# Control, Well-Being and the Meaning of Home in Care Homes and Extra Care Housing

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## INTRODUCTION

Promoting choice and control for older people is a policy priority that spans the fields of housing, health and social care (Cm 6737, 2006). Central government is committed to increasing the number of people being cared for in non-institutional environments and is promoting extra care housing (also referred to as very sheltered housing or enhanced sheltered housing), as a possible 'alternative option to residential care' (Department of Health, 2002a).

Residents of extra care housing should be able to receive equivalent levels of support to older people in care homes, but in an environment more akin to mainstream housing because accommodation consists of self-contained flats or bungalows, rather than rooms, and residents are tenants or leaseholders, rather than licensees. The philosophy behind this model of care is that people will be living in their own homes (Riseborough and Fletcher, 2003), yet in a more supportive environment than that found in mainstream housing in the community. The expectation is that under these arrangements, people will feel more at home and more in control because their independence is being supported for longer.

## RESEARCH AIMS

The study aimed to:

- Compare residents' sense of control in care homes and in ECH from both an objective and subjective point of view.
- Explore whether the positive relationship we expect to find between subjective control and well-being varies according to people's desire for control.
- Find out what is important in making a place feel like home to residents of different care settings and whether residents who do not experience the qualities they rate as important have lower well-being than those who do.

## METHOD

Interviews were conducted with 183 older people living in care homes (N=89) and extra care housing (N=94). Information was collected about:

- Background (age, time lived in the scheme/home, etc.)
- Dependency (ability to perform Activities of Daily Living (ADLs))
- Self-perceived health
- Desire for control
- Objective control
- Subjective control
- Well-being
- The meaning of home

The objective control scale was designed for the purposes of this study and consisted of 19-items designed to be particularly relevant to the daily lives of older people receiving care and living in specially designed environments, rather than family homes. Respondents were asked to state to what extent they agreed/disagreed with the statements.

Subjective control was measured using a question used in a number of previous studies, including the 2006 older home care service user experience survey. Control over daily life was defined as having the choice to do what you want, when you want to, for example having meals, going to bed and getting up, going out, etc.

## THE HOMES AND SCHEMES

The aim of this study was to compare good quality extra care schemes with good quality care homes. Details of sampling are provided in the final report (Towers, 2006).

The final sample consisted of 24 care homes (a response rate of 69%) and 14 ECH schemes (a response rate of 100%). Care homes ranged in size from 10 to 47 places. The average number of total places per home was 27 and the average number of old age places was 25, which is representative of the size of the average UK care home for older people in 2005 (Laing and Buisson, 2005). The majority of the homes in the sample were run by private providers (17), followed by charitable organisations (4) and the local authority (3).

Extra care schemes ranged in size from 23 to 59 flats. The average number of flats in a scheme was 32. All schemes catered primarily for older people with some care needs but there was a range of dependency. with the majority of tenants receiving very sheltered services (four hours care a weeks or more) but a minority only receiving ordinary sheltered services (less than four hours a week care). An average scheme in the sample housed 35 tenants, 30 of whom were receiving very sheltered services and five ordinary sheltered services. For comparability with the care home residents, only the very sheltered tenants were invited to take part in the study. The tenure of the schemes was all private or social rent, reflecting the nature of the tenure arrangements in the schemes in that particular authority.

## THE RESIDENTS

Interviewees (44 men and 139 women) were all permanent residents or tenants. They all classified themselves as White or White British. Care home residents were significantly older (mean 87.2 years) than the extra care housing tenants (mean 82 years).

Although there was no difference between the overall level of dependency of the care home residents and the ECH tenants, the ECH tenants were statistically more dependent on two key ADLs: getting dressed/undressed and getting in/out of bed. These ADLs and age were controlled for where necessary in the further analyses.

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The study was carried out by Ann-Marie Towers and Ann Netten and this summary was written by Ann-Marie Towers.

## SELF-PERCEIVED HEALTH

Despite no overall difference in the level of dependency of the residents in each type of setting, the ECH residents rated their health as significantly worse than the care home residents. This difference held even after we controlled for age and dependency. As self-perceived health was found to be the most significant predictor of well-being in our sample, without controlling for SPH, the ECH tenants actually had lower well-being than the care home residents. However, allowing for the fact that they rated their health as worse, well-being did not vary according to where people lived.

Further research is required to investigate the differences in SPH. It may be that SPH reflected a form of illness of disability not measured in this research (e.g. cancer) and that there was a higher incidence of this in the ECH schemes. However, we suspect that the difference may be due to ECH tenants comparing themselves to a fitter population than the care home residents, thus viewing their own health worse. We treated SPH as an unwanted difference between the care home and ECH residents and its effects were controlled for in further analyses.

## OBJECTIVE AND SUBJECTIVE CONTROL

The ECH residents reported experiencing higher levels of objective control than the care home residents. However, the ECH tenants did not *feel* more in control of their lives.

Contrary to our original expectations, objective control was not directly related to subjective control. The nature of the relationship between objective and subjective control differed according to the dependency of the resident. Those with low levels of dependency felt most in control of their lives, regardless of the amount of control they experienced in practice. For these people objective control was not associated at all with their own sense of control. Although high dependency residents consistently reported feeling less in control of their lives, their sense of control did improve when the amount of objective control they experienced increased. Thus it seems that while health is the biggest predictor of how in control people feel over their lives, we can improve the sense of control of the most dependent people by giving them more control over their daily routine and living environment.

We expected to find that highly dependent ECH residents felt more in control of their lives than highly dependent care home residents. This was not the case. It seems that objective control, although important, is not the only factor considered when judging subjective control and in this study objective control was not enough to make the ECH respondents *feel* more in control of their lives. Clearly, a better understanding of what these other factors are is needed.

## SUBJECTIVE CONTROL AND WELL-BEING

There was no relationship between objective control and well-being but, after self-perceived health, *feeling* in control was the largest predictor of well-being in our residents. Furthermore, the positive relationship between feeling in control and well-being was found to depend upon desire for control. The association was weaker for people with low desire for control. It was people with a *high* desire for control whose well-being benefited most from feeling in control and suffered most from not feeling in control.

## THE MEANING OF HOME

There was considerable agreement amongst respondents about what features are important in making a place feel like home and the majority of people in our sample also told us they experienced these positive features, which should certainly help them to feel at home where they live. Features over which there was particular agreement included (in order of agreement):

- Being in control of when friends/ relatives visit
- Being able to live in the home or scheme for as long as you want to
- Having control over how you spend your time
- Being able to come and go as you please
- Being able to arrange your room/flat to suit your own tastes
- Being allowed to be alone if you want to

We did not find any evidence that the ECH tenants felt more at home than the care home residents, despite the fact they live in self-contained accommodation and experience more objective control over their daily lives.

## KEY MESSAGES

The evidence from this study is that although ECH affords residents more control over their daily lives this does not mean that they necessarily feel more in control or report higher levels of well-being. The good quality care homes in this study provided their residents with an equal sense of control over their lives, an equally high level of well-being and an equally home-like environment. Thus, although positive experiences were most certainly reported by the ECH residents, supporting the argument that it is an effective model of housing with care from a user perspective, there was no evidence to suggest that it is was leading to better outcomes for service users compared with good quality traditional care homes.

## REFERENCES


Cm 5570 (2002) *Opportunity and Security for All: Investing in an enterprising, fairer Britain. New Public Spending Plans* 2003–2006, The Stationery Office, London.

Cm 6737 (2006) *Our health, our Care, our Say: a new direction for community services*, The Stationery Office, London.

Croucher, K., Hicks, L. and Jackson, K. (2006) *Housing with Care for Later Life: A literature review*, Joseph Rowntree Foundation, York.

Laing & Buisson (2005) *Care of Elderly People: Care Market Report 2005*, Laing & Buisson, London.

Riseborough, M. and Fletcher, P. (2003) *Extra Care Housing: What is it?* Factsheet No. 1, Housing Learning and Improvement Network, Department of Health, London.

Towers, A. *Control, Well-Being and the Meaning of Home in Extra Care Housing and Care Homes*, PSSRU Discussion Paper No. 2342, Personal Social Services Research Unit, University of Kent, Canterbury.



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