Retaining independence and autonomy in a rural area: Older people's preferences for specialised housing

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Abstract

Objective: This paper aims to identify older people's preferences from a range of supported living environments. It compares the importance of privacy and physical space, physical care, domestic services, security, social activities, and control or autonomy in future accommodation. Random sampling procedures were used to draw a proportional sample of people aged 70 years and over from each rural community (N=423) in Gwynedd, North Wales as part of the HAPPI (Housing for an Ageing Population: Planning Implications) project. A questionnaire was administered through face-to-face interviews. The findings show that more participants rated privacy and physical space and control of life as important, compared with the other domains. Participants were most likely to indicate that sheltered housing would meet their needs in each of the domains. The paper concludes with implications for planning of supported living environments.

INTRODUCTION

A number of different housing and care models exist in the UK, which provide access to health and social care services. Models, which involve the relocation of older people to supported environments, include sheltered housing, residential care and extra care sheltered housing.

Sheltered housing

Some 5% of people aged 65 and over in Great Britain live in sheltered housing (Tinker, 1997). However, the location, size and stigma associated with sheltered housing impact on the desirability of this form of supported living for older people. Older people often wish to remain in the community in which they have established social networks (Burholt, 2006). However, availability of local housing specially designed for older people in some *rural* communities seems to be an obstacle to those wishing to move, as they are frequently located several miles away from the person's social network (Burholt, 1998a). Also, the size of specially designed housing impacts on their desirability. Policy makers have assumed that older people want 'compact' houses that are easy to maintain and heat. This is not always what older people require. A key issue in planning future housing for older people is to understand the importance of providing the correct size and number of rooms which older people desire (Heywood, 2001).

The perception of the suitability of housing stock is also a factor that impacts on preferences for certain types of housing. As sheltered housing tends to segregate older people from the rest

of the population it is perhaps not surprising that for some people they have become stigmatised and often associated with the end of life (Burholt, 1998a). The negative perceptions of sheltered housing for some older people may be outweighed by the benefits associated with this form of congregate housing. Sheltered housing is popular with older people who have moved to these facilities (Nocon & Pleace, 1999). While it has long been observed that sheltered housing is conducive to the formation of new friendships and a sense of community (Jerrome, 1981), other evidence suggests that some tenants feel lonelier after moving to sheltered housing (Field *et al.,* 2002), have fewer visitors and fractured social relationships (Walker *et al.,* 1998).

Some sheltered housing has become obsolete and is now difficult to let (Tinker *et al.,* 1995). In addition to the aforementioned factors, this may be because lifts are not provided, bathrooms are shared or that there are inadequate communal facilities (Royal Commission on Long Term Care, 1999). However, modern models of sheltered housing with the right facilities and environment are in high demand (National Assembly for Wales, 2002a).

Residential Care

Much of the literature about residential care has focused on the negative aspects of institutionalisation (e.g. Goffman, 1961). Studies have looked at the loss of autonomy and learned helplessness of individuals who live in these environments (e.g. Lidz & Arnold, 1990). Others have observed that a reduction in living space, loss of contact with friends, loss of control over the environment, decreases in decision making and loss of privacy can lead to a fall in self esteem (Dougherty, 1985; Taft, 1985; Chowdhary, 1990). The

stereotypical view of residential care tends to emphasise the differences between 'public/private space' and 'strangeness of people/ familiarity of people' (Higgins, 1989) and the deleterious affects of provision of help above the needs of the individual (Ransen, 1978). Therefore, it is not surprising that studies show overwhelmingly, that older people in the community do not desire to enter residential care (e.g. Burholt, 1998b).

In order to minimise the negative effects of relocation to residential care various attempts have been made to maintain autonomy or promote the empowerment of the individuals in residence. Well-organised facilities promoting both self-directed behaviour and providing support had residents that rated their well-being higher than in other facilities, and required fewer health services (Coppola *et al,.* 1990; Timko & Moos, 1991). However, policy has consistently failed to define the objectives of residential care and there remain considerable differences in the quality of provision in residential care homes, consequently older people are unsure of what they can expect or demand as a resident (see Bland, 1999).

Extra care sheltered housing

Extra care sheltered housing (also referred to as very sheltered housing) broadly differs from models of sheltered housing in three main ways: the provision of a meal or meals; the provision of additional support services; the possibility of a barrier-free environment (Oldman, 2000). It tends to offer self-contained accommodation, equipment for care, 24-hour cover from care staff, catering and communal facilities and social activities (Baker, 2002; King, 2004). When compared with residential care, extra care sheltered housing offers a larger living space,

extra disposable income for tenants, a more vibrant community and flexible packages of care (Oldman, 2000). To date there are fewer examples of research and evaluation conducted in extra care sheltered housing than in other forms of supported living environments (Croucher *et al.,* 2006).

The research that has been conducted in extra care sheltered housing has indicated that care packages increase as well as decrease, and are more finely tuned with the client's needs. There is a greater involvement of relatives in the schemes that means there are hidden subsidies from relatives' informal caring (Oldman, 2000). Although limited evidence exists to suggest the benefits of extra care sheltered housing compared to other supported environments (Croucher *et al.,* 2006), the Royal Commission on Long Term Care noted the absence of research examining the acceptability of extra care sheltered housing to people outside of the schemes (Royal Commission on Long Term Care, 1999).

The need for research

Despite the need for supported living environments for a small proportion of the older population, there continues to be little known about exactly what features of supported housing are liked and disliked by older people, and what models of care may meet these preferences (see Tinker, 1997). In order to address this gap in knowledge a study was conducted in North Wales to identify which types of supported housing would be preferred by older people, should they have to move in the future.

The purpose of this paper is to indicate the relative importance of privacy and physical space, physical care, domestic services, security, social activities, and control or autonomy for older people in future accommodation. The analyses establish which type of accommodation (sheltered, extra care sheltered housing and residential care) older people believe would be most likely to meet their needs. The analyses are exploratory, as there were no indications from the literature as to which domains would be most important for older people.

METHOD

The research setting and sample

Data were collected in Gwynedd, North Wales as part of the HAPPI (*Housing for an Ageing Population: Planning Implications 2001-2003*) project. Gwynedd is a rural area with a population of 45.8 people per square kilometre (National Assembly for Wales 2002b)[1]. The sample was selected to provide a representation from a diverse range of areas in Gwynedd. Random sampling procedures were used to draw a proportional sample of people aged 70 years and over from each community (N=423). Briefly, the sample comprised of 59% females and 41% males. The mean age of participants was 78 (s.d. 5.55). Over half (52%) of the sample were married and nearly two-fifths (38%) were widowed. Very few participants had never married (7%) or were divorced or separated (4%). Three-quarters (75%) of the older people in the sample were home owners and only 17% lived in houses rented from the local authority or housing associations. Less than one-tenth (8%) of the sample lived in other types of tenure. Two-fifths (40%) of participants lived alone but nearly one-half (47%) lived with a spouse. Just over one-tenth (12%) of the sample had other living arrangements, including living with members of a younger generation.

Data collection

English and Welsh versions of the questionnaire were administered in the participants' own homes in the form of a structured face-to-face interview. In order to establish which domains older people considered would be important in the consideration of supported environments, the questionnaire included the following:

> *If you were in a situation in which you required regular physical care, and staying in your present home was NOT an option we want to find out what things would be important to you. We would like you to rate the importance as either very high, high, moderate or low. We also want to find out how your needs might best be met by comparing sheltered housing, extra care sheltered housing and residential care.*

Participants were read a description of each type of housing and then asked:

> *How important would privacy and physical space be in your accommodation?*

The importance of each domain was coded as 'very high', 'high', 'moderate' or low. Participants were then asked:

> *Which type of accommodation do you think would best meet your needs for privacy and physical space if you were to compare sheltered housing, extra care sheltered housing and residential care?*

Responses were coded according to the type of supported environment that the respondent selected. The questions were repeated for each of the five domains (physical care, domestic services, security, social activities, and control/autonomy). Any comments that were made by participants demonstrating why the choices were made were recorded verbatim.

Data analysis

The importance of each domain was coded as 'very high', 'high', 'moderate' or low. For the purpose of these analyses the categories are collapsed to very high/high and moderate/low. To determine whether the differences between the participants' ratings of importance were significant binomial tests were performed.

The characteristics of the participants were measured in three areas: socio-demographic factors (age, gender, marital status, household composition), physical health (long standing illness, self-reported health), and social support (support network type). A set of indicators for each domain were selected to have a high degree of statistical efficiency. Each group of factors were examined for relationships with particular domains. Pearson chi-square test was used to determine whether key variables (see Table 1) were independent or showed a relationship.

The Phi Coefficient was used to determine the strength and type of association between two variables. Independent sample t-tests were performed for the continuous variables (age, and self-reported health). For all statistical analysis, significance was assumed if p values <0.05. In this paper, only significant findings are reported. Verbatim comments were transcribed and examined for key themes that illustrated preferences for types of supported living environments.

TABLE 1. Variables used in analyses

Variable	Categories
SOCIO-DEMOGRAPHIC	
AGE	70-74
	75-79
	80-84
	85+
GENDER	Female
	Male
MARITAL STATUS	Single
	Married
	Widowed
	Divorced/separated
HOUSEHOLD COMPOSITION	Living alone
	Not living alone
PHYSICAL HEALTH	
SELF ASSESSED HEALTH [2]	Excellent, very good or good health
	Fair or poor health
LONG STANDING ILLNESS [3]	No
	Yes
SOCIAL SUPPORT	
NETWORK TYPE [4]	Family dependent (FD)
	Locally integrated (LI)
	Local self contained (LSC)
	Wider community focused (WCF)
	Private restricted (PR)
	Inconclusive

FINDINGS

Privacy and physical space

Eighty-six percent of participants reported the importance of privacy and physical space as high or very high. These participants were more likely to prefer the sheltered housing option (79%) than extra care sheltered housing (13%) or residential care (7%) (Chi square = 12.19 (d.f.2) p<0.005; Φ = 0.176, p<0.005). Overall, over three-quarters of the total sample (77%) thought that sheltered housing was more likely to meet their needs for privacy and physical space. People who had chosen sheltered housing as a preferred option thought privacy within a self-

contained unit was more acceptable than communal living facilities.

"I like people, company, but you can't choose who you'll be with. Dread sitting in a room with a row of people, TV blaring." *(Female, 78)*

Only 14% of participants considered that extra care sheltered housing would meet their needs for privacy and physical space. Being able to retain some independence, whilst having the availability of care if necessary was a typical response for those who expressed this preference:

"I'd like to be able to go down for a meal then go back to my own flat. As

long as you can walk and do things for yourself. Have my own TV."
(Female, 74)

Less than one-tenth (9%) of participants thought that residential care would be suitable to meet their needs for privacy and physical space. This appeared to be influenced by personal knowledge of local care homes. However, residential care also appeared to be chosen if the respondent thought they had no choice over relocation.

Physical care

Eighty-two percent of participants reported the importance of physical care as high or very high. A low association was found between the importance of access to physical care and gender (Chi Square = 4.60 (d.f. 1) $p<0.05$; Φ = 0.108, $p<0.05$). Three-fifths (61%) of women rated this domain as high or very high compared to only two-fifths (39%) of men.

Overall, over half of the total sample (51%) thought that sheltered housing would meet their needs for physical care. However, nearly one third (31%) of the sample though that extra care housing would provide suitable physical care, and nearly one-fifth (18%) considered that residential care would provide adequate care provision.

People who preferred the sheltered housing or extra care sheltered housing option felt that having a warden 'on call' or having access to 24 hour care if necessary was very important. Participants felt that in sheltered housing they would be able to access services but retain their independence. Typical responses included:

"It would be better [than other options] because we'd have our own

place but still 24-hour access to help if we needed."   *(Male, 70)*

It was also evident for some participants that extra care sheltered housing was a preferred option to residential care, especially as they recognised that a high level of health care was unlikely to be provided in sheltered housing:

"No use moving into sheltered accommodation if you can't take care of yourself."   *(Female, 73)*

Participants who expressed a preference for residential care thought that there would be more health care professionals available than within the other supported living environments. Personal knowledge of local care homes also influenced choices.

Domestic Services

Eighty percent of participants reported the importance of domestic services as high or very high. Overall, 61% of the total sample thought that sheltered housing would meet their needs for domestic services. Over one-fifth (23%) of the sample thought that extra care housing would provide suitable domestic services, and 16% considered that residential care would provide adequate provision.

Some participants who chose the sheltered housing or extra care sheltered housing option were already using some form of domestic service or had family support and felt that this would continue should they relocate to this form of supported environment. Others considered that if the need for help with household tasks arose that domestic services would be provided within these environments:

"I have a home help come in once a week now, so I'd get the same if I

moved somewhere with a warden."
(Female, 81)

Residential care was the least preferred supported living environment. Unlike the other participants those who chose this option appeared to be keen for all household tasks to be 'done for them'. A typical response was:

"There is someone there to clean the home for you–you only have to get up." *(Female, 85)*

Security

Three-quarters (75%) of participants reported the importance of security as high or very high. Nearly two-thirds of these participants had a long-standing illness, disability or infirmity (Chi Square = 4.287 (d.f.1) p<0.05; Φ = 0.103, p<0.05). Overall, 64% of the total sample thought that sheltered housing would meet their needs for security. Nearly equal proportions of the sample thought that extra care housing or residential care (17% and 18% respectively) would provide suitable security.

Participants had not viewed security in terms of avoidance of threat of crime, but instead related it to avoidance of injury by other risks. Participants who chose sheltered or extra care sheltered housing as their preferred option felt that having a warden and an alarm present would alleviate any difficulties that might arise.

"I would like someone on hand such as a warden who I could contact in an emergency." *(Female, 73)*

Similarly, participants who chose residential care based their decision on the knowledge that there would be full-time care staff available in a crisis.

"I'd feel safer with people around, particularly if I'm ill".
(Female, 84)

Socialising and taking part in activities

Although just over half of the participants (54%) rated socialising and partaking in activities as very high or high the binomial test failed to reject the null hypothesis that there is no difference in preferences (p = 0.1). Fewer participants considered that this domain was important compared with the other domains. Analyses showed a low association between marital status and the importance of socialising and partaking in activities (Chi square = 9.01 (d.f.3) p<0.05; Φ = 0.149, p<0.05). Only one-fifth (20%) of participants who were divorced or separated thought that socialising was very important compared to over a half of participants who were single, married or widowed (59%, 52% and 59% respectively).

There was also a low association between network type and the importance of socialising and taking part in activities (Chi square = 20.88 (d.f.5) p<0.005, Φ = 0.277, p<0.005). As would be expected, participants with network types that included integration with local friends and neighbours (locally integrated (62%) and wider community focused (66%)) were nearly twice as likely to rate this domain as important compared to participants with private restricted network types (36%). This is not surprising, given that the private restricted network type is characterised by low levels of contact with neighbours and the community.

Overall, 67% of the total sample thought that sheltered housing would meet their needs for socialising. Nearly equal proportions of the sample thought that extra care housing or residential care

(17% and 16% respectively) would provide suitable opportunities for socialising. Participants who preferred the sheltered or extra care sheltered housing option were concerned about retaining a choice over socialising activities. This included retaining the privacy they experienced in their own homes with the freedom to choose visitors. Typical responses included:

> *"I'd prefer my own friends and to organise my own social life. I don't think age stops you having fun."*
> *(Male, 72)*

It was felt that extra care housing may afford more opportunities to socialise and extend their friendship networks:

> *"As long as I had my privacy in my flat, I could meet other people in the café."*   *(Female, 75)*

Participants who preferred residential care tended to stress the importance of organised activities and opportunities for socialising e.g.:

> *"I like the company of others and would like organised social activities." (Male, 81)*

Control of life

Eighty-seven percent of participants reported the importance of control of life as high or very high. Overall, over three-quarters (77%) of the total sample thought that sheltered housing would meet their needs for control. Only 14% of the sample thought that extra care housing would give them control over their lives, and less than one-tenth (9%) considered that this would be an option

within residential care. Participants that preferred sheltered or extra care sheltered housing cited choice, independence and being in control of decision making as important criteria. Typical responses included:

> *"I like to take care of my own purse strings as regards expenditure or otherwise."*   *(Male, 70)*

> *"We could still have control of our lives, our own flat and everything, but I'd feel comfortable knowing people were around to help."*
> *(Female, 75)*

Very few participants (9%) felt that residential care would enable them with control over their lives. For those who did express this preference the qualitative data suggest that for a small minority control over life was not an important factor.

DISCUSSION

Five of the six domains were rated very high/high in their importance by over three quarters of the sample (see Figure 1 below). The largest proportions of participants rating the domains as important were found for privacy and physical space (86%) and control of life (87%). The gap between high and low in importance was far closer for the socialising domain. This suggests that socialising and partaking in activities are not considered as important as privacy and physical space, physical care, access to domestic services, security and control of life. These findings give a very clear picture of what older people consider to be desirable aspects of supported living environments.

FIGURE 1. *Proportion of participants giving high or very high importance to each domain.*
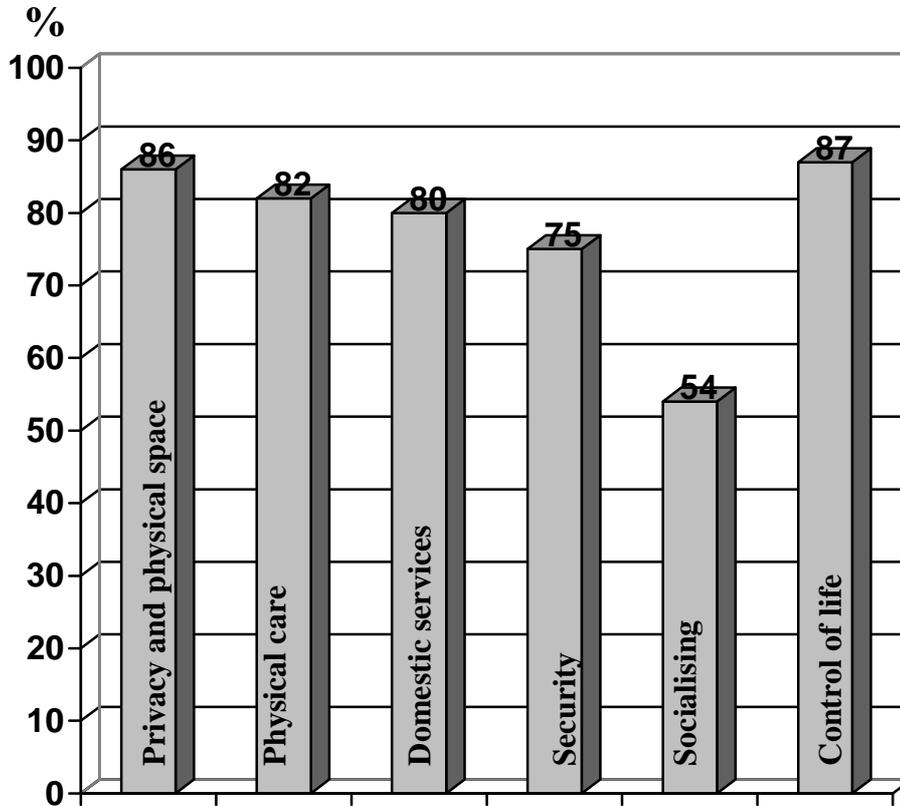
Although this study was carried out in a rural area of Gwynedd, North Wales it is likely to be applicable to the population of older people across a broad range of settings. The participants in the study comprised those that had lived in the area for most of their lives and migrants to the area (thus representing the opinions of people from other areas in the UK). In particular, the findings are topical as there is continued investment in housing with care (Croucher *et al.*, 2006). The new forms of supported living environments include a range of accommodation (e.g. flats, bungalows, small houses) with variation in size, space, amenities and provision of care and support. Thus, the quality of the supported living environments will depend on how closely the provision

meets older people's needs. To date, this study provides some of the only evidence in the UK about the preferences of older people for certain features of supported housing and what models of care may meet these preferences.

Given only a limited choice of supported living arrangements, participants chose sheltered housing as the preferred option for each domain. In our opinion, extra care sheltered housing is more likely to meet needs in the six domains that were rated highly (i.e. provision of privacy and physical space, physical care, access to domestic services, security and control of life). However, the findings are strongly influenced by older people's perceptions regarding each of

the supported living environments. Firstly, residential care in the UK has continually been identified as a 'last resort' and in this and other studies the data shows that for many people the stereotypical image of residential care endures (Oldman & Quilgars, 1999). This is exemplified in some of the verbatim comments, such as "[I] dread sitting in a room with a row of people, TV blaring".

A majority of older people in this study did not believe that residential care would meet the dominant needs for privacy and physical space and control of life. The ratio of shared rooms to single room provided by local authority residential care ranges from 20 percent to 100 percent (Day *et al.,* 1996), these settings are unlikely to meet older people's desire for privacy. Older people believe that control over one's life is an integral part of independence which, in this context, appears to be in opposition to the implicit view of some residential care staff who take the approach that only people who are physically independent are able to retain 'control' over aspects of decision-making (Bland, 1999). Privacy and control for residents in supported living environments are unlikely to be upheld if notions of independence continue to be regarded as privileges rather than rights.

Despite the indication that negative stereotypes of residential care are firmly embedded in society, there has been positive change in provision of care in residential settings (Oldman & Quilgars 1999). This is supported by the evidence from those respondents whose preferences for housing were influenced by personal knowledge of local care homes, usually through a family member being in residence. In addition to preferences being affected by negative perceptions of supported living environments, a lack of knowledge regarding alternative facilities was also likely to impact on the findings (Tinker, 1997). Few people in the sample were likely to have had experience of extra care sheltered housing. Although a description of the extra care housing was read to the participants, it was likely that the choice of supported environment was more likely to be made by comparing sheltered housing and residential care.

The assumption that lack of knowledge impacted on stated preferences for housing could perhaps be supported by the evidence presented regarding the importance of physical care. Over four-fifths of participants (82%) considered that access to physical care was very important. However, it has long been noted that sheltered housing is unable to house and care for very frail older people (McCafferty, 1994). The inability to discern between the different living environments is not surprising given that there has been a failure within policy to define clearly and publicly the objectives of residential care, sheltered housing or extra care sheltered housing. Fairly recently the Department of Health's Housing Learning and Improvement Network (see Riseborough & Fletcher, 2003, p. 1) defined extra care housing as 'a concept rather than a housing type that covers a range of specialist housing models. It incorporates particular design features and has key guiding principles. It can be referred to by several different names'. This lack of conceptual clarity means that older people continue to be unsure what they can expect or demand from each of the services (see Bland, 1999).

One of the most significant findings in this study is the importance of control and privacy for older people. The verbatim comments from participants illustrate that older people are not necessarily aiming for a quite life. A

majority of the participants were adamant that they wished to remain in control of their lives for as long as possible. Very few were keen on a living situation where household tasks or financial matters were carried out by others as a matter of routine.

In conclusion, the debate must continue on the best methods of delivery of care in supported living environments that incorporate privacy and physical space, physical care, domestic services, security and control. However, attention as ever needs to be paid to the way that the services are packaged. The findings showed that gender, marital status, support network type and health impact on the importance attached to some domains, demonstrating that older people have diverse expectations for housing and care. In addition, staff and residents often have different perceptions about the meaning of independence (Croucher *et al.,* 2006). One package of care or supported housing solution will not satisfy all (Nocon & Pleace, 1999). Older people need to be taken seriously as consumers of services and the aims of supported living environments need to be clear, to indicate to clients the level of support that can be obtained. The maintenance of stimulation and independence has to be taken seriously and combined with assurance of around the clock care, if required.

ENDNOTES:

[1.] Using the OECD definition for rural populations, i.e. less than 150 residents per square kilometre.

[2.] Self assessed health: The EuroQol visual analogue scale 'thermometer' (EQ VAS thermometer) generates a self-rating of current health-related quality of life. The measure has been validated and tested for reliability (van Agt *et al.,* 1994, Brooks, 1996)

[3] The variable was constructed from a question that was replicated from the General Household Survey conducted by the Social Survey Division of the Office for National Statistics (Walker *et al.* 2001). The question established whether the respondent had any long-standing illness, disability or infirmity.

[4] Network type was operationalised by the Wenger (1989) support network typology. This typology includes five types of networks differentiated on the basis of: the availability of close kin, levels of contact with family, friends and neighbours, and community involvement. They can be summarised as follows:
The Local Family Dependent Support Network (FD) - the older person relies for most help and support on relatives living in the same community.
The Locally Integrated Network (LI) – associated with helping relationships with local family, friends and neighbours.
The Local Self-contained Network (LSC) – reflects a more privatised household-centred life style with reliance on neighbours if essential.

The Wider Community Focused Network (WCF) – is associated with an absence of local kin and primary focus on friends and involvement in community groups. *The Private Restricted Network* (PR) – is associated with an absence of local kin and low levels of contact with neighbours and the community.

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