 Religion and well-being

A range of research has shown an association between religiosity and well-being, and this may well be stronger among older people than in the wider population. A study of a relatively healthy and wealthy sample of older Californians concluded that those who were religious 'showed higher levels of life satisfaction than their nonreligious or spiritual seeking peers' (Dillon and Wink, 2007). From an analysis of religious activities and attitudes in a longitudinal panel Blazer and Palmore (1976) report 'several significant and substantial correlations between religion and happiness, feelings of usefulness, and adjustment; these correlations also tended to be stronger for older persons.' Among centenarians, Bishop (2011) found that religious coping seems to diminish negative affect but increases feelings of stress.

Research is available from different countries and religions, with lessons that might be applicable in cosmopolitan urban areas. However, it is not immediately clear to what extent any effect is a social phenomenon – *i.e.* a consequence of congregation – and/or an individual psychological (or spiritual) benefit. Rocha and colleagues studying older people's families in Brazil (2009) found that 'spirituality and religion are mixed and are very expressive sources of support.' Krause (2002) suggests that people who receive more spiritual support will be more likely to adopt religious coping responses.

The health literature generally supports the assumption that religious coping brings well-being benefits, for example in terms of mortality (Oman and Reed, 1998) or in reducing the negative psychological effect of disability for older adults (Cummings *et al*, 2003). A study of the association of church-going with depressive symptoms in older Dutch people found that attendance was negatively associated with the course of depressive symptoms, and this held after adjustment for explanatory variables. The researchers add:

> Among respondents with functional limitations, lower depression scores are found for those who attend church on a regular basis. (Braam *et al* 2004)

Among Muslims in Peninsular Malaysia the relationship between chronic health problems and psychological well-being was found to be 'significantly moderated' by religiosity (Momtaz *et al*, 2009). In their Californian study, Dillon and Wink (2007) claim there was no evidence of an association between religion and physical health in late adulthood, although the protective effect of religiousness on psychological health was present even after controlling for other factors. Among older Kenyans, frequency of

religious attendance was found to be *negatively* associated with health (Kodzi *et al,* 2010). The authors note:

> While this sound[s] counterintuitive compared with studies in the Western world, it is conceivable that religion may be a means to cope with the stresses of poor health — religious participation may invoke a sense of hope and optimism in dealing with failing health.

The Kenyan study is also of interest because it found a consistency of effect across different religious denominations; as did Chaaya and colleagues in a study based in two deprived suburban neighbourhoods of Beirut and a Palestinian refugee camp. They used three measures of religiosity: organisational (attendance); non-organisational (*e.g.* fasting, prayer); and subjective. In the refugee camp, they found that

> the odds of being depressed were significantly lower for older Palestinian refugees who had a regular attendance of religious activities.

However, in the other two neighbourhood contexts, which comprised mostly Muslim and Christian Lebanese residents, 'Religiosity in its three aspects was not related to depression' (Chaaya *et al*, 2007).

Differences between ethnic groups in the same religion have been observed by Krause (2002) who found that 'older blacks were more likely to be deeply involved in each facet of religion than older whites' and 'more likely than older white people to reap the health-related benefits of religion.' Koenig and colleagues (1989), meanwhile, found a potentially significant benefit relating to socio-economic status:

> results suggest that while in general there appears to be little difference in coping between religious and non-religious copers, for older persons of lower social class who experience high levels of stress, religious behaviors may be associated with high levels of adaptation and coping.

For those with higher levels of social support, according to Oman and Reed (1998), there appear to be health benefits in that 'religious attendance tended to be slightly more protective.'

Several studies suggest that at least some of the benefits of religiosity are associated with sociability. A study of older people in Kuwait found that respondents with a high degree of religiosity had high social support from their friends and relatives, more frequency of contact, and more strength in their relationships with them (Al-Kandari, 2011). Elsewhere, it could be that social status plays a role: according to a study of Jewish older people in Israel,

> the religious observant elderly person, who is religiously active, retains a social status that earns him *[sic]* respect because of this activity. This status even provides him with a source of power in his social group, as a result of which he functions more effectively and is more satisfied with life. (Shkolnik *et al*, 2001)

Analysing data on religiosity, social support, and life satisfaction among older Korean immigrants in New York city, Park and colleagues (2011) found that greater religiosity was related to greater life satisfaction and that social support partially explained the positive relationship between religiosity and life satisfaction. A study of Japanese elders (Krause *et al*, 1999) concluded that 'greater involvement in religion is associated with providing help to others more often' – but this applies only to older men.

The local impact of religious geographical communities (in the sense of appearing to dominate a locality) was studied in Toronto by Agrawal (2008). The study focused on a number of 'organically evolved ethnic communities (South Asian, Italian and Jewish) based on four major religions (Islam, Sikhism, Catholicism and Judaism)', and concludes that such faith-based communities are 'not strikingly at variance from a typical Canadian neighbourhood' in terms of their social and physical characteristics.

The associations between health and religiosity are questioned by an analysis of longitudinal data covering religious affiliation, religious attendance, beliefs, and religious practices in Taiwan (Yeager *et al*, 2006). The researchers note a strong correlation between religious attendance and health outcomes, but 'this relationship disappears in the presence of controls for health behaviors, social networks, and prior health status.' Further, they find that

> in all cases, private religious practices and stronger beliefs are associated with worse health.

Yeager and colleagues suggest that reverse causality may partly account for the established positive and negative correlations between religiosity and health. They point out that even after controlling for prior health, *participation in social activities* had a more robust effect on health than religious attendance. Consequently, they question whether the purported health benefits are attributable to religion or to social activity in general.

# 4

# Social support and social connection

## 4.1 Family

There is no single narrative about the role of the family in providing care and support. Many researchers have sought to identify consistent features in the ways in which families do or don't support their older members, over time and in different countries. However, a range of complications arise such as assumptions about cultures, gender differences (Silverstein *et al*, 1995), the complex interaction of formal and informal care (Fast *et al*, 2004), and the apparently increasing diversity of families (Phillipson *et al*, 2001).

A full-scale historical study (Phillipson *et al*, 2001) across three localities in England concluded, first, that for older people 'kinship relationships revolve around the immediate family (and often just one or two ties within it)' and not necessarily a wider web of kin; and secondly, that family support tends mostly to cover instrumental help such as household chores, transport, and financial help. This latter finding echoes research reported by Coward (1987) who found that 83 per cent of the informal helpers named by his sample of 900 were family, for tasks covering transportation, home repair and maintenance, household chores, and personal health care. Phillipson and colleagues claim that it is in these areas of support that

> the inner circle of the immediate family is central, spouses and daughters in particular. Beyond this, support such as confiding and providing reassurance brings in other types of relationships, notably that of friends. (Phillipson *et al*, 2001)

There may be no significant association between family networks and health outcomes, according to a study of the contribution of social networks to the mental and physical health of older people (Golden *et al*, 2009). Social networks with children and family did not appear to have any effect on survival in older Australians (Giles *et al*, 2005), although older people without children in their network have fewer neighbouring relationships among their core ties (Thomese and Van Tilburg, 2000). It has been shown that 'even when living with their families, older people can still feel socially isolated' (Hemingway and Jack 2013). Survival is extended by having a

spouse and close ties with friends and (for twins) with the co-twin (Rasulo *et al*, 2005).

However, for women, lack of connection with close relatives may be a risk factor for mortality (Iwasaki, 2002). Recent research in the Netherlands found that receiving frequent help in the household from children was not associated with receiving care from public services (Schenk *et al*, 2013). Detailed research into close family relationships among older people has highlighted complex questions in relation to loneliness (see section 4.7): Dykstra (2004) found that

> the absence of children does not contribute to loneliness in older adults. Having children but not interacting with them frequently is what makes older adults more prone to loneliness.

Silverstein and colleagues (1995) looked at the factors that predispose middle aged children to provide instrumental and social support to their parents, noting the gender differences:

> Our findings indicate that intergenerational affection is the factor that most motivates daughters to provide support, while filial obligation, legitimation of inheritance, and frequency of contact most motivate sons.

Distance has a clear impact on how often older people see their family, but surprisingly, a UK study found that only 17 per cent of older people would like to see their children more often (WRVS, 2012) – suggesting that 83 per cent either are not bothered or actively wish to remain detached. In light of this, increasing government pressures on families to take on more of the care burden (*e.g.* in China,[8] and the UK[9]) are likely to be at best partially successful. A recent newspaper letter summed up the efforts made in one case, adding a touch of personal reality:

> My elderly mother lives 150 miles away and refuses to move nearer to me so I can see her more often. I drive round the motorways from Dorset to Essex nearly every time she is in hospital: three times this year. I speak to her on the phone every other day. I organise her care over the phone; she has help with shopping and personal care. I helped her fill in the forms for attendance allowance so she has enough money to go to church in a taxi, to her church club on Tuesdays, and to the hairdressers.

[8] http://www.bbc.co.uk/news/world-asia-china-23127936

[9] http://www.bbc.co.uk/news/uk-politics-24572231

> We try and see her as often as we can, at least every two to three months, but we also have six grandchildren who live all over the country. I have three voluntary jobs too. Oh, and I have osteoarthritis myself.[10]

There seems to have been relatively little consideration given in this debate to the use of online technologies, especially email, Skype and social media, to sustain connections over distance; not least because – going by Wellman's (1979) first East York study – only a small minority of people's intimate ties live in the same neighbourhood as their respondents. While online connection may be more rare as an option for the oldest old, a US study has found that

> for adults over the age of 50, staying in touch with family is the number one reason they use social networking sites. (Zickuhr and Madden, 2012)

This finding may raise a concern that those who don't have family, or whose families do not use social media, will be less motivated to use the internet to connect with others and therefore may be at greater risk of becoming isolated (see section 4.5.6).

Research has pointed to cultural differences in family support for older people, but there may be less variation than is widely supposed. In China, 'distant' family networks appear to be nearly as beneficial to older people, in terms of well-being, as are family-focused networks (Cheng *et al*, 2009). In Spain, co-residence with children 'is very common and it is associated with good self-perceived health and low prevalence of depressive symptoms' (Zunzunegui *et al*, 2001). These assertions may come to look outdated, however, when the social effects of the economic recession in that country have been assessed. In a cross-cultural study, Chappell (2003) finds little difference in the experience of ageing among older people in Shanghai and Canada. She notes that

> the importance of sons is clearly evident in Shanghai, whereas spouses are more important in Canada.

The forces of globalisation and immigration may continue to erode cultural differences and expectations. In the US, questions have been raised about the effect of a culture where the emphasis on independence and individualism may discourage family involvement in providing informal support for older relatives (Lee, 2008; see also Treas and Mazumdar, 2002). In the UK, Callan (2013) argues that:

[10] Dickins, L. Letter to *the Independent*, 22 October 2013, http://www.independent.co.uk/voices/letters/letters-shifting-burden-of-care-for-the-old-8894854.html

> Family breakdown loosens the bonds of responsibility and makes it less likely adult children will feel they should care for ageing parents.

A Canadian focus group study (Weeks and Leblanc, 2010) identified ‘a value shift’ regarding children’s provision of support to parents in ethnic minorities. One participant is quoted as saying:

> The kids are growing up, and the difference is that they don’t care for the seniors.

This change is echoed in a UK study (Sin, 2006) which found that

> the high level of expectation for family support amongst Asian-Indian respondents coexists with a high level of expectation for state support and an acknowledgement that the ideal of family support may not always materialise. Amongst White British respondents, the high level of expectation for state support exists regardless of whether the respondent has satisfactory informal social networks.

Issues for older people around decisions to relocate have been discussed (section 2.13), and families are often involved in this process. This seems to be an under-researched and under-theorised area. Mulder (2007) calls for a research agenda to investigate ‘the influence of the wider family context on the residential choices of households and the feedback of these choices to segregation with regard to socioeconomic status and ethnicity.’ Weeks and colleagues (2005) have drawn attention to linkages between family support currently provided, and the future housing preferences of older people.

What Phillipson (2004) calls the ‘continuing preoccupation with kin' has long been questioned. Wellman and Hall (1986), focusing on East York in Toronto, argued that

> gerontologists may have focused too narrowly on studying supportive ties with kin... Many East Yorkers have few ties with kin, and many do not contact frequently the kinship ties they do have.

More recent research in the same city has echoed this insight:

> kin were not part of the everyday neighborhood interactions of study participants. (Gardner, 2011)

If the attention paid to family ties is to be a reduced, it is worth noting the risk of overlooking their resilience. Research into the termination of older adults’ relationships concludes that:

> Close kin relationships are most likely to be continued, and relationships with less close kin, friends, and neighbors have a higher chance of being discontinued. (Klein Ikkink and Van Tilburg, 1999)

## 4.2 Friends and neighbours

> Among the present generation of elderly, kin are clearly considered the primary source of help, regardless of the task. Only to the extent that family, particularly children, are not available and with respect to certain well-defined tasks do friends, neighbors, and formal organizations become important in the provision of informal social supports.
>
> (Cantor, 1979)

Philip Abrams' seminal work *Neighbours* (1986) includes some key insights into the nuances neighbouring and friendship:

> Friendliness is a desirable quality of casual, contingent interaction: it involves a restricted conviviality which flourishes by carefully respecting each party's right to preserve the privacy of a 'back-stage' realm. Friendship, by contrast, is chosen, committed and encompassing it… It is precisely the guarded quality of neighbouring that is absent from friendship. Yet at the same time it is clear that neighbours *can* be friends.

In research reported over 40 years ago, Rosow (1970) emphasised the extent to which friends and neighbours in many (US) contexts were perceived as a compensatory substitute for family. He noted class differences, claiming that 'friendships are formed primarily between old persons with similar status characteristics,' and suggests that 'middle-class people distinguish between friends and neighbors while those in the working class do not.' An even earlier study by Lawton and Simon (1968) underlines the importance of 'casual contacts which lead to exploratory conversations as the basis for viable friendships.' (See section 4.5.2 for a discussion of 'opportunity structures' and 'third places' which enable such casual connections).

In her assessment of friendship and neighbouring, drawn from a UK rural study, Clare Wenger concluded that friendship, being based on choice and shared interest, was 'primarily an expressive relationship,' while neighbouring is based on proximity and is 'primarily an instrumental relationship' -

> Both friends and neighbors are shown to provide important, overlapping types of support and assistance which contribute to continuing well-being and independence in old age. (Wenger, 1990)

Among research that has explored these potential roles more closely, a Canadian study found that

> friend and neighbour carers differed on age, marital status, geographical proximity and relationship closeness. Friends were more likely than

> neighbours to assist with personal care, bills and banking, and transportation. Neighbours were more likely to assist with home maintenance. Friends provided assistance with a greater number of tasks and provided more hours of care per week, suggesting a more prominent role in the care of non-kin than neighbours. (Lapierre and Keating, 2012)

A UK study noted that in addition to providing intensive and frequent help, some friends and neighbours play a key role in co-ordinating other services. The researchers stress the nuanced and sensitive nature of the support, rather than its practicality:

> One of the main forms of direct support related to older people's quality of life, at a broader level than the practical help provided by statutory services. The flexibility of such support, and the friends' and neighbours' concern for older people as individuals, were particularly important to the people they helped. (Nocon and Pearson, 2000)

### 4.2.1 Friendships and neighbourly relations can be vulnerable

The fact that close family ties are less likely to be discontinued than are friendships or neighbour relations (Klein Ikkink and Van Tilburg, 1999) has been noted (section 4.1). This is confirmed in research by Lee and Shehan (1989) who noted that

> kinship relations are bounded by norms of obligation and are virtually impervious to termination. Friendship relations, in contrast, are based on mutual choice and may be terminated if they prove to be costly or unrewarding.

Wenger also offers cautionary reflections with regard to ties with neighbours:

> Withdrawal of neighborly involvement appeared to occur in instances where demands are potentially heaviest. In several instances, the concentration of potentially dependent old people in one small neighborhood and/or the occurrence of anxiety-inducing events, led to the evolution of a defensive pattern of neighborhood behavior which contrasted with the accepted norms of good neighborliness emphasizing helpfulness and concern in times of difficulty or emergency. In these cases, what started out as normal neighborliness developed, with increasing dependency, into commitments beyond the expected scope of neighborly involvement. Withdrawal, when it came, was painful for both parties. (Wenger, 1990)

### 4.2.2 Neighbouring: 'looking out for each other'

> The peculiar hallmark of relations between neighbours in relatively open, mobile societies such as our own is frequent interaction coupled with *limited* commitment, helpfulness and distance.
>
> (P. Abrams, 1986, original emphasis)

Some definitions of neighbouring and neighbourliness have been reviewed and distilled by Harris (2008a):

> The term neighbouring refers to the actions and behaviour of neighbours in each other's interest, which contribute both to positive relations between them and to a sense of belonging.
>
> Neighbourliness involves non-obligatory willingness to share some social and practical responsibility for others who live in the same locality.[11] The term refers to the *attributes* of the behaviour that guides *neighbouring* – usually comprising friendliness, helpfulness and respect for privacy. Its use as a term tends to be more attitudinal than 'neighbouring' and suggests a qualitative judgement about the attitudes and behaviour that comprise neighbouring.

Neighbours often provide one another with instrumental help, emotional support and companionship, and even financial support. The complexity of these relations means that it is too limited to view them as exchange relationships (Thomese *et al*, 2003). Roles can begin in very simple ways:

> For example, assistance with opening bottles and cans, help with washing clothes, shopping errands, gardening or minor household maintenance items. Initial steps involve little commitment, though their importance to recipients is significant and greater commitments can develop over time, and often these are not explicitly negotiated. (Del Aguila *et al*, 2006)

Contributions of these kinds are also made by family and friends of course; but neighbouring often involves another, crucial but more passive activity, known as 'looking out for each other'. This form of behaviour, for which proximity is a pre-requisite, is often highly valued by older people, as in the following example:

> A 90-year-old woman claimed to have 'the best possible neighbour' who keeps an eye out for her, and she herself keeps an eye out for someone else:

[11] This is based on a definition provided by Dominic Abrams (2006).

> ‘I check to see if John’s blinds are up. The blinds go up at eight o’clock. If he’s not up I tell another neighbour.’
>
> This is a balanced example of non-intrusive neighbourly support, apparently trivial and yet loaded with implications for the sense of well-being of those involved. (Harris, 2008a)

Various studies have sought to identify the factors that contribute to high levels of neighbourliness. McGahan (1972) for example points to:

> long residence, being unmarried, living alone, and frequent participation in other formal and informal groups.

Perren and colleagues (2004) found that ‘socio-economic assets, such as home- and car-ownership, increase the likelihood both of having done a favour for a neighbour and of having received one.’

From time to time central and local government initiatives are put forward to promote neighbourliness. These can range from good neighbour schemes and municipally-funded tea and cake sessions, to street parties, lunches and national neighbours days.[12] From the point of view of older people, some of these initiatives can be on a scale which is too daunting (Harris, 2008b); but Shaw (2005) argues that any programmes which develop neighbourhood support networks and increase older people's awareness of neighbours

> could have a substantial public health impact in communities by delaying functional decline among the elderly.

Systematic evaluations of large-scale formal schemes are hard to come by, nor is it easy to find evidence of the public health impact anticipated by Shaw. But as one older resident put it,

> People would like to be neighbourly but they need things to facilitate neighbourliness - community activity. You can't force it, but you can make it more likely! (quoted by Thewlis, 2006)

### 4.2.3 Gender and sexuality

Generally speaking researchers have tended to find little difference in neighbouring behaviour between men and women. McGahan for example looked at the range (extensiveness) and depth (intensity) of neighbourhood relations in a US high rise apartment complex and found that ‘both men and women had similar levels of extensiveness and intensity of neighbouring’ (McGahan, 1972). Campbell and Lee (1990) suggest that women are the

[12] See for example Neighbours Day Aotearoa, http://www.neighboursday.org.nz/; Australia, http://www.neighbourday.org/.

more ‘active’ neighbours, but it is not clear if this is based on more than relative amounts of time spent within the neighbourhood (as well as definitions of ‘active’). Neither of these two studies focused on older people, but both note the association of length of residence with neighbouring activity.

Rudkin and Indrikovs (2002) claim that 'In general, women have markedly higher levels of social interaction than do men.' The received wisdom that women are more likely to provide emotional support (Wellman and Wortley, 1990), and men more likely to provide instrumental support, seems to be uncontested, although one study found that ‘lone older men tend to be excluded from the practical exchange of support that typifies neighbourly relationships’ (Perren *et al*, 2004).

But as might be expected, there are reported gender differences in the way neighbouring is practised and experienced by older people. Some of the key findings are as follows:

- The older people interviewed by Godfrey and colleagues placed clear value on ‘keeping an eye out for each other.’ Frequently, according to the researchers, ‘this was described as a role assumed by men.’ (Godfrey *et al*, 2004)
- In a detailed study in the Netherlands, Thomese and Van Tilburg (2000) found that women had smaller neighbouring networks than men.
- Men are more likely than women to be receiving formal or informal care, according to a Swedish study (Larsson and Thorslund, 2002); but when controlling for co-residence, the researchers found that the gender differences disappeared. The distinction is about whether people are living alone or co-residing.
- Phillipson and colleagues suggest that older women are often not just ‘kin-keepers’ but also ‘“neighbourhood keepers” as well, vigilant about the changing fortunes of the localities in which they have “invested” much of their lives.’ (Phillipson *et al*, 1999)
- Research on English data by Perren and colleagues found differences related to the experience of widowhood:

> Among women, widowhood has the effect of increasing “useful” interaction with neighbours but among men it seems to have the opposite effect. (Perren *et al*, 2004)

- Older men ‘are more likely to have frequent conversations with their neighbours than older women.’ (Perren *et al*, 2004)

Perhaps the most significant issue is whether or not the older person is living alone. Perren and colleagues found that:

> Among women, living alone increases the likelihood of having *done* a favour for a neighbour; it also dramatically increases the likelihood of having *received* a favour, compared to women living with others. By contrast, among men the reverse is true; older men living alone are less likely to have done a favour or to have received one compared to older men who live with others. (Perren *et al*, 2004)

For older lesbians, gay men and bisexuals, the quality of relations with neighbours can be magnified by acceptance or prejudice. For people whose lives may be relatively localised (perhaps through being frail, reluctant or unable to travel, or for other reasons), where prejudice is manifested in neighbour relations it can have a poisonous effect on the quality of life. One policy briefing suggests that ‘assumptions of heterosexuality’ are often a strong factor in social isolation (Age Concern England, 2002) and a UK study refers to the 'differential age-consciousness in gay men’s and lesbians’ cultures' (Heaphy *et al*, 2004).

### 4.2.4 Friendship: further insights

A range of studies point to different aspects of friendship in later life, which augment our understanding of social networks (section 4.6) and social participation (section 4.5). UK statistical data suggests that the importance of friendship increases with age. Respondents were asked if friendships and associations they have with other people in their neighbourhood meant a lot to them. Of those aged 50 to 54 years old, 64 per cent agreed or strongly agreed. This rose to over 80 per cent for those aged 70 and over. In each older age group a larger percentage of respondents said that local friends meant a lot to them than the average for all aged 16 and over.

Research in North Carolina suggests that older people’s friendships are underpinned by ‘egalitarianism, sociability, and religiosity’ (Adams and Torr, 1998). The research by Lee and Shehan (1989) concluded that ‘friendship interaction is positively related to self-esteem.’ Age–segregated housing appears to favour friendship networks compared to other housing forms (Davidson *et al*, 2001).

A German study (Maier and Klumb, 2005) distinguishes between social activities, where the older person is in direct interaction with others, and time spent in ‘social contexts’ (in the presence of others). The research

suggests that being in the company of friends but not necessarily involved in activities was significantly related to increased survival.

Finally, Wu and Chan's Singapore study (2012) offers insights into how relationships help to address the sense of isolation in older people:

> contact with friends has a far more positive effect on alleviating isolation compared to contact with non-coresiding relatives including children. Contact with neighbors does not have any effect on perceived isolation.

Isolation and loneliness are reviewed in section 4.7.

## 4.3 Living alone

An important dimension of quality of life for many older people is being able to continue to live at home, either alone or with family members. In the UK, among the oldest old (90 years or older), four out of ten men and seven out of ten women live alone.[13]

However, living at home alone is also recognised as one of the predictors of loneliness (*e.g.* Demakakos, 2008; Woolham *et al*, 2013; Wu and Chan, 2012. See section 4.7). Delisle (2010) argues that the complexity of solitude among older people has been overlooked in research and gerontological practice. The increase in the number of people living alone in western countries means that more will be dying alone (Howse, 1997). As Seale (2004) has shown, dying alone is negatively portrayed, with 'a degree of stigmatisation, sometimes of those who die alone, sometimes of those perceived to have caused this.'

Both men and women are less likely to receive formal care if they are living alone (Larsson and Thorslund, 2002). Reporting on a two-year ethnography of 47 older people who live alone in the US, Portacolone (2013) characterises their situation in terms of 'a sense of precariousness.' They may struggle to maintain their home and experience physical impairment; have difficulty navigating the complex range of services and the bureaucracy of eligibility criteria and conditions; but still feel some ideological pressure to retain their independence.

Luken and Vaughan (2003) are concerned in a more political sense with the 'culturally standard idealizations of old age,' and the ways in which these are realised through the institution of housing and have an impact on older women living alone. The way housing is organised makes these women's experience 'invisible' and makes it possible

> to define and ameliorate the situation of living alone, especially with respect to the maintenance of "independence" under contemporary capitalism.

Fifteen years earlier, McCartney (1988) had drawn attention to the importance of respect for individuality, autonomy and control:

> elderly women who want to live alone, have much to teach us about the struggle of the elderly to maintain a sense of self.

[13] See *Understanding the oldest old*, http://www.scribd.com/doc/155902890/Understanding-the-Oldest-Old

## 4.4 Social support: informal and formal care

### 4.4.1 The interdependence of informal and formal care

> When the formal system provides care it enters at least some of the same areas of assistance, that is, activities of daily living, as the informal network. Almost never is there a complete division of labour between the two systems of care… The complementarity between the two systems is a sharing when the informal network cannot do it all.
>
> (Chappell and Blandford, 1991)

The word 'interdependence' is used in two ways in the literature about older people. The first is as an alternative to the dichotomy of dependence on others or independence from others, whereby it is stressed that most older people have something to offer to others, whether or not they are in need of support themselves. This meaning is discussed as an aspect of social networks, in section 4.6.4. The second use of the term refers to the relationships between informal support and formal care services. In this use, it is argued that

> an individual's experience and expectation of one type of support is often made in relation to his or her understanding, expectation and experience of [how] other associations operate… (Sin 2006)

There is potential for confusion. Beeber (2008) for example discusses the interdependence of older people within their social networks, but also in relation to family support and formal services delivered in the home – which is what others would describe as interdependence.

The debate about the relation between informal and formal care at neighbourhood level certainly goes back to the 1970s and presumably beyond. Philip Abrams (1986) initially argued that they were 'radically opposed modes of social organisation' and 'incompatible,' although his scepticism diminished in the light of wider discussions about what was then called 'interweaving.' Much of the research reported in *Neighbours* – edited by Martin Bulmer after Abrams' early death – is concerned with the 'basic dilemma' that

> neighbourhood care as service delivery does not have anything to do with neighbourhood care as neighbourliness, or *vice versa*.

Although they can be observed and studied separately, the informal and formal systems are complementary, as various studies confirm. Functioning efficiently in combination, they allow older people 'to maintain autonomy in

old age, even when they have to depend on help from others' (Dunér and Nordström, 2006). Wellman and Wortley (1990) confirm this with reference to East York, Toronto:

> informal social support is often interwoven with institutionally provided care.

The inter-relationships are nonetheless enormously complex and potentially contested. An increase in the provision of formal care does not necessarily lead to a decrease in the number of hours of support from informal sources (Lafrenière *et al*, 2003). An important US study looked at the ways in which informal networks of care overlap with formal provision. They identified a pattern of network expansion, in which declines in health status were accompanied by reports of assistance from sources increasingly distant from the older person. They note that this pattern

> suggests that formal services supplement care provided by informal helpers, particularly when the needs of the older person exceed the resources of the informal network. Contrary to the myth of service substitution, which argues that informal assistance is withdrawn when helpers perceive that formal services are available, people who receive formal services also receive informal care. (Stoller and Pugliesi, 1988)

Informal care often leads in time to professional, formal care (the 'bridging hypothesis'). A study based on Dutch data suggests that it is probably the closeness or strength of an informal tie that determines whether informal care has substitutive or bridging effects (Geerlings *et al*, 2005).

Issues of gender, territory, control and co-operation arise, as explored in the Canadian context by Martin-Matthews (2007). Another Canadian study which looked at informal care for frail older people, found that their networks vary considerably in size, relationship composition, gender composition, age composition, and proximity. The researchers note that

> these network characteristics were found to help explain variations in the types and amounts of care received. (Fast *et al*, 2004)

This variety echoes the findings of Coward (1987), who reported that

> age, gender, marital status, health and life satisfaction of the elders were all found to be significantly associated with differences in the configurations of the helping networks that surrounded the respondents.

A major assessment of the complementarity of the two care systems found no clear separation between the two in terms of the areas of help received. The authors concluded that:

> Use of the formal system in conjunction with informal care appears to take place in two instances: when seniors are in need and critical elements of their informal network are lacking, or when they have an intact informal support network, but their health needs are extremely high. (Chappell and Blandford, 1991)

They also note the significance of functional disability as 'a primary factor in the receipt of both systems of care regardless of the type of combination.' The study by Lafrenière and colleagues (2003) found that higher use of formal care services was related to 'having no surviving children and being disabled in terms of dexterity or mobility / flexibility.'

Different kinds of formal services will have different kinds of impact on informal networks. Thus the provision of day care is a formal service which replaces informal support for the specified period, 'with the recipient removed from their informal network and supported in a formal setting' (Del Aguila *et al*, 2006). Residential care narrows the options for informal support, often to little more than visits; while home care may be viewed as 'supplementary' to informal support. Del Aguila and colleagues (2006) found that the informal networks of applicants for day care services 'were insufficient to accommodate challenges presented by the immediate physical environment of the residence.'

The research reported by Godfrey and colleagues stresses that formal help was in some ways preferred by older people because it helped avoid 'becoming a burden' on family or friends (Godfrey *et al*, 2004). Other researchers have also suggested that 'the use of community services was perceived as facilitating such independence and avoiding the need for residential care' (Giummarra *et al*, 2007). Another study puts it like this:

> Paying others to perform occasional chores allows older people to feel that they are still managing on their own and minimizing demands on their children and other informal helpers. (Stoller and Pugliesi, 1988)

This issue is very close to the themes of independence and control, discussed for example by Clark and colleagues (1998; see section 2.12).

### 4.4.2 The politics of social support

A study in Flanders (Demaerschalk *et al*, 2012) shows that informal home care is more likely to take place where there is a higher mean income per inhabitant and a lower population density. The amount and types of care that an individual receives can vary greatly, according to where they live.

This is a reminder that the provision of services is heavily subject to political influence. And so is the culture of informal support, as is apparent when ministers in governments of various hues exhort citizens to more responsible neighbourliness and family care; and with some commentators challenging notions of help and interdependence which fail to address problems of inequality (Fine and Glendinning, 2005).

Thirty years ago it could be argued that the emotional and social elements in informal support were under-estimated (Chappell and Havens, 1985). It was also suggested at this time that

> Too often, helping programs have underemphasized the importance of friends and neighbors as resources and have overburdened the family with virtually all of the responsibility for a bereaved and grieving relative. Heinemann (1985)

The idea of 'crowding out,' discussed in section 2.4, also resurfaces from time. The theory suggests that the widespread availability of formal services discourages informal support, but has been discredited for example by Motel-Klingebiel and colleagues (2005) who conclude that:

> in societies with well-developed service infrastructures, help from families and welfare state services act accumulatively.

Alongside the possible 'reverse crowding out' of state services by voluntary (see section 2.4), there has since been what one commentator has described as a 'quiet de-professionalisation of care' (Wiles, 2005). In this account, as the home becomes a site for the care of older people, and with the reduction of institutional care, the expectation is that families will compensate for the decline in public services. Wiles notes:

> Most care for the elderly is provided on an unpaid, lay basis, and decisions about who provides care are not always made by choice so much as by crisis and necessity.

It is also the case that in many countries, the proportion of older people living in poverty has increased. A UK study points out that

> Older people who are already disadvantaged in terms of poverty or ill health are disproportionately affected by the loss of local services. (Scharf *et al*, 2002)

### 4.4.3 Informal care and support

The mix of provision of informal support by family, friends and neighbours is complex and fluid. Echoing the work in the 1970s of Abrams (1986) and others referred to above, Heinemann argued in 1985 that the informal support systems of family and friendship are structurally and functionally different as well as interdependent and complementary:

> the family support system tends to be stronger than the friendship support system among elderly, urban widows regardless of their life stage; however, both informal support systems are viable and coexist simultaneously...

Phillipson (2004) has drawn attention to the wide range of relations in which older people are embedded and argued that more could be done 'to highlight the diversity of such relationships, and to move from the continuing preoccupation with kin.' One UK study reported that

> Older people valued having alternatives to always having to ask the family, which could undermine their sense of independence. (Clark *et al*, 1998)

This distinction is addressed to some extent in an unusual study of data from the 1996 General Social Survey of Canada, which drew the following conclusions:

> Friends were more likely than neighbours to assist with personal care, bills and banking, and transportation. Neighbours were more likely to assist with home maintenance. Friends provided assistance with a greater number of tasks and provided more hours of care per week, suggesting a more prominent role in the care of non-kin than neighbours. Age, income, a minor child in the household, proximity and relationship closeness significantly predicted amount of care provided. (Lapierre and Keating, 2012)

In an analysis of panel survey data, Gray (2009) found that social support was strengthened more by informal social contacts than by being active in organisations.

The support provided by family, friends and neighbours is seen as fundamental to the health and well-being of older people, largely because of the implications for autonomy and managing decline. According to one Canadian study, 'the most common form of care provided was transportation' (Turner and Findlay, 2012). However, maintenance of the home, as described by Clark and colleagues (1998), may be the most valued:

> keeping a well-maintained house was central to many older people's sense of well-being and of being part of society, as well as to their confidence about coping at home.

The authors report that for older women in particular,

> Help with housework and related activities was seen as central to their ability to retain their independence, preventing or delaying the need for residential care… Women viewed housework as skilled work in contrast to the low status often accorded it by social services departments and other professionals.

### 4.4.4 Formal care

Although much of it is beyond the scope of this review, the diversity of formal services to older people needs to be recognised. Distinctions such as those between services which supplement or replace social networks, described by Del Aguila and colleagues (2006), are not trivial. The relationship between formal and informal social support can be mediated for example by community development processes (Hampson, 2006) that seek to engage with isolated older people (*e.g.* Toseland *et al*, 1979), and/or to empower groups of older people to engage with the decision-making processes that affect them. Evans and colleagues (2013) call for better integration of formal care services with care homes in order to improve quality of life for residents.

The effect on sociality of insensitive formal care provision should not be overlooked. Lawton (2013) offers a summary of how the social facet of care gets eroded:

> Councils are under growing pressure to cut costs by focusing on the price of care rather than giving higher priority to the quality of care on offer. Contracts are usually centered on how much time carers spend with clients and what tasks they complete, rather than on what home-care enables older people to do. A provider's track record or local connections are not always taken into account when contracts are awarded, which means that they can struggle to facilitate social connections for the people they care for.

The consequences of the policy emphasis on choice have also been questioned, for example in an Australian study based on interviews with service providers:

> The policy construction of the client's right to 'choice' and its implementation in service provision has a paradoxical effect on the agency accorded to older people. It does not extend to the right to choose a worker whom one knows and likes, or to spend non-instrumentally oriented time with her or him. (Russell and Schofield, 1999)

The extent to which formal care helps older people to age in place is assessed in clinical terms by reduced nursing home admissions (Beswick *et al*, 2010). Several commentators (*e.g.* Wiles, 2005) have noted the changing and changeable nature of relations between the older person and the visiting carer representing the formal service. Where relationships form they could in theory make it easier for older people to accept dependence gradually, although Clark and colleagues (1998) note that 'this may have not been recognised by the purchasers of services who tended to discourage personal attachments.' They add that:

> What older people saw as important to their independence shifted in line with changing capacities and other circumstances. They would accept help but only for things they could no longer manage themselves. Service provision was not always sufficiently responsive to such changes.

### 4.4.5 Social support for lesbian, gay, bisexual and transgender older people

In a recent book exploring the merging of sexuality and ageing in relation to formal care services for older people (Ward *et al*, 2012), it has been claimed that much of the existing debate on sexuality still overlooks ageing, and

> both academic and practice-related considerations of old age have failed to consider sexuality as anything other than an 'add-on' to how we understand and make sense of the ageing process. This oversight has led to the social and cultural invisibility of older LGBT identities and a failure in both policy and practice to take account of the needs of LGBT people as they age. (Ward, 2012)

It is not just a matter of discrimination and 'historic invisibility' (Brotman *et al*, 2003) in service provision or local social relations, although these remain causes of marked concern. There is in addition, as one literature review points out, a lack of understanding of needs, and research is scarce (Addis *et al*, 2009). The authors add that 'the focus of research tends to be on gay men and lesbians; consequently, the needs of bisexual and transgender people remain largely unknown.' The point is reinforced by Bailey (2012) who argues that:

> The low priority of gender reassignment, combined with issues of ageism within healthcare, creates a double barrier for older trans people.

Studies of non-heterosexual older people typically report low levels of confidence in formal services, and this has implications for the community sector. The Opening Doors London project reports extensive community engagement experience including the basic principle that 'services need to 'come out' as LGBT-friendly before they can ever hope to engage fully with

older LGBT service users' (Knocker *et al*, 2012). Jacobs and colleagues (1999) concluded that services for older lesbian and gay people 'may be best provided in a lesbian/gay environment'. They found that 'gay/lesbian community services were significantly rated as more adequate in meeting needs in times of emotional crises than non-gay/lesbian services' and that both women and men were interested in participating in social groups segregated by gender within the lesbian/gay community.

Grossman and colleagues (2000) studied the social support networks of 416 lesbian, gay, and bisexual adults aged 60 to 91. They concluded that:

> The sexual orientation, gender, and age of network members did not influence respondents' satisfaction with the support received. Participants were more satisfied with support from those who knew of their sexual orientation. The more satisfied respondents felt with the support they received, the less lonely they felt. Those living with domestic partners were less lonely and rated their physical and mental health more positively than those who lived alone.

This suggests that for older lesbian and gay people who live alone, it could be important to provide forms of social support in which the disclosure of sexual orientation is felt to be a realistic option, this being more likely to lead to greater satisfaction with the support received and hence reduced sense of isolation. A recent US study emphasises the prevalence of non-kin relationships in caregiving and receipt of care for older LGBT adults (Croghan *et al*, 2014). The International Longevity Centre UK, meanwhile, has published several pieces of work celebrating intergenerational diversity among LGBT people.[14]

### 4.4.6 Who cares? Gender differences and other characteristics

Based on 2008-2009 data, more than one-third (35 per cent) of Canadians aged 45 or older reported caring for a senior with a short- or long-term health condition or limitation. They were more likely to be women (Turner and Findlay, 2012). An analysis based on a random 3 per cent sample of the UK census (Dahlberg *et al*, 2007) found that

> 11.3% of women were carers compared to 8.6% of men and overall women committed more time to caregiving than men. However, this pattern was reversed in later life (70+), where there was a higher proportion of carers and greater time commitment to caregiving amongst men.

[14] http://www.ilcuk.org.uk/index.php/publications/publication_details/celebrating_intergenerational_diversity_among_lgbt_people

Research exploring gender differences in access to formal care and informal support for 81-100 year-olds in Sweden found that the main distinction was not between men and women, but 'between persons living alone and persons co-residing' (Larsson and Thorslund, 2002). Nonetheless, in view of the extent to which 'men are perceived as less able to provide care to their female partners,' Dutch researchers have recently advised caution 'against introducing policy measures that increase pressure on female partners' (Schenk *et al*, 2013). The UK population-based analysis effectively broadens this point, arguing that

> informal caregiving is most prevalent in groups of the population that… may experience most strain from doing so: elderly people who may be frail and often are in a spousal relationship with the care-recipient, and middle-aged women with multiple roles. (Dahlberg *et al*, 2007)

### 4.4.7 Practical approaches and new agendas

A study of older people in California found that 'it is unusual to plan for the future when mobility might become limited' (Yen *et al*, 2012). If this is more than a function of living in a healthy and wealthy environment, then formal support becomes even more important as the care responsibility on family, friends and neighbours increases (Sigurdardottir *et al*, 2012).

Non-intrusive interventions on the part of formal services can enhance the quality of care in the home without jeopardising the sense of independence. Stewart and colleagues (2010) describe one example where experienced family caregivers provided weekly telephone support. The carers receiving support reported various processes that overcame support deficits in their social networks. An evaluation of a community health educational programme with older people in 'anonymous housing complexes' (Lyons and Magai, 2001) provides another example of how formal interventions can contribute to quality of life and well-being. The CASI project in Vancouver reports higher levels of life satisfaction, health and community involvement as a result of community-based approaches to delivering non-medical home support services. However, in this case, participants also reported a decline in the level of support they get from others, and in the level of safety and security in their home (Chomik Consulting & Research Ltd, 2012).

Harris (2008a) offers a model of 'four sources of support' for older people, comprising friends, family, neighbours and services. He argues that, ideally,

> as one source of support atrophies or depletes, the others would take up the slack. It may be, however, that pressure is increasingly being placed on formal services, because the ecology of social support is vulnerable in each of the other areas.

That ecology is assessed in a research review by Dalley and others (2012), in terms of risk, trust and confidence in informal and semi-formal caring and supportive relationships. Their paper articulates a range of salient social questions, including:

> What would help make people more confident to make better decisions about caring for and supporting each other?
>
> What helps or sustains people in local communities who offer help and support to others within their social network?

However, the striking dearth of clear answers in the literature serves to demonstrate the need for more thorough research on this agenda. It may be that some will be clarified in the work of the Interlinks programme, funded by the European Commission to develop solutions to issues at the interface between social and health care, and formal and informal care.[15]

[15] http://interlinks.euro.centre.org/project

## 4.5 Social participation and social connection

> The links between social engagement and better health outcomes highlight the potential benefits of older adults' participation in broader social activities and may encourage older adults to maintain high levels or increase their social engagement as one of several ways to maintain better physical and cognitive health.
>
> (Thomas, 2011)

'Social participation' is a broad concept. A report from the VoisiNuAge study in Montreal (Richard *et al*, 2013) used the following four levels to describe it:

- interacting with others without doing a specific activity with them
- doing an activity with others
- helping others, and
- contributing to society.

Another report from the same study has identified five independent predictors of social participation: the first four are positively associated - frequent walking episodes (almost every day); higher vitality and general health scores; and perceived accessibility to key resources for older adults. A fifth factor, age, was a negative predictor (Richard *et al*, 2008).

The extent to which older people are willing and able to participate with others is influenced by a range of factors including the local environment, and their own health and sense of well-being. Low mobility is associated with low social engagement (Levasseur *et al*, 2011), even in the absence of disability (Rosso *et al*, 2013). Similarly, Baker (2005) points to the importance of physical function for independence. One study notes that understandings of 'independent mobility' can mean 'avoiding lifts provided by next of kin, friends or others for getting around' which in turn could mean reduced social participation (Schwanen *et al*, 2012).

This immediately suggests that a Matthew Effect may apply (whereby those who have a certain asset, benefit disproportionately, and those who lack the asset are penalised).[16] People with disabilities or long term physical

[16] The Matthew Effect is the theory of accumulated advantage, and the term refers to a biblical quotation: 'For unto every one that hath shall be given, and he shall have abundance: but from him that hath not shall be taken even that which he hath.' http://en.wikipedia.org/wiki/Matthew_effect

impairments (Casey and Stone, 2010) may struggle to gain the health benefits from social engagement (including helping others, discussed in section 4.5.3 below) unless structures are put in place to promote opportunities for them to do so.

Research by Newall and colleagues (2009) showed that causal beliefs which are internal and controllable - *e.g.* believing that making friends depends on effort - were related to greater social participation, and hence to reduced loneliness. Ageing may imply reduced network size, but as Cornwell and colleagues note (2008), some later life transitions, such as retirement and bereavement, may prompt greater connectedness.

### 4.5.1 Health benefits

Where suitable engagement opportunities are accessible, and people are able to take advantage of them, there are undisputed benefits. As Cattell (2001) notes in a study of social capital in low income urban neighbourhoods (not age-specific) 'for those involved in local activities, it is clear that participation has health promoting qualities.' In a study of health and social care use and medication use, older people with higher social engagement were

> significantly less likely to have seen their family doctor, the district nurse or home help services, and to be taking two or more medications cross-sectionally. (Bath and Gardiner, 2005)

A review of research relating to depression and social networks concluded that 'older people who were part of a social group intervention had a greater chance of survival than those who had not received such a service' (Windle *et al*, 2011). A German study also found that 'time spent with friends affords a survival advantage among older adults, above and beyond the effects of other leisure activities' (Maier and Klumb, 2005). In Japan, Iwasaki (2002) highlighted negative health implications for older men from lack of social participation.

Opportunities for social participation vary over time, and so does the individual's health. A study by Thomas (2011) sought to take such variability into account. Her findings suggest

> greater health benefits for those who were more attached to the social structure through high levels of social engagement across time and greater health problems for those who had fewer attachments to the social structure through low and decreasing levels of social engagement.

### 4.5.2 Space, place and proximity of resources

A study of social capital and health in the general population, carried out in Australia, found that

> Higher levels of social and civic participation took place in areas where people held a positive image of their environment, where environments were green, and had open spaces and considerable opportunity structures. (Baum and Palmer, 2002)

The term 'opportunity structures' – similar to Oldenburg's (1989) concept of 'third places' - is used to refer to public and community places and spaces that allow for the possibility of interaction. Baum and Palmer mention 'well maintained parks, community cafés, neighbourhood houses and local shops' as examples. Other examples include leisure centres, hair salons, post offices, libraries, and even buses (Harris 2008a). Maynard (2004) found that 'in terms of purpose, friendships and social networks, community centres were of particular importance to the minority ethnic women' in her study.

The significance here may lie in the potential for such spaces to stimulate informal and unstructured encounters which are safe and escapable, but which allow people the opportunity to connect with relatively anonymous others, on the grounds that 'even minimal cues of social connectedness affect important aspects of self' (Walton *et al*, 2012). Similar opportunities arise through pet ownership, which has been found to be positively associated with some forms of social contact and interaction (Wood *et al*, 2005). Gardner distinguishes 'transitory zones,' places which are passed through during the course of daily life. Older participants in her study occupied these places 'purposefully and intentionally' -

> rather than simply moving through them, transitory zones were used as places to connect with people, even for just a moment. (Gardner, 2011)

Based on a study of two older women in a disadvantaged area, Ziegler (2012) argues that social participation in later life has to be seen in terms of 'life-long relational practices'. Her participants saw their neighbourhood primarily as 'relational spaces based on everyday social interaction', which have since become compromised by societal and structural changes. The perceived accessibility of key local resources is strongly associated with levels of social participation (Richard *et al*, 2008; Levasseur *et al*, 2011). Bowling and Stafford (2007) found that older people's perceptions of their area as neighbourly and having good facilities were independently associated with lower likelihood of low social activities. Objective measures of proximity are also associated with social participation: the VoisiNuAge study found that

> among the group of respondents living the closest to resources (mean distance = 994 m), 34.1% reported the highest level of social participation; by contrast, among the group of respondents living the furthest away from resources (mean distance = 2528 m), only 12.7% reported this highest level of social participation. (Richard *et al*, 2013)

An interview-based study in California (Yen *et al*, 2012) found that older people who *are* able to leave their homes, participate in many activities outside their immediate residential neighbourhoods. Older residents' social integration within their own neighbourhoods was explained in an Israeli study by a combination of factors:

> younger age, better self-rated health, and fewer limitations of outdoor mobility, lower levels of ageism reported by a sample of younger respondents, and higher socioeconomic status of the neighborhood. (Vitman *et al*, 2013)

This seems to suggest that integration could be problematic for less mobile older people above a certain age, living in low income areas. By contrast, a UK study (Bowling and Stafford, 2007) found that respondents living in affluent areas were less likely to have low levels of social activity.

The impact on older people's social lives through having to stop driving and cope without a car is widely acknowledged (*e.g.* Davey, 2006). One study found that 'driving cessation was strongly associated with decreased out-of-home activity levels' (Marottoli *et al*, 2000). It is often suggested that it is the loss of 'discretionary' occasional journeys that most diminishes the quality of life.

When it comes to accessing social opportunities in controlled environments such as extra care housing schemes, it has been argued that 'communal facilities and a diverse range of organised activities need to be available when schemes open as they help residents interact' (Callaghan *et al*, 2009). In practice such environments can have their own third places or 'opportunity structures': one report refers to facilities that included

> shops, restaurants, communal areas, hairdressers, beauty salons, gardens, day centres and guest rooms. Many of these facilities were situated on indoor 'streets', providing an accessible and safe environment in which tenants can access a range of services. For many tenants, such facilities were at the core of their *social* lives... (Evans and Vallelly, 2007, emphasis added)

### 4.5.3 What kinds of connection?

In an analysis of views of middle aged and older people concerning social connectedness, Emlet and Moceri (2012) identified three themes: social reciprocity (noting the benefits of both formal and informal occasions); meaningful interactions (in this case, mostly through volunteering); and structural barriers to connectedness and interaction. Volunteering here appears to be seen as an expression of formalised interdependence.

In an article reflecting Dutch experience of interventions that have a positive impact on the participation of the elderly in neighbourhood activities and urban renewal, Heins (2010) seeks to distinguish different kinds of occasion for social connection:

> Meeting at village fairs, street festivals, city talks, dialogue projects and coffee mornings is often laborious and draws only people already active and with a positive attitude towards the neighbourhood. More is to be gained by 'meeting with a shared concern', such as around mentorships for young people or an allotment project.

Others have also stressed that there is no 'one-size-fits-all' approach to stimulating social connections. Some people are less comfortable in larger groups, for instance. A project working with lesbian, gay, bisexual and transgender older people found that

> In the women's groups we noticed a tendency for women to come along to a few of the main groups, meet a friend or friends and then choose to meet those friends independently from the project... [this] highlighted the need to accommodate different patterns of sociability and approaches to the development of networks. (Knocker *et al*, 2012)

Various commentators note the apparent benefits of helping others, and age is positively related to volunteering (Cornwell *et al*, 2008). Older people who provide assistance to others are more likely to rate their health favourably than those who are less involved in helping others (Krause *et al*, 1999). This might suggest that a community project supporting volunteering by older people could have direct health benefits. Callaghan and colleagues found that

> Residents involved in running social activities found it gave them ownership of their social lives, supported their independence and encouraged others to join in. (Callaghan *et al*, 2009)

The mutuality and potential reciprocity of such participation is clearly an important component. Reporting on a study of older people in Ireland, Gallagher (2009) highlights what she calls 'enclaves of sociality':

> Through dense reciprocal relationships involving kin, neighbours and friends, as well as through the work of intermediate groups such as voluntary groups, clubs and church-based groups, enclaves of sociality are co-created where older people experience a sense of worth and purpose.

Some contexts involve volunteers and professionals as well as older people as participants. A study of friendship clubs concluded that

> club members and volunteers viewed themselves as assets for each other, offering support, advice and friendship. (Hemingway and Jack 2013)

Not all participation in organisations will necessarily lead to social support. Analysis of British survey data suggests that

> Amongst many different forms of organisational activity, the only ones that had a positive association with social support were being in contact with others through religious activities, and engaging in sports clubs. (Gray, 2009)

The direct and indirect health benefits of social participation for older people seem to be clear; it is also apparent that their ability to enjoy these benefits may be very much dependent on their local environment and mobility. Undoubtedly, there are also advantages in terms of social capital, since that naturally accrues from association, although social participation may not be 'the main source of social networks or capital' (Cattell, 2001).

### 4.5.4 How does the internet help older people to connect with others?

Since at least the mid-1980s there has been speculation about the ways in which electronic communication might promote social interaction. With the development of the technologies usually described as social media, in the last ten years or so, the dominant questions have shifted from 'how' to 'who' – who uses these technologies and benefits, and who does not? Numerous programmes have been developed to encourage and support older people's use of the internet, to the point where in some countries, such as Australia (Russell *et al*, 2008) the over-65s constitute the fastest increasing age group in terms of connectivity.

A study by the Pew Research Center, notes that 'after age 75, internet and broadband use drops off significantly' (Zickuhr and Madden, 2012). This may be due at least in part to the perception that sufficiently user-friendly systems emerged too late for many older people to take the trouble to familiarise themselves with it. The drop-off may therefore become less stark in time.

For those who are accustomed to being connected, the benefits seem clear. One Australian study which recruited older participants online (Sum *et al*, 2009) found a positive association between a sense of belonging to an online community, sense of community, and well-being. Another, involving 'confident and competent ICT users' with 'good stocks of locality-based social capital' and few health-related limitations, reported

> substantial use of the online environment in relation to connections that involve looser forms of associational participation and community engagement. (Russell *et al*, 2008)

According to the Pew study, 'one in three online seniors uses social networking sites like Facebook and LinkedIn' (Zickuhr and Madden, 2012). A study of a large sample of adults over 50 found that frequency of contact with friends and family, and attendance at organisational meetings (not including religious services) had a significant positive association with internet use (Hogeboom *et al*, 2010).

New developments that simplify video connections with known contacts through the television may help to extend the participating age range: at the time of writing, Speakset, for example, was being marketed with the slogan 'Video Call Your Grandparents' – with further encouragement to 'Share important moments with the whole family… See them face to face… Have more meaningful conversations.'[17]

Policy statements have been prepared to explore the potential of social technologies in addressing loneliness and isolation among older people (*e.g.* ActiveAge, 2008). It is noteworthy that not only is low mobility associated with lower levels of social engagement: recent research found that this includes use of the telephone and the internet (Rosso *et al*, 2013). Nonetheless, the potential is significant. Another US study, published by the Pheonix Center for Advanced Legal and Economic Public Policy Studies, suggests that

> internet use, based on a direct 'Yes-No' question and controlling for significant differences in use between younger old people and the older old, reduces the categorisation of depression by 34 per cent. (Ford, n.d.).

This is supported in a recent European multi-country study (Lelkes, 2013). Controlling for personal characteristics such as income, marital status, gender and health condition the researcher concludes that:

> those who use the internet regularly have a lower chance of being isolated, more so for those who use the internet every day.

[17] http://www.speakset.com/

## 4.6 Social networks and social capital

*Social networks* are made up of recognisable and revivable connections between people. *Social capital* is the realisable value invested in those connections. The extensive literature covering these topics confirms their importance in terms of a range of personal, social and economic benefits (such as health, safety or civic engagement) through the mechanisms of trust, mutuality and reciprocity.[18]

It is realistic to suppose that there are people (of all ages) who never think strategically or purposefully about their social ties. These are surely exceptions. In his seminal study of 'the intimate networks of East Yorkers,' Wellman (1979) noted that

> respondents often perceive their intimate connections as a type of general utility.

This pragmatism certainly seems to apply to many older people, who are often keenly aware of the importance of maintaining a social network, especially when theirs might be subject to erosion through death and lack of mobility. A study of men's support networks before and after retirement found significant changes at this symbolic point in the life cycle:

> Approximately a third of the personal relationships were no longer part of the network. The average size of the networks had not changed. A larger proportion of network members was unemployed and most of the relationships with colleagues were terminated. The relationships were evaluated as being more pleasant and the frequency of the contact was higher. (Van Tilburg, 1992)

As might be expected, age is negatively related to network size, closeness to network members, and number of non-primary-group ties (Cornwell *et al*, 2008; Litwin, 2011); older people's networks have a higher proportion of kin and network members are less frequently seen (Ajrouch *et al*, 2001); and older adults with larger and more supportive networks tend to be less lonely (Dykstra, 2004; see section 4.7).

While it is widely agreed that neighbourhood characteristics make a difference to quality of life and well-being (see sections 2.2 and 3.1 above), there seems to be no consensus on the extent to which they have an impact on social networks. One study concluded that social networks and loneliness

[18] The Benevolent Society of New South Wales (2013) has published a useful short summary and review of practice issues on *Promoting social networks for older people in community aged care*.

are probably more strongly related to the psychological or social characteristics of individuals than they are influenced by the characteristics of neighbourhoods (Moorer and Suurmeijer, 2001). But physical and social disorder have been found to play 'a substantial role' in weakening social cohesion and trust, and informal social control (Oh, 2003).

### 4.6.1 How family-based and how local are older people's networks?

The variations in older people's networks have been mapped, for example by Wenger (1991) who identified five types:

> 1. Family dependent (close family relationships, few peripheral friends and neighbours)
>
> 2. Locally integrated (close relationships with local family, friends and neighbours)
>
> 3. Local self-contained (reliance on neighbours, infrequent contact)
>
> 4. Wider community focused (distant relatives, few neighbours)
>
> 5. Private restricted (no local family, minimal neighbour contact, no nearby local friends).

Wenger reports that these categories were found to be highly predictive of service use and availability of informal support.

Cheng and colleagues (2009), in a study based in Hong Kong, also identified five network types: in their case they were less concerned with local connections and more concerned with nuances of family relations. Their categories are:

> diverse, friend focused, restricted, family focused, and distant family.

Litwin's (1997) analysis of data on older people in Israel produced the following six network types:

> (1) diversified, (2) friend and family, (3) narrow family focused, (4) attenuated,(5) religious family focused, and (6) traditional extended family support networks.

For older people, family relationships are more likely to *substitute for* informal social connections, and *vice versa*, than they are to be complementary (Kohli and Kunemund, 2009). Joong-Hwan Oh studied the neighbourhood-level ties of older people, measured in four dimensions: friendship; social cohesion and trust; informal social control; and neighbourhood participation. He reported that:

> Length of residence in a neighbourhood helps to increase the number of local friends among elderly urban residents. However, there is no evidence that length of residence has any impact on the three other measures of social bonding. (Oh, 2003)

Given that older people tend to stay in the same home longer, and tend to spend a higher proportion of daily time in the neighbourhood than younger age groups, this might help to explain the common development of neighbour-friendships.

A study of the networks of white and African American older people in Detroit concluded that the latter had

> smaller networks, more contact with network members, and more family members in their networks. (Ajrouch *et al*, 2001)

The social networks of refugees in the UK have been studied by Cheung and Phillimore (2013), who found that there were clear social capital benefits from family reunion. However, not only are most people's social networks probably less family-based than is widely believed, they may also be less local. The original East York study (Wellman, 1979) suggested that neighbourhood ties

> are usually just one component of a more diverse set of relationships and that they rarely comprise the more intense intimate relationships.

### 4.6.2 What do social networks do?

The significance of social connections for older people has been demonstrated by Eric Klinenberg in his study of the 1995 Chicago heat wave. In one week of intense heat, 739 more Chicago residents died than in a typical week for that month. Of these, three-quarters were over 65 years old. A key conclusion of the study was that:

> anything that facilitated social contact, even membership in a social club or owning a pet, was associated with a decreased risk of death; living alone was associated with a doubling of the risk of death; and those who did not leave home each day were even more likely to die. (Klinenberg, 2002)

The individual's understanding of their social network is naturally closely related to their sense of the social support they might be able to call on in time of need; the latter being an important predictor of health in older people (Auslander and Litwin, 1991). Social networks don't stop people getting sick, but they help them to recover if they do (Halpern, 2005).

People use social networks to access information, financial aid, and emotional and instrumental support. Seeman and Berkman (1988) assessed

the availability and perceived adequacy of instrumental and emotional support in the networks of a sample of older people. They report that:

> the presence of a confidant is strongly associated with both [the availability and perceived adequacy] of instrumental and emotional support; the presence of a spouse is not. And, while ties with children are most strongly related to aspects of instrumental support, ties with close friends and relatives are more strongly related to aspects of emotional support.

Greater emotional support from social networks is related to better cognitive functioning (Seeman *et al*, 2001). Cheung and Phillimore (2013) found that refugees who were in contact with a formal group were less likely to need emotional support. Where older people benefit from emotional support more than they give in the relationship, it decreases the chance of the relationships continuing. When it comes to instrumental support, where older people receive more than they give, there is a higher chance of the relationship being continued (Klein Ikkink and van Tilburg, 1999). Reciprocal symmetry in social ties is always relative, but imbalances can be problematic. Keating and colleagues provide a reminder that

> From the perspective of network members, resource differences may be experienced as high levels of strain in some networks as they struggle to meet competing demands of care and other paid and unpaid work. (Keating *et al*, 2004)

### 4.6.3 Who benefits?

Social capital is not equally distributed or available. Cattell (2001) provides a reminder that 'a certain level of pre-existing resources are required to build social capital.' Social networks were found to be important for older women in alleviating the problems of loneliness and isolation, in a UK interview-based study: according to the researchers, 'At stressful times in their lives they were able to draw on existing support networks' (Boneham and Sixsmith, 2006).

Researchers have explored differences in older people's social networks that relate to being married and to having children. Those without children or who have been continuously without a partner tend to have relatively poor social support (Gray, 2009). Giles and colleagues (2005) found that social networks with children or other relatives had no effect upon survival of Australians age 70 and over. Comparisons of specific types of ties analysed by Seeman and Berkman (1988) suggest that neither spouses nor children tend to be primary sources of support. On the other hand, in a group of 70-79 year olds, better cognitive functioning was found to be correlated with being unmarried: this may be explained by the possibility that the presence

of a spouse is associated with greater burdens for care of the spouse, which could have had negative effects on cognition (Seeman *et al*, 2001).

Fast and colleagues (2004) identified a number of network characteristics that might place older people at risk of receiving inadequate care: they include small network size and having higher proportions of non-kin, male, and geographically distant members. However, other research suggests that *quality* should be favoured over *quantity*:

> The perceived quality of support tends to have a greater impact on mortality than the quantity of social interaction. (Halpern, 2005)

The balance of quantity and quality in relationships is also relevant in relation to loneliness. An analysis study of Belgian data suggests that

> the respondents who attached great importance to both the quantity and the quality of social relationships were less inclined to feel socially lonely. Moreover, attaching much importance to the quantity went hand-in-hand with a higher number of good friends and higher contact frequency. The latter also positively correlated with the importance attached to the quality of social relations. (Heylen, 2010)

### 4.6.4 Interdependence of older people with others

As has been noted, there are two uses of the term interdependence (see section 4.4.1). In what follows, the sense used is when it is argued that

> the individual's relationship to his or her sources of support is better seen as *interdependent*, rather than within a model of dependency; having opportunities to contribute to the well-being of others should be recognised among the 'needs.' (Harris, 2008a)

Chris Phillipson (2004) has noted that 'elderly people contribute as well as receive support from their social network,' but there has been surprisingly little debate extending Robertson's (1997) concept of 'a moral economy of interdependence,' discussed in the Introduction above. As noted, Robertson offered examples where interdependence could be promoted. Beeber (2008) has since explored the concept within the context of gerontological nursing practice:

> Current practice frames care of older adults in terms of independence and dependence, a conceptualization that focuses on older adults' deficits instead of the supportive environment or the effects of supportive services on function.

> Interdependence is based on the idea that people rely on social networks for survival. Through interdependence, older adults can gain support from their reciprocal relationships.

This understanding of interdependence might be seen as little more than a re-interpretation of long-established patterns of behaviour. Wenger, for example, in her 1987 study of women as informal caregivers (especially spouses and daughters), draws attention to 'the reciprocal and interdependent nature of caring relationships.' Similarly, a report for the Joseph Rowntree Foundation has highlighted the ways in which older people with high support needs take up active roles based on 'mutuality and reciprocity' (Bowers *et al,* 2011). For many older people, this reciprocal involvement with their peers is invaluable and it need not be immediately contemporary: anthropological research in the southern US concluded that

> Independence is the key concern for all the elderly people in this study. No matter which strategies they use predominantly, they all share a reluctance to accept 'charity'. For most people… independence is 'interdependence'. Independence means accepting support from the network into which one has invested over a lifetime. (Wentowski, 1981)

This may help to explain Litwin's (2011) finding that among older Jewish Israelis, 'those who give help have better morale and greater likelihood of 7 year survival.'

Perhaps the strongest account of mutuality in interdependence is to be found in the 2004 study of older people in two English urban localities by Godfrey, Townsend and Denby. Seeking to explain how the participants 'construct a good life,' the authors conclude:

> The central and underpinning value they carried through into old age and which informed their conception of a 'good' old age was interdependence. The notion of interdependence held within it a number of key values that at first sight might appear to be in conflict. These were: the importance attached to being part of a community where people cared about, and looked out for, each other; a determination 'not to be a burden' on close family and, in this sense, to be 'independent'; and an emphasis on helping each other and maintaining reciprocity in relationships. Success in managing the changes that accompanied ageing, then, was in large part determined by the extent to which people were able to maintain interdependent lives: being able to view themselves as both givers and receivers of emotional, social and practical support. (Godfrey *et al*, 2004)

This helps to clarify the point that interdependence is not necessarily just about mutuality with other older people. It can involve 'being part of a community where people looked out for each other.' And as Wiles and

Jayasinha's (2013) distinctive study illustrates, it can also involve 'care for place,' through volunteering, activism, advocacy, and nurturing.

### 4.6.5 Some further reflections on independence

The theme of independence permeates the literature of ageing and appears in various sections of this review. It is found in material from most disciplines (housing, care, psychology and so forth) and is consistently viewed as a positive and desirable objective. However, any impression of universal and harmonious consensus as to quite what it means and how much of it is good for you, may be exaggerated. Bowers (2001) points out that

> Professionals view independence in terms of the ability to undertake self-care unassisted, while disabled people see independence as the ability to be in control and make decisions about one's life.

It has also been noted that the value and emphasis placed on independence is culturally constructed, partly by the extent to which society presents ageing as a problem (Harris 2008a). Katy Gardner has illustrated the ways in which Bengali elders resist the pressures put on them by UK health care professionals to be as active and independent as possible, because this is seen as a negation of what is their due, as older relatives and as citizens. The idea of independence was 'rejected as threatening to the moral economy of ageing by the elders' (Gardner, 2002).

### 4.6.6 Future directions

This review suggests that there is scope for deeper understanding of the ways in which social networks bring benefits to older people, especially the less formal kinds of connection which punctuate everyday life at local level. It is apparent that networks which are heavily dependent on family relationships are less promising, and in part this has to do with the lack of a sense of control and autonomy. The ability to choose network relationships and to manage them may be critical. Research into the psychological and physical health dimensions of older people's networks, suggests that

> *elective relationships and social engagement* are the 'active ingredients' of social networks which promote health in later life. (Golden *et al*, 2009, emphasis added)

Neighbourhoods change and networks adapt. Having studied neighbourhood networks in Rotterdam, Blokland (2001) found that their historical sense of class-based familiarity did not necessarily produce 'communities' as people imagined them, 'but it did produce quite local, and categorical, networks.'

Blokland explores the ways in which older people generate collective memories; establish new local networks, by using local facilities as meeting points; and develop a sense of 'localness'.

A number of commentators (*e.g.* Phillipson, 2004) have suggested ways in which social network theory and analysis might develop in the future to contribute to understandings of ageing. Potential areas of interest include network analysis for older people in care settings (Abbott *et al*, 2012; 2013); and the identification and promotion of relationships in 'natural neighborhood networks' (Gardner, 2011). Perese and Wolf (2005) call for knowledge of social network interventions among mental health nurses in order to help reduce loneliness.

Meanwhile in the UK there have been recent calls for policy to address better support for older carers; measurement of older people's relationship health; embedding relationship support in the local service landscape, so that impact on relationships is integral to the decisions of local authorities and clinical commissioning groups; and an innovation fund to target resources at community innovations that look to develop new and strengthen existing relationships (Harries and de Las Casas, 2013).

But the most important steer may be that of Gardner, who draws attention to the fact that informal networks do not have to be about 'providing support for the continued independence of older … family members.' Her attention is directed towards

> a type of informal, community-based social structure founded on principles of interdependence, rather than (functional) independence, and sociality, rather than support. (Gardner, 2011)

## 4.7 Loneliness and social isolation

The literature on isolation and loneliness is substantial, but a number of useful reviews exist (Victor *et al*, 2000; Findlay, 2003; Routasalo and Pitkala, 2003; British Columbia Ministry of Health, 2004; Perlman, 2004; Cattan *et al*, 2005; Walker and Herbitter, 2005; Campaign to End Loneliness, 2011; Windle, *et al*, 2011).

### 4.7.1 Definitions and distinctions

In considering future trends, Victor, Scambler and Bond (2009) conclude that 'loneliness and isolation will remain an experience that is confined to a minority of older people.' It is unsurprising that they convey loneliness and isolation here in the singular, as a single experience: both are referred to by these researchers as subjective experiences with common characteristics.

Loneliness and social isolation are strongly associated and will be discussed together in this section, but the distinctions are important. Generally, loneliness is described as subjective and is a negative experience. It is often described in terms of a perceived discrepancy between desired and actual social contact. Isolation by contrast is usually regarded as an objective measure and not necessarily experienced negatively.

Two sample definitions follow:

> **loneliness** is defined as an enduring condition of emotional distress that arises when a person feels estranged from, misunderstood, or rejected by others and/or lacks appropriate social partners for desired activities, particularly activities that provide a sense of social integration and opportunities for emotional intimacy. (Rook, 1984)

> At its most basic level, **social isolation** has been defined as the lack of meaningful and sustained communication, or as having minimal contact with either the family or the wider community. (Victor *et al*, 2000)

Further, some researchers (*e.g.* Van Baarsen, 2002; Drennnan *et al*, 2008) have distinguished emotional loneliness from social loneliness:

> Emotional loneliness manifests in the lack of an attachment figure – an intimate or confidant – while social loneliness is caused by deficits in the broader circle of social contacts. (Heylen, 2010)

### 4.7.2 Prevalence of loneliness and social isolation

Loneliness and isolation can be experienced as severe and persistent, or chronic and transitory. It affects all age groups, and the broad category of 'older people' is not noticeably more vulnerable than other age groups.

In a UK sample of over 65 year olds, the prevalence of 'severe loneliness' was just seven per cent, which according to the researchers represents little change over five decades (Victor *et al*, 2005); with 'no vast increase in levels' predicted in the future (Victor *et al*, 2009). In a recent UK survey, eight per cent of the same age group said they felt lonely 'regularly' or 'all the time,' while 48 per cent say they 'never' feel lonely (ComRes, 2013).

However, research has identified a steep rise in reported loneliness among the oldest old (80+), where roughly half the respondents report feeling a lack of companionship, compared with around 30–35 per cent for over-65 year olds generally (Age UK, 2010; Demakakos, 2008). These reports claim that similar figures apply in other countries. In Finland, 39 per cent of older people suffer from loneliness (Savikko *et al*, 2005). Newall and colleagues conclude that

> across several countries, it appears that a sizable proportion of older people experience persistent or chronic loneliness. Furthermore, results showed that 43% of participants reported being lonely at least once over two points in time. Together, results suggest that loneliness is a chronic or transitory problem for a significant proportion of older adults. (Newall *et al,* 2013)

Among those aged over 75 who live alone in the UK, according to one report, nearly three-quarters experience loneliness (WRVS, 2012).

Figures for social isolation may be highest in low-income areas. Scharf and colleagues (2002) concluded that a quarter of the older people in their UK study of socially deprived areas could be described as being socially isolated, while around one in six were 'severely lonely.'

In 'small town and small city' British Columbia, approximately 17 per cent of those aged 65 or over are socially isolated (Cloutier-Fisher *et al*, 2006; Kobayashi *et al*, 2009).

In terms of the probability of becoming socially isolated, it is important to draw attention to the circumstances of non-heterosexual older people. A UK survey reported by Guasp (2011) found that lesbian, gay and bisexual people over 55 are:

● More likely to be single. Gay and bisexual men are almost three times more likely to be single than heterosexual men, 40 per cent compared to 15 per cent.

● More likely to live alone. 41 per cent of lesbian, gay and bisexual people live alone compared to 28 per cent of heterosexual people.

● Less likely to have children. Just over a quarter of gay and bisexual men and half of lesbian and bisexual women have children compared to almost nine in ten heterosexual men and women.

● Less likely to see biological family members on a regular basis. Less than a quarter of lesbian, gay and bisexual people see their biological family members at least once a week compared to more than half of heterosexual people.

### 4.7.3 Characteristics of older people who experience loneliness and social isolation

Numerous studies have identified characteristics which appear to predict loneliness and social isolation: while there is some consensus, discrepancies remain and the variety is striking. An evidence review carried out by Wenger and colleagues (1996) concluded that

> the critical factors for isolation are: marital status, network type and social class; and, for loneliness: network type, household composition and health.

This seems to suggest that health might not be a significant predictor of social isolation, although other studies identify it as such. Health, gender and marital status are considered in more detail below. A Canadian study found that

> increasing age, less education, urban residence, and higher number of chronic illness(es) are associated with higher level of social vulnerability. (Keefe *et al*, 2006)

Educational attainment is also identified by Savikko and colleagues (2005). Research appears to support the belief that religiosity is protective against loneliness (Lauder *et al*, 2006) and social isolation (Cloutier-Fisher *et al*, 2006). Nonetheless, a recent UK survey found that people who practice a religion report *higher* levels of loneliness (Tarver, 2013): across all age groups, there appears to be a difference of about nine per cent.

A US national study offers a number of characteristics of people who tend to experience loneliness:

> Subjects who were lonely were slightly older (71.3 *vs* 70.5 years) and were less likely to be white. Subjects were also more likely to be female; had lower socioeconomic status (SES) across all measures; were more likely to smoke, have most comorbid conditions, have greater baseline functional impairment, and have sensory impairments; and were less likely to drink alcohol and less likely to engage in frequent physical activity. While lonely subjects were more likely to live alone, the majority of lonely persons lived with someone. Moreover, while lonely subjects were more likely to be depressed, most lonely subjects were not depressed. (Perissinotto *et al*, 2012).

Other factors range from 'co-residence with adult children' as a predictor of social isolation (Wu and Chan, 2012); to 'caring for a spouse or relative at home' (Drennan *et al*, 2008); to 'length of residence' as an indicator of lower levels of social isolation (Cloutier-Fisher *et al*, 2006). Rural dwellers are less vulnerable than urban dwellers according to a Canadian study (Keefe *et al*, 2006); but the opposite is concluded in research in Ireland (Drennan *et al*, 2008). Lower income status has been identified as an important factor in both social isolation (Cloutier-Fisher *et al*, 2006) and loneliness (Savikko *et al*, 2005; Perissinotto *et al*, 2012).

Other studies add some further nuances, occasionally without reference to either health or marital status. For example -

> living alone, not enjoying life, needing help with personal care, and not being in touch with people as often as liked all predicted loneliness. (Woolham *et al*, 2013)

Newall and colleagues explored determinants of loneliness among four groups of older people: those who became lonely, those who overcame loneliness, who were persistently lonely, and who were persistently not lonely. Unusually, their analysis draws attention to perceived control:

> the persistently lonely, compared with the persistently not lonely, were more often living alone, widowed, and experiencing poorer health and perceived control. (Newall *et al*, 2013)

It is widely assumed or reported that isolation and loneliness increase with age. Tijhuis and colleagues for example found that in their large sample across ten years, 'for the oldest group (born between 1900 and 1910) loneliness scores increased' and this increase was 'attributable to ageing' (Tijhuis, *et al*, 1999). According to Jylhä (2004), based on a longitudinal study in Finland,

> loneliness does increase with age, not because of age *per se*, but because of increasing disability and decreasing social integration.

However, Victor and colleagues (2005) found that 'advanced age' was independently protective of loneliness; and Heylen (2010) reports that

> greater age lowered the risk of social loneliness... the oldest-old both had and preferred good quality social contacts.

A recent study of the extent to which older people are alert to their vulnerability found that 'awareness of loneliness-provoking factors is high among third agers' (as opposed to fourth agers who are subject to network erosion). Older people who were not lonely themselves however had 'lower awareness of the risk factors' (Schoenmakers *et al*, 2013).

### 4.7.4 Physical and mental health

Numerous studies suggest a strong association between loneliness in older people and poor health outcomes, for example functional decline and increased risk of death (*e.g.* Tomaka *et al*, 2006; Havens *et al*, 2010; Perissinotto *et al*, 2012). Others have reported a consistent association of loneliness with disability (Jones *et al*, 1985) and with having a chronic disease (Penninx *et al*, 1999). In contrast to the critical factors identified by Wenger and colleagues (1996) mentioned above, a recent study finds that

> Both social isolation and loneliness were associated with increased mortality. However, the effect of loneliness was not independent of demographic characteristics or health problems and did not contribute to the risk associated with social isolation. (Steptoe *et al*, 2013)

In a US national study of African American older women,

> Respondents who were extremely socially isolated were three times more likely to die within 5 years than respondents that were not extremely socially isolated. (LaVeist *et al*, 1997)

In an unusual study, Baumeister and colleagues (2002) found that the fear of 'ending up alone in life' can affect cognitive function among people who experience exclusion. This study did not specifically involve older people.

Emlet (2006) looked at the social networks of older and younger adults living with HIV/AIDS. The older group (aged 50 years or more) were 13 per cent more likely to be at risk of social isolation. More than half of those in the older adult group who were from a Black ethnic minority, were at risk of social isolation.

Depression has consistently been associated with loneliness and social isolation (e.g. Prince *et al*, 1997; Singh and Misra, 2009; Aylaz *et al*, 2012).

However, once again there are discrepancies. Interviews with a sample of depressed older people found that they were

> more likely to report contacts with friends than those who were not depressed, and equally likely to report involvement in volunteer activities. Their likelihood of seeking social support was also comparable. (Wilby, 2011)

Similarly, the US national study reported by Perissinotto and colleagues concluded that

> While symptoms of depression may overlap with feelings of loneliness, our study demonstrated that loneliness strongly predicted the outcomes even after adjusting for depression. Most persons who were lonely were not depressed. (Perissinotto *et al*, 2012)

Some researchers have questioned the direction of causality in the association of health and loneliness. One Canadian study of social isolation and loneliness among older men found that, as we might expect, it is bi-directional:

> poor health increases levels of loneliness, while loneliness negatively affects health. (Hall *et al*, 2003)

### 4.7.5 Marital status, widowhood, family and other relationships

The evidence is compelling that widowhood is strongly associated with loneliness and social isolation (*e.g.* Jones *et al*, 1985; Hall and Havens, 1999; Savikko *et al*, 2005; Drennan *et al*, 2008). The loss of a partner can be especially devastating if it is unanticipated:

> partner loss lowered self-esteem, resulting in higher emotional loneliness and social loneliness, that is, perception of less support. (Van Baarsen 2002)

Loneliness is hardly less problematic for those who are single. Dykstra (2004) concluded that 'By far the highest levels of loneliness are observed among the unpartnered,' and Scharf and colleagues claim that in areas of social exclusion,

> Loneliness appears more prevalent among people who are single and have never married and among those who are separated or divorced. (Scharf *et al*, 2002)

Dykstra noted that 'different types of partnerships provide differential protection against loneliness, and that the pattern varies by gender.' Strikingly, she also reports that

> the absence of children does not contribute to loneliness in older adults. Having children but not interacting with them frequently is what makes older adults more prone to loneliness. (Dykstra, 2004)

The point is accentuated in a UK report, which claims that 'older people who see their children once a month or less are twice as likely to feel lonely as those who see their children every day' (WRVS, 2012). Against that, we have Wu and Chan's Singapore study which suggested that co-residence with adult children is 'the second main predictor' of social isolation in older people (Wu and Chan, 2012).

A study of older men in Manitoba found that those who were isolated and lonely 'had fewer visits from friends and family while participating in fewer social activities' (Hall *et al*, 2003). But perhaps counter-intuitively, friendships and close family relationships are not necessarily associated with overcoming isolation and loneliness. Van Baarsen (2002) found that the presence of close friends

> seemed to increase emotional and social loneliness (*i.e.*, decrease perceived support) in the long term, particularly among bereaved participants with lower self-esteem.

Another study suggests that subjective perception of the relationship might be the key here (echoing Newall and colleagues' (2013) references to the older person's 'control'):

> Feelings of loneliness were found not to be related to the frequencies of visits elderly people received from relatives and friends but to whether they considered that they were seeing enough of them. (Jones *et al*, 1985)

### 4.7.6 Are women more vulnerable than men to loneliness and isolation?

Much of the evidence is also inconclusive in respect of gender. Some research concludes that women experience loneliness (*e.g.* Jones *et al*, 1985; Savikko *et al*, 2005; ComRes, 2013) or social isolation (*e.g.* Hall and Havens, 1999) more than men do. Others (*e.g.* Lauder *et al,* 2006; Drennan *et al*, 2008; Hawkley *et al*, 2008) suggest the opposite.

More nuanced interpretations may be called for. In the British Columbia study, women comprise the higher proportion of those who are socially isolated, but men were noted to be 'especially vulnerable to social isolation' (Cloutier-Fisher *et al*, 2006). A UK investigation published in the same year concludes:

> The extent and nature of loneliness in later life does not show a consistent relationship with gender… Gender was no longer independently associated

> with loneliness once the confounding influences of marital status, age and living arrangement were excluded. The overall self-reported prevalence of severe loneliness shows little difference between men and women. (Victor *et al*, 2006)

### 4.7.7 Loneliness and isolation among lesbian, gay, bisexual and transgender older people

Research in Chicago has suggested that many older lesbians and gay men have 'solid' social networks (Herdt *et al*, 1997), but for those who have only partially come out, or have not done so at all, there is a risk of social isolation. Hinchliff (2009) reports indications that 'some people who had lived an open and confident life have found they had to go 'back in the closet' in older age because of their increased needs for support.' A UK study by Heaphy, Yip and Thompson (2004) found that

> Those who were most likely to have access to support systems in non-heterosexual communities were likely to live in urban areas with many non-heterosexual residents. In other areas there is more likely to be reliance on local networks, and in some cases on Internet-based networks. Significantly, 21.6 per cent of women and 32.9 per cent of men felt isolated from other non-heterosexuals: most had little or no access to community supports, principally because of the absence of non-heterosexuals in the areas where they lived.

Brennan-Ing and colleagues (2014) found that the networks of older lesbians and gay men tend to be friend-centred. They report that older lesbians expressed particular concern about limited opportunities for socialisation. Herdt and colleagues, suggest that as they grow older, lesbians tend to become more confident about their identities, whereas gay men by contrast tend to grow more anxious. This could contribute to problematic isolation for older gay men.

### 4.7.8 Cross-cultural comparisons

Loneliness and isolation are influenced by cultural phenomena (De Jong Gierveld and Havens, 2010). It has been argued for example that loneliness reflects the extent to which the ideology of individualism prevails in society (Jylhä and Jokela, 2008).

In Spain, where cultural expectations on family members are strong, older people receive high amounts of *instrumental* support and this proves to be a protective factor against loneliness. In a country such as the Netherlands where independence is more strongly emphasised, the receipt of *emotional* support proves to be protective against loneliness (Rodrigues *et al*, 2013).

A cross-cultural study exploring national differences in partnership, kinship, and friendship, found that older people in Manitoba, Canada scored comparatively high on emotional loneliness while older people in Tuscany, Italy scored high on social loneliness (Van Tilburg *et al*, 2004). More noticeable differences emerged in a cross-European study of loneliness:

> Older adults in the southern and central European countries were generally lonelier than their peers in the northern and western European countries. In the southern and central European countries, loneliness was largely attributable to not being married, economic deprivation, and poor health. (Fokkema *et al*, 2012)

In almost all countries it was found that frequent contact with adult children, and providing support to family members were important in preventing and alleviating loneliness (Fokkema *et al*, 2012). Data from an eleven country European study suggest that feelings of loneliness were more prevalent in areas where living alone was rarest and where community bonds were strongest (Jylhä and Jokela, 2008).

There do not appear to be significant ethnic differences in loneliness (Tomaka *et al*, 2006): Hawkley and colleagues (2008) conclude that differences in their Chicago study were explained by differences in education and income.

### 4.7.9 What works? Practical and methodological issues

There have been criticisms of the lack of a 'lifecourse approach' to the study of social isolation. In their conceptual and research review, Victor and colleagues (2000) argue that:

> it would be useful to look in more detail at the experiences of the older people from a life-course perspective. There is a failure in the existing research to look at the life course of individuals, which would allow researchers to distinguish between people who have always been lonely and people who have only become lonely in later life, also between people who have always lived alone and people who have only lived alone as they have got older. There are clear differences between these groups that the existing research fails to pick up on and thus has not, to date, explored in full.

A number of studies report and reflect on practical initiatives designed to reduce loneliness and social isolation among older people. As an example, Bernard's (2013) report includes a number of short case studies from which key practical issues are summarised. At the same time, the Joseph Rowntree Foundation has established an influential programme of work on

'neighbourhood approaches to loneliness,'[19] which has produced a series of infographics on the perceived causes of loneliness (JRF, 2013), and a resource pack which includes case studies, ideas and guidance (Robbins and Allen, 2013). Osage (2012) also offers a practical guide to 'connecting with socially isolated seniors.' An evaluation of Canadian projects reports 'decreased isolation, increased health and well-being, more appropriate use of the traditional health care system, increased capacity for maintaining independence in the home/community, and increased community capacity.' (Zena Simces & Associates & CS/RESORS Consulting Ltd, 2003).

However, in 2003 a review of interventions to address social isolation amongst older people concluded that 'there is very little evidence to show that they work' and calls for evaluation to be built in to all such projects in future, from inception (Findlay, 2003). Insights into the methodological and practical challenges associated with applying evaluation measures in community-based interventions are offered by Bartlett and colleagues (2012). Practical initiatives have also been reviewed by Dickens and colleagues (2011), who found that effective interventions were typically those developed within the context of a theoretical basis, and those offering social activity or support at a group level compared with one-to-one interventions. The researchers further suggest that interventions in which older people are active participants also appeared more likely to be effective – a point emphasised by Age UK (2010):

> If schemes to target loneliness in older people are to be effective, they must involve older people at every stage, including planning, development, delivery and assessment.

Group-based interventions are endorsed in a review by Cattan and colleagues (2005). They also conclude that 'the effectiveness of home visiting and befriending schemes remains unclear' (Cattan *et al*, 2005). Befriending schemes may be best used in conjunction with other services (Age UK, 2010). (The term 'befriending scheme' is described by Age UK as unhelpful as it covers several types of intervention and means different things to different people). According to one research review, older people who use befriending or 'Community Navigator' services reported that they were less lonely and socially isolated following the intervention. However, the outcomes from mentoring services are inconclusive (Windle *et al*, 2011).

It has been pointed out that 'interventions not specifically targeted at combating isolation and loneliness can still have a tangible positive effect on them' (Age UK, 2010): in such cases, it is particularly important to

[19] http://www.jrf.org.uk/work/workarea/neighbourhood-approaches-loneliness

ensure thorough evaluation and dissemination of findings. The Age UK review also notes that

> Intergenerational contact is probably more effective in combating loneliness than contact with one's own age group, although both have proven successful.

The literature offers a number of reviews related to interventions. A programme of projects funded by the Calouste Gulbenkian Foundation in Portugal and the UK, which address ageing and social cohesion have been reviewed (Calouste Gulbenkian Foundation, 2012). Cutler (2012) draws attention to the role of the arts in addressing loneliness in older age. The business case for companies to get involved in the social participation of older people has been argued, on the grounds that they would thereby 'benefit commercially, while also increasing their positive social impact' (Bazalgette *et al*, 2012).

Recommendations specific to women, men and those who have been widowed have been put forward. An account of a 'friendship enrichment program' recommends that support for older women should be

> multi-dimensional, focusing not only on friendship but also on other personal and situational factors contributing to loneliness. (Martina and Stevens, 2006)

For older men, it has been noted that they respond to schemes that help maintain or pass on skills:

> In focusing on active pursuits and skills, 'Men in Sheds' schemes in rural and urban areas have been successful in engaging traditionally 'hard to reach' older men. (Bernard, 2013)

Focusing on those who have been widowed, Stewart and colleagues (2001) report reduced loneliness as a consequence of weekly support groups, as well as 'increased hope, improved skills in developing social relationships, enhanced coping [and] new role identities.'

From the psychological perspective, a review by Masi and colleagues (2010) distinctively concludes that 'correcting maladaptive social cognition' (negative self-image) offers the best chance for reducing loneliness. Other powerful recommendations come from Victor and colleagues (2005), who conclude that 'policies and interventions should reflect the variability of loneliness in later life, for undifferentiated responses may be neither appropriate nor effective;' and from Newall and colleagues (2013), who conclude that

> interventions to reduce loneliness could be aimed at the more malleable predictor: such as enhancing or maintaining high levels of *perceived control*. (original emphasis)

Where the spotlight of responsibility plays over the community and voluntary sector, it is widely assumed that support agencies are most likely to be able to reach and serve those in need. This assumption has to be reassessed and reconfirmed from time to time; and agencies' capacity to carry out what they are competent to achieve also has to be justified. A thorough example of how this can be done comes from North Simcoe Muskoka in Ontario (NSMCSS, 2013). In an even more complex context, an attempt has been made to map the sector's contribution to the health and well-being of older people in four states of India (Sonali Public Shiksha Samiti, 2011).

# 5

# Conclusion: age-friendly societies?

> Improving social interaction among the oldest old is potentially a far less costly challenge than providing health services for improving physical quality of life.
>
> (Grundy *et al*, 2007)

It has been argued that accounts that label the global ageing phenomenon as a 'catastrophe' are unhelpful and problematic (Friedland and Summer, 2005). Putting aside the semantic niceties of what constitutes a 'challenge' or a 'crisis' at the macro level, the *individual* challenges of millions of older people have the potential to become crises, or even catastrophes, unless far more attention is paid to the social context in which they age.

Policy invariably struggles to get to grips with the so-called 'soft' issues of social relationships with which this review has largely been concerned. It is vividly clear that social networks and connection are of huge importance for the health, well-being and quality of life of older people across the world. And yet the contrast between the policy emphasis placed on 'hard' issues like pensions, employment or formal care on the one hand, and interventions to address informal support or social capital on the other, remains stark. Even in Wacker and Roberto's (2011) imaginatively-compiled international guide to social policy on ageing, it is striking that there is no reference to social networks or social capital.

Few governments seem prepared to use that sort of language. Perhaps the most distinctive example is to be found in the Netherlands, where the Social Support Act – the 'WMO' – came into force in 2007 'to foster the life skills and social participation of citizens and to increase the social cohesiveness of Dutch society' (Netherlands Institute for Social Research, n.d.). While the act appears to have emerged in the neo-liberal post-welfare context of market restructuring and choice, it was notable for a strong emphasis on *informal care*, and on 'the self-reliability of citizens with their own dedicated social network' (Kruijswijk, 2012).

A recent summary suggests that assessment of the individual's social network is now embedded in Dutch social care practice (Van Campen *et al*, 2013). Meanwhile, however, the associated transformation in Dutch social

support has been described as a transition to a ‘cynical’ welfare state (Steyaert, 2013), reflecting the perceived contemporary attitudes of politicians and managers in talking about people in need of care. This cultural shift may come to be seen as widespread in western societies, having a profound effect on attitudes to the support of older people who experience loneliness or isolation.

As this review has shown, the benefits of investing in the social relationships of older people have been demonstrated and re-confirmed, and could lead to straightforward savings of public money through ‘service non-utilisation’ (Del Aguila *et al*, 2006). While some discrepancies remain – such as the lack of clarity about the kinds of older people most likely to experience loneliness and isolation – the research is unequivocal and the moral, social and economic imperatives to address the issues are compelling. Social connections matter. Perri 6 has argued that

> ‘care in the community' quickly becomes neglect in the community and 'domiciliary care' can readily become a humane form of house arrest if little or no attention is paid to the social networks of those who use these services. (6, 2004)

His view at the time was that governments should be cautious in trying to influence the social capital of citizens: but that they should 'make it a priority to try to limit the clear harms their interventions do to people's social networks.' In many countries, it would be hard to claim that this advice has been followed.

Since the global economic crisis of 2008, which has had a visible and lasting effect on social support in many countries, policy makers and think tanks (see *e.g.* Lawton, 2013) have begun to recognise the need for innovation in the ways in which the state can stimulate older people’s social networks. Watson and Sinclair (2011) call for policy to focus on

> providing facilities that support neighbourliness and social interaction and help people to feel in control of their own lives.

Even the Centre for Social Justice, a right-wing Westminster think-tank, has recently called for a national strategy in the UK with ‘a public health approach to building and sustaining good quality relationships’ in order to engender greater resilience in old age (Callan, 2013). The debate now includes the business case for the private sector to help ‘increase the opportunities for older people to make social connections in their local area’ (Bazalgette *et al*, 2012). Various other commentators have added their voices. Although the literature shows that these calls are not necessarily new – for example, Gloria Heinemann was calling nearly 30 years

ago for programmes that could help widows to 'develop some of the skills necessary for or provide an environment conducive to the formation of informal supports' (Heinemann, 1985) – they may represent a new imperative. Certainly it is hard to see how 'age-friendly societies' could evolve without attention being paid to people's non-kin connections from the time they reach late middle age. This attention includes recognition that the sense of control appears to be a critical factor in the health benefit of social ties (Golden *et al*, 2009; Newall *et al*, 2013).

The role for community sector projects working with older people who experience loneliness and social isolation, is shaped by this blustery political climate. The material reviewed here describes the power of social connections and informal care in influencing quality of life: knowing this, community agencies have to be part of new relationships with providers of formal care, even though these relationships may often be forced by economic and/or ideological imperatives with little reference to the circumstances of older people in need of care.

At the same time, the state clearly has a role in maintaining the valued locations where informal connections can flourish. Ziegler (2012) concludes her study of older women's social participation by arguing that:

> more resources have to be made available to support those established venues which allow older people to remain active in a way which is meaningful to them. Valuing the spaces which older people frequent would illustrate a real commitment to respecting and integrating older people in society.

One other feature of an age-friendly society would surely be the consistent involvement of older people in the governance and co-production of services, initiatives and activities. The literature covered in this review seldom makes reference to this theme. Fashionable choice-based policies have been criticised for precluding the notion that older people 'have the right to participate in the design and execution of services that suit them' (Russell and Schofield, 1999). But in a future of personalised care services, supported by network technologies and recognising the value of social connections, it is to be hoped that older people themselves will be encouraged and supported to play influential roles in the inclusion of their isolated peers. Supporting the involvement of older people in matters of governance can be expected to bring about purposeful and sensitive strategies to address social isolation. Here too, there is a leading role for community agencies.

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