The Needs of Older People Living in Sheltered Housing.

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ABSTRACT

Eighty-seven residents of three sheltered accommodation schemes for people over 60 years, were interviewed about their physical and mental health, their decision to move in, and how they found living in sheltered housing. Their social networks and social support were investigated along with any needs they might have, environmental, physical, psychological or social and who, if anyone, met these, family, friends, health, social or voluntary services.

Residents had a wide range of needs and varied greatly in the number of needs they had. Environmental needs e.g. housework, shopping and managing money, and physical health needs e.g. medication, physical health and self care were reported most frequently and were usually met. Psychological needs e.g. distress and memory and social needs e.g. activity, relationships and company were reported less often but a greater proportion of these were unmet. Particular needs varied as to whether they were more likely to be met by family, services, either or both together. No relationship was found between the number of needs or unmet needs and resident gender, age or scheme lived in. Single people had more needs but not more unmet needs than married people. Activity limitation, somatic symptoms, dementia and depression were all associated with numbers of needs and of unmet needs. Residents' with private restricted or family dependent support networks had most needs, those with locally integrated networks had least. Residents with private restricted networks had the most unmet needs on average, and those with locally integrated networks had fewest. Residents with private restricted networks needed formal help with more needs than did other residents.

Residents often moved to sheltered accommodation because: they or their spouse were in poor health; they could not manage in their old home; they wanted a warden or alarm. Most residents were happy living in sheltered accommodation. Many made use of 'sheltered' features such as the common room, the communal laundry, the warden and the alarm. A minority of residents were lonely and a few were unhappy with sheltered accommodation.

CHAPTER ONE

INTRODUCTION

Sheltered housing has been described both as
"the most humane and successful formula for long term assisted independent living in use today in western society" (Heumann & Boldy, 1982, p203) and also as
"the unjustified provision of so much for so few" (Middleton, 1987).

OVERVIEW

Sheltered accommodation, designed for older people with particular environmental features and support staff attached, houses a sizeable minority of older people, and more than residential care. With the growing number of the very old, and the reduction in the number of available carers due to social changes, now is the time to investigate sheltered housing and its residents? Why do people move in? What are their needs, are they met, and if so, by whom?

This chapter begins with an overview of the health and housing of older people in Britain, with a particular focus on sheltered housing. There follows a discussion of the needs of older people and of their social networks, which have a major impact on health and needs and service use. The aims of the present study are then outlined.

THE HEALTH, SOCIAL & HOUSING PROBLEMS OF OLDER PEOPLE

In the United Kingdom over 9 million people (16% of the total population) are aged 65 and over. More than 4 million people (7.1%) are over 75 and more than 1 million (1.8%) are over 85 (Population Trends, 1998, cited in Age Concern, 1998). Almost two thirds of those 75 years and over and almost three quarters of those 85 and over are women. The number of older people (i.e. over 65 years) is projected to continue

increasing over the coming years with the steepest increase being in numbers of the very old (National Population Projections, 1996, cited in Age Concern, 1998).

While for practical reasons the discussion that follows talks about older people in general terms it is important to remember older people are a very heterogeneous group spanning an age range of well over 30 years with widely differing health status, personal, social and financial resources. Categorising older people as a group in order to discuss the health, social and housing issues they may face raises important issues about segregation, stigmatisation and stereotyping as well as practical issues. Numbers alone are of limited value in deciding what, if any, support older people may need and how it should be delivered.

Health and Disability

Physical dependence, dementia and depression are common reasons why older people may need assistance (Harrison, Savla & Kafetz, 1990). While not exclusive to older people these do increase in frequency with age. Chronic illness is considerably more common among older people. In Britain 59% of people aged 65 - 74 and 66% of those aged 75 and over had a long standing illness as compared to 35% of people of all ages. Over 40% of those aged 65-74 years and over 50% of those 75 years and over said chronic illness limited their lifestyle (General Household Survey, 1996, cited in Age Concern, 1998).

The majority (70%) of the 6 million people in Britain with a disability were aged over 70, 75% of those over 80 years have some form of disability (Fletcher & Minter, 1991). Over a million people aged over 65 could not walk down their street alone, over half of whom could not walk in the street even with support. Over 700,000 could not use stairs (General Household Survey, 1985, cited in Fletcher & Minter, 1991).

People over 75 years tended to stay longer in hospital once admitted. Of people aged over 75, 24% had attended casualty or out patients in a three month period compared to 15% of the population as a whole (General Household Survey, 1996,

cited in Age Concern, 1998). In England around 470,000 households reported receiving home help or home care services and the vast majority (88%) of recipients were over 65 years, most were over 75 (Community care statistics, 1997 in the Department of Health Statistical Bulletin, 1998, cited in Age Concern, 1998).

Social Support

Despite these higher levels of illness and disability older people provide a considerable proportion of the informal caring required, often caring for a spouse. Amongst the carers in Britain who devoted at least 20 hours a week to caring, 27% were over 65 years, and 47% were aged 45 - 64 (General Household Survey, 1995, cited in Age Concern, 1998).

The majority of men (74%) and of women (53%) aged 65 - 74 were married, with considerably more women (35%) than men (13%) widowed. Fewer of those aged 75 and over were married (62% of men and 28% of women) and many more were widowed, more women (62%) than men (29%). A large proportion of older people lived alone, 39% of women and 21% of men aged 65 - 74 years, increasing to 58% of women and 31 % of men aged over 75 (General Household Survey, 1996, cited in Age Concern, 1998).

Finance

Older people tend to be poorer than the rest of society and they are over represented among those with the lowest incomes (Fletcher & Minter, 1991). About half of pensioner households depend on state benefits for at least three quarters of their income (House of Commons Hansard 18/2/98 and Pensioner Income Series 1995/96 cited in Age Concern, 1998). They also spend a greater percentage of their income than other households on housing, fuel and food (Family Expenditure Survey 1996/7 cited in Age Concern, 1998). A significant minority of those entitled to state benefits do not claim them (Income related benefits - estimates of take up in 1995/6 DSS, cited in Age Concern, 1998).

Housing

Of households headed by an older person 56% were owner occupiers without a mortgage, 6% owner occupiers with a mortgage, 26% rented from the local authority, 6% rented from housing associations and 6% rented privately (General Household Survey, 1996, cited in Age Concern, 1998). Twenty percent of people aged 75 and over lived in poor housing, this percentage rose with age and was greater still for those living alone (English House Condition Survey, 1996, cited in Age Concern, 1998). Older people were more likely to live in unsatisfactory housing than younger people because they tended to live in older housing. Many owner occupiers did not have the income to maintain the property and a disproportionate number of older people lived in private rented accommodation where the worst housing was found (Oldman, 1990). A reasonable home in the location wanted is a precondition for a sense of security, continuity and autonomy (Fletcher & Minter, 1991).

Older people have an even greater need than younger people for appropriate housing as in retirement many spend a much greater percentage of their time there. Inappropriate housing can exacerbate chronic health problems and disabilities; it can prevent people getting out, or friends visiting and can make daily tasks impossible for those with restricted mobility. Housing that is difficult or costly to heat has serious implications. In 1996, 365 older people died of hypothermia (House of Commons Hansard 4/11/97 cited in Age Concern, 1998). Excess winter deaths in England and Wales were 19% above average in 1991 compared to only 4% in Germany (Henwood, 1991, cited in Age Concern, 1998). Although there is little direct evidence that improving housing circumstances enhances older people's health and social circumstances older people did report that improved housing helped them maintain their independence (Oldman, 1990) and people with severe mental illness rated housing as one of the most important contributors to their quality of life (Thaper & Rowland, 1989). In adults aged 17 to 65 damp housing was significantly and independently associated with higher scores on the General Health Questionnaire even after controlling for confounding variables (Hopton & Hunt, 1996).

Problems with housing can be split into two types. "Dwelling specific problems" such as damp, and overcrowding are income related and not specific to older people. "Dwelling use problems" generally relate to age or disability and not particularly to income, e.g. a home may no longer be suitable because decreased mobility means the stairs or large size are problematic (Struyk, 1987).

The ability to live independently in the community depends both on the type and quality of accommodation as well as on the support received. Warm, dry and accessible housing is an essential ingredient of community care (Oldman, 1990). Despite this the housing implications of an ageing society have been discussed much less than the caring implications, although Government housing policies over the years have to some extent recognised the importance of housing to older people e.g. Ministry of Housing and Local Government Circulars 30/58, 47/60 and 82/69 (cited in Fletcher & Minter, 1991). Older people have various housing options although availability depends on geography. These include staying in their home or moving, possibly to types of housing specifically for older people such as sheltered housing, residential homes, or nursing homes.

Residential homes provide personal care, nursing homes provide a greater level of care including nursing care. In both, meals are provided. Residents may have their own room or they may share. Living rooms, bathrooms and dining rooms are communal. Generally people with high dependency needs, including many with moderate to severe dementia, live in these forms of housing. Around 5% of older people were living in institutional care in England (Community Care Statistics, 1997, cited in Age Concern, 1998). This comprised 2% (209,000) in registered residential homes. The majority of these people lived in private homes (60%) with about 22% in local authority homes and 18% in voluntary homes. 1.5% (133,733) lived in nursing homes and 1.5% lived in long term hospital accommodation, most of whom are aged over 85 (Private hospitals, homes and clinics, 1997 in the Department of Health Statistical Bulletin, 1998, cited in Age Concern, 1998)

SHELTERED HOUSING

Sheltered housing in the UK generally comprises groups of on average 30 flats or bungalows, most of which are self contained, consisting of living room, kitchen, bathroom and bedroom, although some are bed-sitters (Williams, 1986). Facilities vary but usually there is a common room, laundry and an alarm or communication system for residents to summon help in an emergency. There is usually a warden, whose role is to be a 'good neighbour', who checks on people's well-being daily and calls in support as required. Wardens are often resident on site, 66% of schemes in Harlow have resident wardens, the rest are visited by a warden most days.

Over 6% of older people lived in sheltered accommodation, more than lived in residential care. In England there were about 281,500 units rented from local authorities and 169,600 rented from housing associations (Department of the Environment, Transport and Regions, 1997, cited in Age Concern, 1998). In addition in the UK as a whole there were 92,500 private retirement housing units of which 87% had a resident warden and 7% had a non resident warden (Elderly accommodation council database, 1998, cited in Age Concern, 1998).

The tenants of sheltered accommodation appear to be slightly older than those older people living in ordinary housing, with a mean age of 75 as compared to 73 years (Butler, Oldman & Greve, 1983). The majority were widowed and single women, with single men accounting for only 5% and couples around 20% of residents (Heumann & Boldy, 1982). In addition to there being more older women they were actually allocated more places than men pro rata (Butler et al, 1983). Schemes tended to try and seek a balance of residents by age and functional impairment within schemes to reduce the demands on the warden but there was considerable variation in the average level of dependency of the residents. The majority of tenants in both council and housing association schemes moved in from council and private rented accommodation (Butler et al, 1983). Fennell (1986) surveyed 867 tenants of Anchor Housing Association's sheltered housing schemes and found that tenants were more likely than

the general population of older people to experience illness, disability and falls and to have no one living with them to help.

Sheltered housing schemes were usually situated in established neighbourhoods near shops, clinics, public amenities and public transport links in order to facilitate independent living (Williams, 1986). As well as checking people daily wardens were usually responsible for maintenance of the property, cleaning the communal areas and helping to organise social activities. Residents have reported that in addition some wardens did occasional shopping, posted letters and provided help at times of illness (Butler, et al, 1983). The warden was said to be important in generating an engaging and supportive environment whilst promoting independence (Williams, 1986). Social environments varied with respect to the amount of communal space, the type and number of social activities happening in the unit and whether these are predominantly run by the warden or the residents. Most schemes (80%) with a common room had regular social activities, these were attended by the majority of residents (62%) at least occasionally (Butler et al, 1983).

History of sheltered accommodation

The origins of sheltered accommodation can be traced back to congregate living with a warden in alms houses. At the beginning of this century 'cottage homes' for the elderly were built as an alternative to the workhouse. Sheltered housing developed in the post war period as attitudes started to shift from institutional to community care. Development was slow due to lack of government guidelines, lack of publicity and a national priority of replacing the depleted family housing stock. In the late fifties and sixties the development of sheltered housing gained momentum following the publication of a Ministry of Housing and Local Government design bulletin (HMSO, 1958, cited in Fletcher & Minter, 1991). This stated that good housing was not of itself sufficient to meet the needs of older people and recommended accommodation for wardens on site, alarms, and communal siting rooms. The idea of a 'balanced population' of tenants was introduced in a joint housing and health circular in 1961

(HMSO 1961, cited in Fletcher & Minter, 1991) This assumed that fit people helped those who were frailer and that the total needs of all tenants should not exceed the capacity of the warden service. This idea of balance has remained influential (Fletcher & Minter, 1991) and was part of the current allocation policy for Harlow District Council at the time of the present study. Another government publication (Ministry of Housing and Local Government, 1969) gave further details of design and split provision into Categories 1 and 2. Category 1 was grouped self contained housing designed for active older people. Category 2 schemes had communal facilities, warden accommodation and an alarm system. The 1972 and 1974 Housing Acts led to the expansion of sheltered housing provided by housing associations. In the late 1970's local authorities built more sheltered housing units as they became aware of the growing demand for smaller houses for older people. Originally schemes were purpose built but adaptation of existing housing stock has become more common.

The rapid growth in the number of sheltered schemes slowed dramatically in the 1980's due to changes in government policies on public sector housing provision and cutbacks in housing capital subsidies. Arguments for subsidies weakened with the belief that older people were better off than their predecessors and possessing house equity wealth. However these changes did focus local authorities on the under occupation by older people of urgently needed larger family sizes homes. Moving older people to sheltered housing was seen as a way of releasing family housing stock (Fletcher & Minter, 1991). The release of money from council house sales also caused councils to review their sheltered housing provision. The private sector (including sheltered housing for sale) however did expand at this time (Williams, 1986; Oldman, 1990). Sheltered housing now has a wide range of tenure arrangements, rented, owner occupied and flexible tenure, part owned part rented.

Recent Housing Developments

Up until 1980 sheltered housing was seen as the primary response to meeting the housing needs of older people (Fletcher & Minter, 1991). Financial constraints on

councils and housing agencies, the huge increase in the number of people over 75, the poor condition of the homes of older owner occupiers, community care and concern about frail tenants in sheltered housing led to the developments of alternative housing options. Improving existing accommodation to enable people to stay at home was one development. Staying put or 'care and repair' services provided support with home maintenance and personal care, along with care alarms and peripatetic warden services. Very sheltered housing was developed to meet the needs of frail older people. These schemes often have extra features such as assisted bathrooms and dining rooms and provide services such as meals and a higher level of staff cover. However great variety between schemes has been noted (Tinker, 1989). Some sheltered schemes have also been designed to meet the needs of older people from particular ethnic groups.

Current issues for sheltered housing

Sheltered housing has tended to be defined not by purpose but by distinguishing features: warden, alarm and restriction to older residents. In contrast the way people applied and were allocated units, the warden's role, the level of disability and dependency of residents and the use of personal care services has varied greatly between schemes (Fletcher & Minter, 1991). This focus on features has masked the lack of clarity about who sheltered housing is designed for and why housing providers have developed it resulting in a number of questions being raised. Is its role housing or care or both? Is it meeting people's needs, and how cost effective is it? What factors influence desires to stay or move in later life?

A Scottish Office report comparing sheltered housing with amenity housing (specially designed for older people but without the 'sheltered' features) made four recommendations for the future (Clapham & Munro, 1988). The first was to abandon the concept of balance so that new tenants were people in need of the greater support available in sheltered housing. The second was to develop greater flexibility in care services to meet the higher levels of frailty that would develop. The third was to use

the communal facilities more as a local community resource and the fourth was to develop more amenity housing.

With regard to the concept of balance there has been little evidence that active tenants care for the less active. Active tenants have tended to socialise outside schemes and schemes housing more dependent people have been found to be as lively and sociable as others (Butler et al, 1983). These authors also recommended abandoning the policy of balance and suggested increasing the level of care services into schemes rather than taking more able tenants in order to address the issue of warden workload. Issues of cost effectiveness of any housing or care provision are notoriously difficult to answer especially given many hidden benefits e.g. a sense of security for residents and their relatives but abandoning the policy of balance was thought to be an improvement (Butler et al, 1983).

Anchor Housing Association found that the percentage of sheltered residents over 85 years rose from 10% in 1984 to 21% in 1993, leading to increased frailty among residents because people were living longer and because of the emphasis on community care (Riseborough & Ninner, 1994). The role of sheltered housing in meeting the needs of frail people needs re-appraising, does it aim to be a final move or to move people on to somewhere better able to meet their needs when frailty increases. The greater flexibility in care services advocated by the Scottish Office report (Clapham & Munro, 1988) has serious costing implications. Finance in terms of affordability of rent and service charges has also been raised as an issue facing sheltered housing providers (Fletcher & Minter, 1991).

Some housing associations (e.g. Springboard) have moved wardens off site. In Harlow wardens were resident on site but also provided a service to a second sheltered scheme. Other suggestions about the warden's role include use as a mobile warden resource for older people living in their own homes and development of the role into a centre manager with community use of the facilities on site (Butler et al, 1983).

Fleiss (1985) went further than the Scottish Office report (Clapham & Munro, 1988) and argued that provision should be 'desheltered' with the focus on good

housing rather than the care aspects. Residents were found to be receiving care they neither needed nor wanted because units were allocated on a housing need basis (Clapham & Munro, 1988; Butler et al ,1983; Middleton, 1987). In a national survey of sheltered housing most tenants said they moved for housing rather than for social or care reasons (Butler et al, 1983) which led these authors to also argue that the housing needs of many older people could be met in other ways such as home improvement schemes or good quality but non sheltered housing. They found that only 19% of residents used the alarm in a year. Few of these were genuine emergencies and most could have been well met in other ways, they reported. Only 62% of residents ever attended social activities on site. Fennell (1986) found a slightly higher level of alarm use, about a quarter of tenants had summoned emergency help in the last year, mostly following a fall and he concluded that sheltered housing and a warden were appropriate for most of these people due to their level of disability and ill health. According to Williams (1986) the alarm system had an important psychological role in making tenants feel more secure and thus facilitated the maintenance of independence. Half the tenants in Butler's study said the alarm made then feel more secure but only 6% recalled feeling more anxious when it was out of action. Butler and colleagues concluded residents only needed telephones (Butler et al, 1983).

Oldman (1990) surveyed 168 people who applied to the council or a housing association for rehousing and then moved into flexible tenure (rent/own) sheltered housing schemes. Most said that despite liking their old home their housing needs could only be met by moving, although a non sheltered option may have been suitable for many. Residents gave either one (35%), two (52%) or three (12%) reasons for moving (see Table 1). About one third (30%) of those moving in reported specifically seeking sheltered housing features e.g. warden, social activities and people of a similar age. Two thirds were not seeking these extra features including many who did have health and mobility problems. People seemed to move more for housing reasons than to seek care services although they often commented that they moved with a view to their likely future needs. These results support Fennell's (1986) suggestion that push

factors (why you move away) are more influential than pull factors (why sheltered housing specifically) in the decision to move.

Table 1. Reasons for moving according to sheltered housing residents (Oldman, 1990)

Reason for moving	% of residents (n=168)
previous home unsuitable because of poor repair or too cold	39%
health or disability e.g. no longer able to use stairs	28%
finance e.g. house costly to maintain or desire to release equity	22%
reassurance of having a warden available	20%
fearful in old neighbourhood	18%
to be near relatives	17%
isolation, bereavement, loneliness	11%
homeless if they did not move in	7%
rehabilitation from residential care	1%

Butler and colleagues reported that people moved for three main reasons, housing (27%), health or an interaction between housing and health (22%) and personal relations - 10% moved to be nearer a relative and 5% moved out of their children's' home. Often these three main reasons combined e.g. poor health led to a need for more suitable accommodation and a desire to be nearer family support (Butler et al, 1983).

Studies have found that many older people did not want to move out of their 'ordinary' home (e.g. Middleton, 1987; Tinker, 1984) and many moved because services to support them at home were not available (Butler et al, 1983). Butler also found that moving fractured social relationships and a move into sheltered housing did not help the socially isolated, however they also found that most people cope well with moving and adapting to a new home. Local moves are likely less disruptive than long

distance moves unless these are to be nearer family and friends or to a once familiar place.

Demand for housing among older people will continue to increase as the number of households headed by an older person, especially households of single women living alone, increases. Community care of older people is on the nations social policy agenda and housing is an important aspect of supporting people with needs to live in the community. Government directives encourage the use of sheltered housing as a community care resource and see it as the preferred option for frail older people along with input from social services (Caring for People, 1989). For those wanting to move sheltered housing potentially has much to offer, warm, dry accessible housing, security, neighbours of a similar age and social activity on site. Consumer evidence is that sheltered housing is popular and demand for public sector sheltered housing consistently far exceeds supply (Oldman, 1990). The future of sheltered housing depends on housing, community care, residential care and social security policies (Mackintosh, Means, & Leather, 1990) which need to be informed by understanding of why older people move in and what their needs are.

Depression, Dementia and Activity limitation in Sheltered Housing Residents

Depression and dementia are the commonest forms of psychiatric disorder among older people and these two conditions have been most often used as indices of morbidity for comparative epidemiological work (Livingston, Hawkins, Graham, Blizzard, & Mann, 1990). The prevalence of depression among residents of sheltered housing in Islington, London was found to be similar to the overall prevalence in the local community (Walker, Orrell, Manela, Livingston, & Katona, 1998). Although the difference was not statistically significant the prevalence of depression in sheltered housing (10.7%) was slightly lower than in the community (15.2%). These prevalence rates are similar to the rates of 12 - 18% found in other community samples of older people (Copeland, Dewey, Wood, Searle & Davidson, 1987; Kay, Henderson, Scott, Wilson, Richwood & Grayson, 1985; Lindesay, Briggs & Murphy, 1989; Livingston et

al 1990). In contrast Banerjee & MacDonald (1996) found that those in sheltered housing were more likely to be depressed than the rest of the sample however they only quoted odds ratios and not the numbers in each group. Their study was restricted to people receiving home care and the prevalence of those in sheltered accommodation not receiving home care was not known. Harrison and colleagues (1990) found that 43% of sheltered housing residents had depressive symptoms. As there was no community control it is unknown how this compares to a community sample and the cut off points used may have resulted in an over identification of people with depression. The use of different measures in the studies affects the prevalence reported and hinders comparison between studies.

The 10.7% prevalence of depression in sheltered housing reported by Walker and colleagues (1998) was considerably lower than the 32.5% prevalence in residential care in the same area (Livingston et al, 1990). A large epidemiological study found an association between depression and living alone, the prevalence of depression was 18.6% in those living alone and 11.3% for those living with others (Katona, Manela, & Livingston, 1997). Although most of the sheltered group lived alone the prevalence of depression in Walker's (1998) study was relatively low. When analyses were confined to people living alone (in sheltered housing or in the rest of the community) the difference in the prevalence of depression between sheltered (9.6%) and other residents (20.3%) was more marked suggesting a possible protective effect of sheltered housing (Walker et al, 1998).

The prevalence of dementia is around 5% in the community and 50% or more in residential care (e.g. Livingston et al, 1990). The prevalence among residents of sheltered housing has been found to be 9%, with up to 39% having possible dementia (Walker et al, 1998). Walker and colleagues found significantly greater cognitive impairment among sheltered residents suggesting that while few had moderate or severe dementia there might be an increased number with mild cognitive problems which do not reach case level in comparison with other community dwellers (Walker et al, 1998). These findings are similar to Harrison et al (1990) who found a high rate

26% of "moderate" dementia but a less dramatic (1%) prevalence of "severe" dementia in sheltered housing residents.

The study in Islington found activity limitation was greater and mild levels of disability were significantly more common among sheltered housing residents than among other older community residents (Walker et al, 1998), in contrast to other studies which reported similar levels of disability in sheltered and community residents (Butler et al, 1983; Watson, Catty, Oyebode & Fairbairn, 1990). Butler suggested that there may have been an improvement in the health of residents upon moving into sheltered housing which resulted in the similar levels. The three studies used different measures of dependency and activity limitation and it may be differences in the detection of mild disability that made the difference. Watson's study was restricted to women living alone, and was done in housing association schemes which may have had had different entry criteria to the local authority schemes where Walker's study was done. In all three studies most sheltered residents were independent and physical dependency was much lower in sheltered residents than in people in NHS continuing care wards and residential homes (Harrison et al, 1990).

NEEDS OF OLDER PEOPLE

Certain needs have been assumed to be universal in humans (Maslow, 1954 cited in Reynolds, Orrell, Thornicroft, Abas, Woods & Hoe, 1999) with different subsections of the population having additional specific needs e.g. older people with dementia have the same needs as everyone else along with additional needs relating to their disability (Murphy, 1992). Older people's needs can be complex because of the frequent co-existence of disability, physical and mental illness and social problems. A sizeable minority of older people live in sheltered housing and while a little information about their morbidity exists very little is known about the needs of residents and how if at all these are met. Accurate identification of needs of a population such as residents in sheltered housing is an essential prerequisite to planning and providing services

(Kamis-Gould & Minsky, 1995) that meet health, social and housing needs and improve well-being and quality of life. This is particularly important given the current climate of health care rationing (Cassel, 1994), e.g. needs led health care provision for the elderly has reduced the cost and length of stay in hospital (McLean, Austin, Neal & Channer, 1994). Screening for needs has been useful in identifying commonly unmet needs and enabling prioritisation of services. Primary healthcare checks on those over 75 found that 43% of people had some unmet needs, however almost all of these could be met at the primary healthcare level (Brown, Williams & Groom, 1992). The majority of unmet needs identified in a study of long term users of psychiatric services could also feasibly be met (Brewin, Wing, Mangen, Brugha, MacCarthy & Lesage 1988). Recent government legislation (The NHS and Community Care Act, 1990) has recognised the importance of assessing need for services. Assessment and monitoring of the needs of older people is also important because of continual change on both an individual and population level.

Defining needs

Several different approaches to the concept of needs exist. These vary according to the definition of need, which potential needs are included, from whose perspective need is defined and whether they are population based or individual focused. Two main approaches to defining need are in use (Hamid, Howard & Silverman, 1995). The first is the humanitarian approach in which need is seen as an equivalent to any disturbance in health and well being (Donabedian, 1974, cited in Hamid et al, 1995). The second or 'realistic' approach defines need in terms of the resources available (Acheson, 1978, cited in Hamid et al, 1995). Holland (1983) defines need for health care as the requirement for preventative, curative and rehabilitative care which arises from disturbance of health as defined by health professionals. This resource definition gives rise to the concept of problems without a corresponding need. If nothing can be done then there is no need e.g. the absence of literacy skills may not be a need if nothing can be done due to the severity of a learning disability (Brewin et al, 1988). Brewin's

(1992) definition which draws the two approaches together refers to need as lack of health, lack of access to services or lack of action by lay or professional health workers.

Official guidelines state that need is a complex concept defined as " the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life, as defined by the particular care agency or authority (Department of Health Social Services Inspectorate, 1991, p10). Need is different to disability or illness. For example psychiatric diagnosis alone does not define a patient as needing medical care or denote a plan of action and so is neither a good predictor of a persons need for mental health services (Hamid, Howard, & Silverman, 1995) nor a good predictor of resources use (McCrone & Strathdee, 1994). Even on a population level epidemiological research indicating the prevalence of psychiatric disorders has proven a poor indicator of service requirements (Bebbington, 1992) and service use statistics cannot be used as a barometer of need as they only reflect limits to existing services rather than what is needed (Baldwin, 1986). Needs assessment procedures were better than diagnostic procedures to assess need for psychiatric treatment in community surveys (Bebbington, 1990). The Medical Research Council recommended the use of needs based approaches in its review on the health of older people in the UK (MRC, 1994).

Need assessment is traditionally classified as either population based or individual needs assessment (Hamid et al, 1995). Individual needs can defined in terms either of the problem or the deficit of functioning or alternatively as interventions needed. Donabedian (1974) argued that as need for health care means need for particular interventions that need could be translated into its service equivalents. Thus you could express need in terms of the services that may be deployed to meet it. In the present study need is defined as remediable disability i.e. if no intervention exists to at least partly remove the disability no need for care exists (Martin, Pehrson, & Orrrell, 1999) however information concerning both the 'problem' and the intervention required was collected.

Personal and professional definitions of need

An individual's needs can be defined either by professionals or by the person themselves. Bradshaw (1972) classified needs into normative need (what professionals define), felt need (what clients would like), expressed need (what clients demand and use) or comparative need (differences in service provision between one area and another). This classification encompassed both the professional - person difference and the problem - resources difference.

Patients, including older patients may have priorities and views about their needs that differ from professionally defined need (MacCarthy, Benson, Brewin, 1986; McEwan, 1992) especially with regard to mental health needs. Carers may hold yet another view. Informal carers and professionals differed in their perception of the needs of people with dementia (Gordon, Spicker, Ballinger, & Gillies, 1997). Recent policy reform in the UK which introduced needs led provision of care emphasised that needs assessment should include both normative assessment of need by professionals and the individuals expressed need (NHS and Community Care Act, 1990). Studies have supported the usefulness of both personal and professional viewpoints. Professional assessment of need is important as people may not recognise they have a mental health problem particularly those with cognitive problems, psychosis or substance misuse e.g. little concordance was found between psychiatric caseness and self rating of poor mental health amongst older Americans in public housing (Black, Rabins, German, McGuire & Roca, 1997). In addition Blazer and Williams (1980) reported a low rate of perceived need for mental health care among depressed older adults in the community. 'Lay defined need' was important in predicting motivation and utilisation of services in severely mentally ill people (MacCarthy et al, 1986).

Stewart (1979) classified need assessment in community mental health care into three components: the problem within its social context, the 'desire' of the person or community to solve the problem and the solution. Studies have not often sought information about the desire for problems to be solved.

Difficulties with needs assessments

There are continuing debates over the relative merits of different approaches to needs assessment (Holloway, 1994) and problems due to the range of differing definitions. According to Baldwin (1986) problems include: assessments not covering a comprehensive range of needs, woolly definitions, omission of specific needs and different methods yielding wildly different results about needs. Baldwin (1986) claims meeting of needs and needs assessment has evolved to serve professional interests rather than the client and that vague general statements about need may be more harmful than beneficial. Many needs assessment measures were designed with only local one off use in mind, often lacked reference to theory and used inadequate sampling procedures (Reviere, Berkowitz, Carter & Ferguson, 1996). These authors recommended using repeatable measures with overlapping questions, qualitative and quantitative data, and multiple perspectives. Planning agencies have rarely identified needs beyond those services already on offer. There are also implications of framing problems within the person when interactions with the environment are important.

Needs assessment tools

Since these criticisms were made considerable work has been done on developing needs assessments. Many have been designed for populations with specific problems and do not cover the range of older people's potential needs. Examples include those designed to measure need in the long term or severely mentally ill e.g. the MRC Needs for Care Assessment (Brewin, Wing, Mangen, Brugha, & MacCarthy, 1987) and the Camberwell Assessment of Need (Phelan et al, 1995). Some needs assessment tools for older people have concentrated on people with dementia (e.g. Care Needs Assessment Pack for Dementia: McWalter, Toner, McWalter, Eastwood, Marshall & Turvey, 1998) whereas the Camberwell Assessment of Need for the Elderly (CANE: Reynolds, Thornicroft, Woods, Abas & Orrell, 1998), used in the present study, was designed to assess needs in the whole population of older people with mental health problems from the three perspectives of the client, the carer, and the staff involved.

The CANE is reasonably comprehensive in its coverage of both general human needs, and those needs specific to mental health and older people. Information about social and practical needs as well as health needs is important because different needs are interlinked. Mental illness has been commonly associated with social adversity as both a contributory factor and as a consequence (Reynolds et al, 1999) e.g. loss of mobility may result in falls leading to loss of confidence and decreased social participation which in turn may cause social isolation, loneliness and depression (Tideiksaar, 1993, cited in Wenger, 1997). Depression has increased vulnerability to threats such as falls (Asada, Kariya, Kitajima, Kakuma, 1994) and was a risk factor for poor nutrition (Fitzpatrick, McGee, Browne, & McLauglin, 1993). The CANE enquires about the problem causing the need, help received from family, friends or local services, help wanted from local services and whether the help received was appropriate and satisfactory. The most frequently identified needs among 102 people using old age psychiatry services were psychological distress, daytime activity, housework, food / shopping and memory (Reynolds et al, 1999). Needs may be met or unmet and the CANE distinguished between the two. In the above study the needs people were most commonly receiving help with were daytime activity (52%), psychological distress (49%), physical health (48%), food (42%), housework (41%), self care (38%) and company (36%). The needs most frequently unmet were memory (31%), money (23%), psychological distress (21%), housework (21%), daytime activity (19%) and food (18%). While many needs were being met a considerable proportion of people known to health services had unmet needs.

A study of older people with a disability found 35% had at least one unmet need, frequently for help with incontinence (Manton, 1989) however only those receiving no help were asked, those receiving some help were not asked if it was sufficient. This is important as those reporting a need for help and those reporting a need for additional help were equally likely to attribute negative consequences to their unmet need (Allen & Mor, 1997). This study looked at the needs of adults of all ages who had a physical disability, excluding those with cognitive impairment. They used

the Index of Activities of Daily Living (ADL) (Katz, Ford, Moskowitz, Jackson, Jaffe & Cleveland, 1963) and the Instrumental Activities of Daily Living Scale (IADL) (Lawton & Brody, 1969) to measure the number of activities for which sufficient help was received and for which there was a need for help or further help (Allen & Mor, 1997), however they did not look at psychosocial needs. Over 40% of those over 65 years needed help with shopping, housework, cooking and transport and bathing. About 25% needed help with dressing, transferring and moving around indoors. The most frequently reported unmet needs were the same as the most frequent needs with the exception of cooking which was usually met. About a third had unmet needs for housework and a quarter for transport, bathing and shopping. A US survey of predominantly African American older people living in large public housing complexes with a social worker on site found 37% had needs for mental health services, 50% of whom were not receiving help (Black et al, 1997). As reported earlier primary healthcare checks on those over 75 found that 43% of people had some unmet needs (Brown et al, 1992). Medical problems were most common, followed by needs relating to activities of daily living and mobility. This confirmed earlier findings (for a review see Brown et al, 1992) that a substantial number of older people had unmet health needs.

Consequences of unmet needs

Unmet needs can have serious consequences for both the individual and society. In the study by Allen and Mor (1997) these included missed doctors appointments and social activities, hunger, falls, infrequent bathing, wetting and soiling and distress. Those with unmet ADL needs had had more visits to doctors and more hospital admissions than those without unmet needs. They reported that their data suggested a link between the adequacy of home based care, health service use and mental health outcomes. High depression scores were associated with unmet needs for ADL, IADL and transportation. They also suggested that even seemingly minor unmet needs such as a messy house or infrequent bathes may have serious quality of life implications when

these are likely to be long term. It may be possible to cope with such things in the short run but having to live with them longer term may trigger depression which in turn may exacerbate poor physical health. As well as a consequence of unmet needs depression could have been a cause of unmet needs or most likely both consequence and cause. Teasing this out was not possible in this study and other factors are also likely to have been part of the equation. Unmet needs for mental health care among elderly supported public housing residents in the USA have been found to put them at risk of having to move out (Holshouser, 1988). Untreated psychiatric symptoms were the most frequently cited reasons for residents of public housing for older people being asked to leave or being refused renewal of their lease. This was most likely to happen to those with few family members or friends, and poor social skills (Barker, Mitteness & Wood, 1988).

Factors associated with unmet need

Needs may be unmet for a variety of reasons such as other problems needing to be solved first, or lack of local resources. The main determinants of unmet need in the survey of disabled adults were inability to meet expenses, having few or no reliable helpers and severity of impairment in ADL and IADL. "Unmet need emerged in the absence of social support and or buying power" (Allen & Mor, 1997). They found higher levels of unmet need than had been found in the studies of cancer patients they cited. This they suggested was because it may be easier to secure adequate assistance in the short run than on a long term basis. If true this has implications for older people who may have both short term needs when acutely ill and longer term needs relating to disability or chronic illness. Another study, of older people in the USA, found inadequate transport, use of mobility aids e.g. canes and wheelchairs and ADL limitations were associated with unmet needs (Jackson & Mittelmark, 1997). White, but not African American, people with unmet needs were more likely to have no daily caregiver and receive little instrumental help e.g. with bathing and dressing (Jackson & Mittelmark, 1997). Factors associated with need for mental health care among older

public housing residents included: having no confidant, poor or fair self rated physical health, age, and ADL impairment. Men, those who were older, those with more ADL impairments and those with no one to count on to help with daily tasks were more likely to need mental health care and less likely to receive it. More than half of those identified as needing mental health care had not used any mental health services in the last six months. Receiving mental health care was associated with being female, younger, having more major physical illness and poor self rated mental health (Black et al, 1997).

Unmet needs are also related to peoples willingness to seek and accept help, this is likely to be influenced by cultural factors such as ethnicity and age cohort. Ethnic groups differed with regard to levels of disability, need for health and social services, demand for services, use of services and levels of social support received in Gale and Erikson's (1997) study. Schultz (1997) found differences between rural and urban US elders in their needs and who they were met by. Tennstedt and Chang (1998) found that minority groups received more informal care and concluded that ethnicity played an important role in determining older peoples need for and receipt of informal care. However a study which looked at ethnicity and attitudinal influences on older peoples use of assistance found that race played no influence but that attitudes were important to assistance use. Those more likely to receive assistance were older women on lower incomes and those more physically disabled (Noelker, Ford, Gaines, Haug, Jones, Stange, Mefrouche, 1998).

Unmet needs are associated with a complex array of functional, social, personal and access factors. Needs may be met by informal sources such as family or friends and thus dependent on the level of social support available or they may be met by formal services and thus dependent on the local services available. Many studies have found that most needs are met by informal sources, usually family, with a minority receiving help from formal services either exclusively or in addition to informal help (e.g. Denton, 1997; Peek, Zsembik & Coward, 1997)

Service Use

Health care utilisation among the old may depend on an interaction between physical health, mental health, attitudes and social factors such as whether they live alone or have children living nearby (Linden, Horgas, Gilberg, & Steinhagen-Thiessen, 1997). As might be expected given the frequent association of depression and poor physical health another study found older adults with mild and severe depression needed and used more medical services but used fewer social and recreational services than older people without depression (Badger, 1998). This study found depression was a significant predictor of need for mental health services, psychotropic medication and financial assistance.

Butler and colleagues (1983) note two competing hypotheses concerning the use of domicilary services by sheltered housing tenants. On the one hand because sheltered tenants have a warden they may be neglected by other providers, on the other hand they may receive more support because tenants are grouped together, accessible and more visible to service providers. Comments from some sheltered tenants have suggested that they thought their family felt absolved of responsibility once they had a warden and so visited them less frequently (Young, 1993). Butler and colleagues (1983) found support for the alternative assertion. Similar rates of disability and activity limitation were found in both their sheltered sample and previous community samples but the sheltered sample had higher rates of provision of home help and meals on wheels. Walker and colleagues (1998) also found those living in sheltered housing were more likely to use health and social services resources. While they did find higher rates of disability in sheltered residents logistic regression analysis suggested that the higher service use could not be entirely accounted for by greater disability and a higher rate of people living alone. This higher service use may have been because residents came to sheltered housing via these services or because the warden's involvement made them more likely to have their needs assessed and therefore more resources provided. It is even possible that over provision of services may be more common in sheltered housing.

SOCIAL SUPPORT AND SOCIAL NETWORKS

Health, needs and service use are affected by a wide variety of factors including social support. Bowling (1994) reported good evidence of a relationship between social support or social network structure, and health status, mortality and the likelihood of institutionalisation. Friendships have been shown to be crucially important to ones sense of well-being in late life (Jerome, 1981, 1984, 1993, cited in Phillipson, 1997) and increased social support was associated with increased satisfaction with life (Kaye & Monk, 1991).

Social support is complex and there have been many attempts to define it. Some have focussed on the size, structure and function of networks, others have attempted to understand the affective, cognitive and behavioural aspects of social support. Social support can be described as the companionship, and the emotional or practical help provided by and received by a person. Social support is provided by those people, who together make up a persons support network. Older peoples social networks usually comprised family, friends, neighbours and others; about 12 or 13 people (Wenger, 1996). Support networks were a subset of about 5 to 7 people who were significantly involved. The availability and adequacy of social support rather than the structural aspects of networks were found to be the crucial factors in predicting health and well being (Blazer, 1982; Chapell & Badger, 1989). Significant associations have also been found between better social support in the elderly and reduced levels of depression at follow up (Russell & Cutrona, 1991).

Research has made an important distinction between instrumental and emotional support. It is lack of emotional support (Brugha, Bebbington, MacCarthy, Sturt, & Wykes, 1987; Lam & Power, 1991) e.g. a confiding relationship (Murphy, 1982) that seems most related to vulnerability to depression. Most evidence suggests that interaction with friends more than with family is associated with emotional well-being (Bowling, 1994).

Another important distinction is between perceived support and that received. It seems it is not just a matter of whether a person receives help but whether they feel it is available that is important. People who perceived their networks as supportive maintained a better psychological state and higher levels of physical function (Auslander & Litwin, 1991). Older people who were not depressed had significantly higher levels of perceived emotional and practical support than those who were depressed (Lam & Power, 1991). Individual differences in response to available social support have been observed. Those with an internal locus of control were least likely to show significant mental health gains as a result of input from others (Reich & Zautra, 1991) which suggests it may be more difficult for previously independent older people to accept help. Social support can also have negative effects if increased interaction brings stress. Negative social interactions have been found to cancel or outweigh the benefits of having relationships (for a review see Rook, 1998).

Self reported dissatisfaction with social networks was significantly associated with the presence of psychological problems but living alone or size of network were not (Goudie & Richards, 1993). In a community survey in Gospel Oak, London depression was found to be associated with feelings of dissatisfaction with the level of support received from friends, having less than two supportive friends, living alone, absence of supportive neighbours, and having problems in a relationship with offspring (Prince, Harwood, Blizzard, Thomas & Mann, 1997). A cumulative effect was noted, the more of these social support deficits a person had the more likely they were to be depressed. In Gospel Oak 29% of the older people reported feeling lonely, 16% often feeling lonely. Loneliness was associated with depression. The prevalence of loneliness varied according to type of housing, and it was most common among women, those over 82 years and those with the social support deficits given above. Contact with relatives was unrelated to loneliness. In other studies in the absence of social support loneliness and social isolation increased and were associated with risk of mental health problems (Wenger, 1997). For this reason socially isolated older people have been targeted by mental health teams (Abraham et al, 1993). Loneliness is potentially a good

target for intervention. A project aimed at improving the social networks and social activity of older people found loneliness was the most responsive quality of life measure (Arnetz 1985; Andersson 1985). Low levels of social participation have been linked to mortality in men (Hanson, Isacsson, Janzon & Lindell, 1990). Participants in community and religious groups also had lower mortality after heart surgery (Oxman, Freeman & Manheimer, 1995).

A number of studies have looked at the relationship between health and disability and social networks. Disabled older adults were more likely to be socially isolated (Stoller, 1984). Worsening health or disability was associated, albeit weakly, with declining size of external social support network as well as reductions in support received from fellow tenants in housing for older people (Kaye & Monk, 1991). Social networks may affect how well a person functions with regard to self care through a behavioural mechanism e.g. helping a person shop enables them to continue cooking for themselves (Auslander & Litwin, 1991).

Fewer studies have looked at needs and social networks. A study in a community mental health team for older people found low levels of social support were associated with high levels of need. Case managers gave clients a total needs scores based on ratings of needs in the following areas: disability, well-being/distress, social relationships and risk. This measure was not standardised and although reasonable for disability needs was found to be inadequate for the assessment of psychological needs (Wilcox, Jones & Alldrick, 1995). Social support has been found to be positively associated with older adults ability to meet their own health needs (Cohen, Teresi, & Holmes, 1985).

Social support in sheltered housing

The Gospel Oak study (Prince et al, 1997) found that those who had been in their home less than 5 years were at a much greater risk of depression even after controlling for the number of social support deficits. Given that living in sheltered housing has usually meant a move in later years it might be expected that depression would be

more prevalent in sheltered housing however in sheltered housing there may be more opportunity for supportive social contact with neighbours and for developing friends.

Butler and colleagues (1983) found that many sheltered residents (70%) lived alone, compared to 50% prior to moving in and 30% of those in the rest of the community. Loneliness however was not reported to increase or decrease after the move to sheltered housing. Watson and colleagues (1990) found no difference in levels of social support among women living in sheltered housing compared to those living independently. However Young (1993) found some residents unhappy with sheltered accommodation, due to changes to their support systems and relationships. Some residents said that their families and friends did not visit so often, as if in some way they felt absolved of their responsibility now there was a warden to call. Alternatively for those with high levels of need the family may be called on to provide more support since links with previous neighbours have been lost with the move to sheltered housing. Many older adults in sheltered housing achieved poor social integration in addition to the loss of social networks which they experienced as part of the move (Young, 1993) so for them the need for company, social activities and relationships may be high. Walker and colleagues (1998) looked at people living alone and found that those in sheltered housing had fewer visitors than other community residents. Depressed people also received fewer visitors than those not depressed, however neither association was statistically significant, possibly due to the small numbers.

Models

Many of the studies discussed above were cross sectional and so did not address the direction of causality between health, life events and social support. Other variables may be acting on all three as well as or instead of a direct link between them. Two main models have been proposed. In the direct effect model social networks and life events are assumed to be unrelated each having independent and opposite effects on health. In the buffering hypothesis social networks determine the impact of life events on health. Prospective studies have shown subjective support to be predictive of onset

(Henderson, 1981) and course (George, Blazer, Hughes & Fowler, 1989) of depression. Loneliness in older people has also been identified in a prospective study as an independent risk factor for the later onset of depression (Green, Copeland, Dewey, Sharma, Saunders, Davidson, Sullivan, & McWilliam, 1992). A US study tested both hypotheses and found evidence of both: social networks and life events acted directly on health, and social networks acted as a buffer rendering the negative effects of life events less harmful (Mor-Barak, Miller & Syme, 1991).

The amount and type of social support provided and whether the needs of a person in sheltered housing are met depends in part on personal factors. Women were significantly more likely than men to receive some assistance from relatives. Those over 75 years old were significantly less likely to receive assistance from friends living elsewhere i.e. those most likely to require help were least likely to receive it from friends (Kaye & Monk, 1991). Many needs of married people may be invisible as they are met by spouses in the normal course of their lives and so not thought of as needs e.g. cooking, company, intimacy. Married people may also have less unmet needs as spouses can meet many needs without further help.

Support networks

The amount and type of social support provided and whether needs are met also depends in part on the type of support network (Wenger & Shahtahmasebi, 1991). Older people's support networks have been classified into 5 types following longitudinal research on ageing (Wenger, 1994). Different network types are distinguished on the availability of local close kin, the level of involvement of family, friends and neighbours and the level of interaction with the community and voluntary groups (see Table 2) (Wenger, 1994, 1997).

Table 2. Types of support networks among older people and the percentage of older people with each network type in an urban sample (Wenger, 1994, 1997).

Type of Support Network	%	Description
Local family dependent	22	Family meet all support needs. Little involvement with friends, neighbours or the wider community.
Locally integrated	42	Close relationships with family, friends and neighbours Current or recent involvement in community groups
Local self contained	12	Infrequent contact with relatives Reliance on neighbours. Little, if any involvement with wider community
Wider community focused	4	Active relationships with distant relatives, no local kin Active involvement with friends, neighbours and community groups.
Private restricted	15	Absence of local kin typically. Few friends Little community involvement.
Inconclusive	5	Features of more than two different network types

Different responsibilities and expectations are associated with different relationships. Among Europeans the hierarchy of expectation tends to be spouse, children, brothers and sisters, friends, neighbours, and finally extended family. Married people tended to concentrate their dependency needs on their spouse who was expected to provide emotional and practical help whenever needed. Children were expected to provide similar help but less intensely, and most widowed people depended primarily on adult children (Wenger, 1994). Family and friends tended to help with different things. Older people typically received practical help from spouses and relatives whereas friends were valued for companionship and emotional support (Kaye & Monk, 1991; Lee, 1985). Neighbours are important as they are on site and can react quickly. They also experience some of the same problems such as bad weather or electricity cuts. They can be important sources of information and monitoring including schemes such as

neighbourhood watch. However the friends and neighbours in a persons support network change more than the relatives do and so does their level of involvement (Bowling, 1994). With increasing age comes increasing dependence on kin and less on non kin, this is likely to be related to increasing dependency and the impact this has on friends and neighbours. The quality of network ties is also important, relationships can be supportive or detrimental.

Networks occur naturally, and can be supported but not created (Wenger, 1994). They are fairly stable over the life course and change in predictable ways. Many have a core of people who remain important with those in the periphery changing more often (Morgan, Neal & Carder, 1996). Networks are in part a product of chance, the marriages and fertility of previous generations creates aunts, uncles, nephews, nieces, brothers and sisters. Size of family, birth order and gender appear important. Economic conditions influence migration patterns of family, friends, and people themselves which affects the number of local contacts. Marriages can bring children and in-laws. Daughters tend to provide more support than sons. Personality and temperament are also important, influencing adaptation to the effects of biology and migration (Wenger, 1994, 1997). In many cases low level of social contact represents a life long adaptation (Wenger, 1994).

Network type has been found to correlate highly with all demographic variables such as age, sex, migration patterns, marital status, household composition, use of statutory services and problems presented (Wenger, 1994). It also correlates with levels and duration of formal service use and is associated with availability and type of help, type of presenting problem, responses to interventions and outcome measures such as health, morale, social isolation, loneliness and depression (Wenger, 1997). Loneliness was more common in networks that were primarily kin (Dykstra, 1990). Good social networks are a powerful influence supporting dependent older adults at home (Wenger, 1997) and may reduce the risk of admission for dementia sufferers (Orrell & Bebbington, 1995). Those without local relatives rely on formal services and needs not catered for by these will remain unmet (Wenger, 1994).

Private restricted networks are associated with greatest risk, locally integrated with least risk (Wenger, 1997). Family dependent networks can support the most dependent people who may be expected to receive a high level of practical support from kin but may feel isolated from important peer contact. Those with wider community focused networks are likely to have good emotional support but it is likely that long term help in the event of chronic illness might be less forthcoming. Those with local self contained networks tolerate isolation well but may resist help when it is needed (Wenger, 1997).

Older people with mental illness or dementia may have smaller support networks than others (Grant & Wenger, 1993). Over half the dementia cases in a community sample were found in family dependent or private restricted support networks probably because of the need for a family carer together and the tendency for people with dementia to become increasingly isolated. People with dementia and in family dependent networks are also more likely to experience depression than those in networks with additional forms of informal support (Wilcox et al, 1995). Those with dementia with a spouse alive were found to be most in need of services and least likely to get them with the burden falling on the elderly spouse (Kitwood, Buckland & Petre, 1995). All this highlights the importance of supporting carers.

Relationships with members of a support network are most likely to breakdown and expectations not be fulfilled when there is loss of reciprocity or the person develops physical incapacity or mental illness e.g. dementia. In such situations where demands exceed expectations the provider may back away (Wenger, 1994). Neighbour involvement can be withdrawn when demands are excessive and the result can be a defensive pattern of neighbour interactions if there are a number of dependent older people in one location (Wenger, 1990). This may be important for sheltered housing managers to consider.

Support networks are important to the health and well being of older people and are likely to affect needs and whether they are met. Unmet needs are also likely to affect the type of network a person maintains.

Family dependent networks would be expected to be associated with high need as they are the type of network best able to support dependent older people in the community (Wenger, 1997) and can be an adaptation of a locally integrated network in the face of increasing dependency (Wenger, 1994). They would not be expected to be associated with more unmet need than other networks as family are around to meet many needs. Private restricted networks would also be expected to be associated with high levels of need for the following reasons: residents with these networks often have long-standing personality disorders or mental health problems and private networks can result from shifts in other types of network e.g. local self-contained, family dependent, or wider community focussed (Wenger, 1994) in the event of the older persons increasing dependency (Wenger, 1997). Unlike family dependent networks private networks would be expected to be associated with high numbers of unmet needs as needs tend to only be identified when there is a crisis due to the social isolation of the older people with these networks. Locally integrated network are associated with least risk (Wenger, 1997). They might be expected to be associated with low levels of need and unmet need as people with these networks usually have local family and regular contact with family, friends and neighbours who might identify and help meet needs. When people with such networks become very dependent the network can shift to being family dependent.

Network type has been found to influence help seeking, self help, problems presented and responses to interventions (Wenger, 1997). The impact of chronic disability and health problems on networks reveals the importance of targeting interventions at factors which will support networks. Neglecting natural helping networks can have costly consequences in terms of needs for formal services and the older persons quality of life. Network type has direct implications for service provision and service planning both in aggregate and on the individual level. (Wenger, 1997; Wenger & Shahtahmasebi, 1990; Wilcox et al 1995). There is support for interventions aimed at improving health by working with both older adults and their social networks (Wenger, 1997). In sheltered housing services could support social networks through

policies and programmes that encourage informal helping networks by promoting social exchange and support between residents and significant others both within and outside the housing scheme. Carer networks are also important to consider as they will impact on the carer's ability to continue caring well.

Awareness of the needs and social networks of the population in sheltered housing, including those needs commonly unmet would enable current resources to be targeted more effectively and would be useful to those predicting future needs and planning health, social care and housing service developments. It should give a better understanding of how to maintain older adults with mental and physical health needs in the community which might reduce their need for institutional care. If the level of unmet need in sheltered housing was high this might have implications for how this type of accommodation is used or modified.

AIMS OF THE PRESENT STUDY

1. To explore why older people moved to sheltered housing, their experiences of living in sheltered housing, and the use they made of sheltered features e.g. warden, alarm and common room.

2. To investigate the demographic and health characteristics of sheltered housing residents.

3. To identify their support networks and their met and unmet needs.

4. To identify demographic, health and social factors associated with unmet needs

5. To test the following hypotheses:

- Residents with depression, dementia, and/or activity limitation will have more unmet needs than those without such health problems.

- Residents with a private restricted network will have more unmet needs than those with other networks.

CHAPTER TWO

METHOD

OVERVIEW

The present study was a survey of residents of three sheltered accommodation schemes in Harlow with reference to their social networks, health and social needs and use of services. Data was collected by one of two researchers (Elizabeth Field and Michael Walker). The study had the support of Mr Chris Hazlehurst, Principal Housing Officer (Special Needs), Strategic Housing, Harlow District Council and of the wardens of the sheltered schemes in Harlow. Ethical approval was granted by West Essex Local Research Ethics Committee (Appendix 1).

PARTICIPANTS

Ninety six residents were living in the three chosen schemes at the time of the study. Seven were unable to be interviewed: 5 were in hospital throughout the data collection period, 1 did not speak English, 1 was away for five months. Five of these lived in Scheme A, two in Scheme B. Of the remaining 89 residents who were approached, 2 declined and 87 (98%) agreed to be interviewed. One interview was abandoned part way through due to the severe hearing difficulties of the resident. The two who declined lived in Scheme A. One of them did start the interview but then, after only a few minutes, asked to postpone it due to her poor health. Upon our return her husband reported that she was no longer willing to continue the interview. All the residents were over national retirement age (i.e. 60 years for women and 65 for men).

SELECTION OF THE SHELTERED HOUSING SCHEMES

For the purposes of the present study sheltered accommodation was defined as a scheme of individual units on one site with a warden who may or may not be resident, but was contactable via an alarm and/or intercom system. Harlow District Council manages 29 sheltered accommodation schemes, 19 of which currently have resident wardens, the others being visited daily during the week by one of the 19 wardens.

In order to select schemes which had sufficiently different environments but together were broadly representative of the range of council run sheltered accommodation schemes in Harlow we developed an environmental questionnaire to be completed by the wardens (Appendix 2). Questions were adapted from the Multiphasic Environmental Assessment Procedure (MEAP, Moos and Lemke, 1992). Elements of the MEAP relevant to sheltered accommodation and answerable by self-completion were selected.

Questions about the residents focused on functional abilities, participation in social activities on site, marital status, medication use, attendance at day centres and reasons for moving out. Questions about policy focused on policies about levels of dependency, dealing with problem behaviours, and whether staff or residents organised social events and made decisions about communal issues. Questions about the scheme covered the type of housing i.e. flats or bungalows, the number of units, rent, facilities available, whether there were volunteer visitors and the type and frequency of activities and services taking place on site.

The questionnaires were distributed with a covering letter (Appendix 3) to the wardens via Mr Chris Hazlehurst, Principal Housing Officer (Special Needs), Harlow and were collected at meeting with the wardens where the rationale for the study was explained. Wardens only filled in questionnaires for the scheme they were resident in.

Sixteen questionnaires were returned (84%). Two were excluded as most questions were left unanswered. The results of remaining 14 questionnaires were entered into a hierarchical cluster analysis using SPSS for MS Windows Release 6.0

(SPSS, 1993). Some variables were not included because of lack of variation e.g. all units were let unfurnished. Others were omitted because of incomplete data e.g. rent, which the majority of wardens answered "Not Known". The remaining variables were scaled to give each equal weight using Z-scores.

In order to have a reasonable sample size of around 90 participants three schemes were required. The three-cluster stage of the cluster analysis gave two individual schemes with the remainder (12) in one large cluster. We therefore used the four-cluster stage of the analysis, taking a member from each of the two large groups and one of the two unclustered schemes. Schemes were chosen from the groups on the basis of their being representative of their group, of sufficient size (20+ residents), and qualitatively different from the other two chosen schemes according to their description in the warden questionnaire. The aim was to obtain an adequate sample size which was representative of the range of schemes in Harlow. One of the larger groups was characterised by schemes consisting of bungalows, a relatively large number of couples (compared to single residents), decisions often made by residents, few meetings and an intolerance of difficult behaviour. The other was characterised by mainly consisting of flats and decisions being made by the staff. It is interesting to note that these appear to correspond to some extent to Category 1 and Category 2 sheltered housing respectively (Ministry of Housing and Local Government, 1969). The unclustered scheme chosen shared some characteristics with each of the other two clusters but was characterised by an emphasis on social activity with an active residents committee and newsletter.

THE SELECTED SCHEMES

Features common to all three schemes

All three schemes had one resident warden and no other staff. These wardens were experienced, having worked for at least 8 years as a warden and at least 8 years in their

current post. Two wardens also provided non residential warden services for other sheltered schemes.

The wardens had keys to every home in their scheme. They visited each resident for a few minutes each weekday, organised or at least attended a few events in the common room each week and were on call on site for the rest of their working week.

There was 24 hour warden cover, provided by a mobile warden service when the resident warden was not on call. Each resident had a pull cord alarm in their home which contacts either the resident warden if on call or otherwise the mobile warden service. Respond was by telephone and/or visiting as necessary.

All the homes were let unfurnished, each had its own kitchen, bathroom, sitting room, front door and address for post. Most had only one bedroom but there were a few two bedroom homes. Rent included heating, hot water, use of common rooms and laundry facilities and warden cover. Each scheme had a communal laundry and a common room with notice board where at least three activities took place weekly, although the number of activities did vary.

The minimum age for tenancy was national retirement age i.e. 60 years for women and 65 for men. There was a waiting list for sheltered accommodation. Anyone over retirement was eligible although people were prioritised by health needs. The local authority Special Needs co-ordinator reportedly balanced individual needs with the scheme's needs to ensure a range of functional abilities in each scheme. People often waited several years for places in popular schemes e.g. Scheme C. Table 3 gives the wardens descriptions of their schemes.

Table 3. The three Schemes

	Scheme A	**Scheme B**	**Scheme C**
Date built	1973	1977	1984
No. of units	29 flats	31 flats	22 bungalows
No. of residents	31	35	30
No. of couples	3	5	8
Visiting Services	hairdresser	hairdresser	none
Activities	coffee mornings	coffee mornings	coffee mornings
	weekly lunch	discussions	keep fit
	bingo	games	games
	occasional parties	occasional parties	occasional parties
		outings	outings
		newsletter	
Residents committee	no	yes	no
Decisions by staff	almost all	most	most
Decisions by residents	regular activities	activities	activities & events
		events	decor of public rooms
Dependent in ADL	some residents	some	few
Tolerance of dependency	high	high	low
Tolerance of difficult behaviour	high	high	low

The three Schemes

Scheme A was located in an uninteresting residential area away from the centre of town next to a large, rarely used, grass playing field. It comprised a block of 29 flats, excluding the wardens. Twenty eight were one bedroom flats, one had two bedrooms. Thirty one older people were living in the scheme at the time of the interviews, including 3 couples. One flat was empty due to the recent death of the resident.

Weekly lunches, coffee mornings and bingo were run in the common room by several residents with the warden often present. Occasionally other entertainments and parties were held. There were no residents committees and virtually all decisions regarding residents, the public environment and events were made by the warden or higher management.

According to the warden the scheme was reasonably tolerant of people with dependency needs and problem behaviour which predominantly affected the person themselves e.g. wandering at night. The scheme was intolerant of serious problem behaviour such as physical violence or stealing. A considerable proportion of the residents apparently needed help with activities of daily living such as shopping, housework, managing finances or cooking.

Scheme B was located in a pleasant residential area near local shops. It comprised 31 flats, excluding the wardens. Twenty nine were one bedroom flats, two had two bedrooms. Thirty five older people were living in the scheme at the time of the interviews, including 5 couples. One flat was empty due to subsidence.

Weekly coffee mornings, discussion groups and game sessions were held in the common room. Several other activities happened monthly, and occasionally entertainments and parties were held or outings organised. These were planned and organised by residents' committees which met regularly. This scheme had the greatest number of organised social activities and the scheme had its own newsletter. Decisions about tenancies, policies and the fabric of the building were made by the warden and management.

This scheme was reportedly more tolerant of people with dependency needs and problem behaviour than the other two. According to the warden a considerable proportion of residents needed help with activities of daily living such as shopping, housework, managing finances or cooking.

Scheme C was located nearer the centre of town than A and B. It comprised 22 one bedroom bungalows, built in a horseshoe around an old farmhouse, the downstairs of which had common rooms and laundry facilities and a warden flat upstairs. Thirty people were living in the scheme at the time of the interviews, including 8 couples. It was the most popular choice among those seeking sheltered accommodation and some had waited several years for a bungalow.

Weekly coffee mornings, games and keep fit sessions were held in the common room. Occasionally entertainments and parties were held or outings organised. There were no residents committees but residents and warden together planned entertainments and the decor of public places. Decisions about tenancies and staffing were made by the warden and management.

According to the warden most residents were independent with respect to activities of daily living. This scheme was reportedly least tolerant of people with dependency needs and problem behaviour.

PROCEDURE

Initial contact

The wardens of the three schemes chosen were approached and permission sought to interview the tenants (Appendix 4). Once they had been contacted all 96 residents of the three chosen schemes were asked to participate. Residents were first contacted by a letter from the two researchers (Elizabeth Field and Michael Walker) which explained the study and informed them that someone would call in person in the next few weeks to invite them to participate (Appendix 5). Residents were then contacted by one of the two researchers knocking on their door and inviting them to participate

either immediately or at a future appointment. The study was explained again and consent sought (Appendix 6). Each consenting resident was seen once in their own home, and semi structured interviews conducted. The interviews usually took about an hour but did vary in length from 25 - 140 minutes depending on the personality and needs of the individual. All the interviews took place in the summer of 1998. Similar numbers of interviews (45 and 43) were carried out by each interviewer.

Information was received from wardens concerning those residents in hospital or away long term otherwise several attempts at different times and on different days were made until they were contacted.

Interviews

The interviews comprised several semi structured interview schedules and several questionnaires which together assessed each resident's health, disability, met and unmet needs, social networks, help received and views on sheltered accommodation. The interviewers were trained in the use of the standardised measures by supervision and co-rating of live interviews. To ensure good inter rater reliability the two interviewers observed and co-rated 4 interviews, 2 by each interviewer, during the piloting of the measures. Results were compared followed by discussion until agreement to remove any ambiguities. Ambiguous answers in later interviews were discussed by the two interviewers and with Martin Orrell who was supervising the projects, until agreement on scoring was reached.

MEASURES

Multiphasic Environmental Assessment Procedure (MEAP: Moos & Lemke, 1992)

This instrument is designed to characterise the physical and social environment of residential settings for the elderly including grouped individual units such as sheltered housing. The presence or absence and condition of a wide range of physical features internal and external to the building and in the garden are rated. These include access,

lighting, noise, safety, facilities, furniture etc. in both public and private areas (with resident consent). Questions relating to policies cover services, activities, orientation of new residents, dealing with problem behaviour and dependency among other things are asked of the warden. There is a questionnaire for a sample of residents. There is also a subjective rating scale to be completed by researchers covering the attractiveness, distinctiveness, cleanliness, activity level and organisation of the social and physical aspects of the residence. The warden questionnaire comprised the questions from the MEAP that could be rated by the warden.

Camberwell Assessment of Need for the Elderly (CANE: Reynolds, Thornicroft, Woods, Abas & Orrell, 1998). This is a brief, reliable, practical and valid tool designed to measure needs in older people particularly those with mental health problems. The individual's view of their needs and the views of carers and staff can be rated, in the present study resident and interviewer views only were rated. The CANE measures both met and unmet need and the level of help received from friends or relatives as well as from statutory services (Appendix 7).

The 24 needs included are accommodation, looking after the home, food, self care, caring for someone else, daytime activities, memory, eyesight/hearing, mobility, continence, physical health, drugs, psychotic symptoms, psychological distress, information on condition / treatment, safety to self, behaviour, alcohol, company, intimate relationships, money, benefits. Each of these potential needs are rated on a three point scale: 0 = no problem, 1 = met need (no problem or only a moderate problem due to help given), and 2 = unmet need (serious problem). Needs are difficulties which can potentially be alleviated at least in part. Unmet needs are needs which could potentially be met at least in part but are not currently met.

For each of the 24 potential needs the following are rated: how much help the person receives from friends or relatives, and from services, how much help they feel they need, whether they receive the right help and if they are satisfied with the level of help. A 4 point scale is used: 0=no help, 1=low, 2=moderate and 3=high level of help.

Face and content validity of the CANE were established at a multidisciplinary conference using a Delphic process of revision. The number of needs identified by the CANE correlates (r=0.66) with level of dependence as measured by the Clifton Assessment Procedures for the Elderly Behaviour Rating Scale which suggests good concurrent validity. Good test-retest and inter-rater reliability has also been shown (Reynolds, Thornicroft, Woods, Abas & Orrell, 1998).

Practitioner Assessment of Network Typology (PANT: Grant & Wenger, 1993). This is a short eight question instrument which assess the individuals support network according to three main features, availability of local close kin, level of involvement of family friends and neighbours, and the level of interaction with the community and voluntary groups. Networks are then characterised either into one of 5 main types: family dependent; locally integrated; locally self-contained; wider community focused; and private restricted or into a combination of two types. Network type helps predict risk and the resources likely to be needed in the event of physical or mental ill health (Appendix 8).

Older Americans Resources and Services - Social Resources Section (OARS: Fillenbaum, 1978). The Social Resources Section assesses the quantity and quality of an older persons relationships with family and friends (social resources). Questions cover size of the social network, frequency of contact and perception of emotional support by asking questions such as how many contacts they had with family and friends in the last week, were there as many contacts as they wanted, are there people to provide instrumental help, do they feel lonely, and do they have a confidant? It has been validated on three older populations in the USA, those living in the community, those attending day care and those in residential care. Test-retest reliability was reported as 0.91 and inter-rater reliability as ranging from 0.67 - 0.87 (Fillenbaum & Smyer, 1981) (Appendix 9).

SHORT-CARE (Gurland, Golden, Teresi & Challop 1984). This is derived from the Comprehensive Assessment and Referral Evaluation (CARE) (Golden, Teresi & Gurland, 1984). It is a semi-structured interview developed for older people and has 6 indicator scales which assess organic brain syndrome (cognitive impairment), depression, sleep problems, somatic symptoms, subjective memory impairment, and activity limitation. There are also diagnostic scales for depression and dementia. The indicator scales are a screening tool to identify potential problems in need of further assessment. The diagnostic scales detect probable cases of pervasive depression or dementia severe enough to warrant clinical intervention (Kay, Henderson, Scott, Wilson, Rickwood & Grayson, 1985). As well as measuring severity the SHORT-CARE is useful for predicting service utilisation.

The scales are reliable whether used by psychiatrist or non psychiatrist. Inter-rater reliability correlations of the depression, dementia and disability scales were 0.94, 0.76 and 0.91 respectively. Internal consistency coefficients of the three scales were 0.75, 0.64 and 0.84 (Gurland et al, 1984). A correct prediction for an older person can be made for 84% of the cases of pervasive depression and dementia and 91% of the non cases (Gurland et al, 1984).

Views on Sheltered Housing. Residents were asked their length of stay in sheltered accommodation, which facilities they used, how much contact they had with the warden and generally how they found living there. They were asked about the decision to move into sheltered housing: who made the decision, why they moved in, and what features attracted them. Residents were asked to rate the importance of particular factors to their decision to move on a 5 point scale (1 = not at all important, 5 = very important). The twelve factors they rated included features of sheltered housing e.g. having a warden, social activities and company of other residents, features of their old home e.g. it was too large, or in need of alterations, and personal factors e.g. poor health, to be nearer friends and family, to enable continued independence and concern

for future needs. They were asked whether their expectations had been met and how, if at all, they thought their social network had changed. (Appendix 10)

Content analysis was carried out on the responses to the open questions. Two raters (one researcher, Elizabeth Field and someone otherwise uninvolved in the study) rated responses to 'How do you find living here?' on a five point scale from 0=very negative e.g. "dreadful", 2=neutral or mixed e.g. "alright" to 4=very positive e.g. "marvellous". Agreement was very good (r_S = 0.86, $p<.001$) and the two ratings of each response never differed by more than one point. Rating scores were added together to give a range of scores from nought to eight.

The responses to the two questions 'Why did you decide to move to sheltered accommodation?' and 'What were the features of sheltered accommodation that most attracted you?' were taken together and coded according to the types of reasons given e.g. problems with old home, poor health, presence of a warden etc. Responses were given as many codes as raters felt were warranted. Agreement between the two raters ranged from Cohen's kappa = 0.58 for 'did not want sheltered accommodation' to 1.0 for 'poor mental health', 'spouses poor health', and 'to leave children's home'. In the results presented responses were assigned codes only if both raters had deemed the reason to have been expressed.

Health Problems and Service Use. Residents were asked about health problems, medication use, sight and hearing difficulties. They were asked whether, and if so why, they had contact with a variety of community and hospital health services, social services, and voluntary agencies (Appendix 11 & 12).

Demographic and Other data. Residents were asked information regarding socio-economic variables such as age, years of education, previous occupation, financial status, ethnicity and whether they live alone.

DATA ANALYSIS

In the first stage demographic, health and social network variables were compared across the three schemes, and associations with social support variables, and experiences of living in sheltered accommodation were analysed. Categorical variables e.g. gender, network type were compared using chi-square. None of the interval data, e.g. length of residency, age, rating of satisfaction, met the conditions for using parametric tests. The data was not normally distributed, nor were the variances between the schemes homogeneous and so the non parametric test, Kruskal-Wallis (H), was used. Where it facilitated analysis, or helped answer research questions, continuous data was converted to categorical data e.g. health variables were transformed into categorical data (presence / absence of clinically significant condition) using prescribed cut-off scores to test associations between health problems and social support variables. Chi-square was then used.

Then the relationship between resident factors such as social network type, demographic and health variables and the number and type of needs was explored. The number of needs per resident was normally distributed and so where variances between the two groups being compared were homogeneous the parametric test One Way Between Groups Analysis of Variance was used. The number of unmet needs per resident, and the numbers of different types of need or unmet need were not normally distributed and the variances between the groups being compared were not homogeneous so non-parametric tests were used e.g. Mann-Whitney (U) when two groups were being compared and Kruskal-Wallis (H) when three or more groups were being compared. Finally in order to investigate the relative influence of the different factors on unmet needs a logistic regression analysis was carried out. The dependent variable was the presence or absence of at least one unmet need. The independent variables entered were chosen as hypothesised predictors of unmet need or because of significant associations found with unmet need in previous analyses.

CHAPTER THREE

RESULTS

The first section of this chapter examines demographic information concerning the residents of the three sheltered accommodation schemes and explores their health and social networks. The next sections investigate people's experiences of living in sheltered housing and why they moved in. The final section covers residents needs and how these vary with respect to resident factors and social networks.

In general residents were able to complete all of the interview. One interview was abandoned early on due to communication difficulties resulting from the resident's poor hearing and some of the seven residents with dementia had difficulty giving accurate factual information about frequency of contact with family and services due to their cognitive impairment. A few residents commented upon answering that some of the social support questions were very personal, and two residents declined to answer the question *'do you have someone to trust or confide in?'*.

RESIDENTS

Age, sex and marital status

Table 4 presents demographic information. Fifty nine women (68%) and 28 (32%) men were interviewed; more women than men were living in each of the three sheltered accommodation schemes. Ages ranged from 64 to 94 years (m = 80, sd = 7.0). There was no significant difference in the mean ages of men or women or between residents of the three schemes. All the residents interviewed were of white British ethnic origin.

Single residents, both those who had never married and those who had been but were no longer married, made up the majority of residents (56, 64%). All single residents lived alone. 43 (49%) residents were widowed, 11 (13%) divorced, and two (2%) had never married. The remaining 31 (36%) residents were married and living

with their spouse. Men were more likely than women to be married and less likely to be widowed ($\chi^2(2) = 10.7$, $p = .01$). Frequency of divorce was the same for both sexes. More men were married (16, 57%) than were living alone (12, 43%), in contrast the majority of women (44, 75%) were living alone, with only 15 (25%) married. (The difference in the number of men and women who were married was because one husband agreed to be interviewed but his wife declined.) The proportions of married and single people differed between the three schemes ($\chi^2(2) = 5.9$, $p = .05$). Scheme A had the most single people, followed by B. In C there were actually more married than single people, which may have explained the higher proportion of men there. Differences in the number of couples was one of the variables used for selecting the three schemes so this is unsurprising. The length of residency in the schemes ranged widely from 1 month to 16 years, with a mean of 5 years 2 months (sd = 4 years 4 months) but there were no significant differences between the schemes (Kruskal-Wallis $H(2) = 2.6$, $p = .27$). Length of residency correlated with age ($r = 0.36$, $p < .001$). The great majority of residents (84%) left school at the age of 14 after 9 years of education. Three had received only 8 years of schooling and ten had received between 10 and 12 years. Information was missing for 6 residents.

Table 4. Demographic information.

	Scheme A (n=24)	Scheme B (n=33)	Scheme C (n=30)	Total (n=87)
Women	17 (71%)	23 (70%)	19 (63%)	59 (68%)
Men	7 (29%)	10 (30%)	11 (37%)	28 (32%)
Single	19 (79%)	23 (70%)	14 (47%)	56 (64%)
Married	5 (21%)	10 (30%)	16 (53%)	31 (36%)
Age (m,sd)	78 (7.5)	80 (7.5)	81 (6.1)	80 (7.0)
Months resident (m,sd)	65 (49)	46 (37)	76 (64)	62 (52)

Health

Almost all residents (90%) reported health problems and most (86%) were taking medication. The waiting list for sheltered accommodation was prioritised by health need so this was as expected. Twenty seven residents (31%) could not see satisfactorily even with glasses. This included eleven (13%) who were limited to large print reading and five (6%) who were blind. Twenty (23%) had inadequate hearing, including nine (10%) with whom the interviewer had to shout and one with whom communication was impossible due to their severe deafness. Thirteen residents (15%) smoked, 46 (54%) used to smoke and 27 (31%) had never smoked.

Table 5 presents mean SHORT-CARE depression, dementia, activity limitation and somatic symptoms scores for residents of the three sheltered housing schemes. There were no significant differences between the schemes in the scores or in the number of people with depression, dementia, activity limitation or somatic symptoms (i.e. scoring above the SHORT-CARE clinical cut-off). In total 20 (24%) residents were depressed and seven (8%) had dementia. Many had clinically significant levels of activity limitation (46,55%) and of somatic symptoms (31, 37%) (see Table 6).

Table 5. Health status - SHORT-CARE scores.

Health Problem (clinical cut off)	Scheme A (n=21)		Scheme B (n=33)		Scheme C (n=30)		All 3 units (n=84)	
	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)
Dementia (7)	2.8	(2.4)	3.2	(2.3)	2.3	(1.8)	2.8	(2.2)
Depression (6)	3.0	(3.5)	3.2	(3.5)	3.6	(3.4)	3.3	(3.4)
Activity limitation (7)	7.2	(6.3)	7.5	(6.6)	8.9	(6.1)	7.9	(6.3)
Somatic symptoms (4)	3.1	(2.1)	2.3	(2.0)	2.8	(2.9)	2.7	(2.4)

Table 6. Residents with clinically significant depression, dementia, activity limitation or somatic symptoms (as determined by their SHORT-CARE score).

Clinically significant health problem	Scheme A (n=21)	Scheme B (n=33)	Scheme C (n=30)	All 3 units (n=84)
Dementia	2 (10%)	4 (12%)	1 (3%)	7 (8%)
Depression	5 (24%)	9 (27%)	6 (20%)	20 (24%)
Activity limitation	12 (57%)	15 (46%)	19 (63%)	46 (55%)
Somatic symptoms	9 (43%)	11 (33%)	11 (37%)	31 (37%)

Married people were significantly less likely than single people to have dementia ($\chi^2(1)=4.5$, $p<.05$) or clinical levels of activity limitation ($\chi^2(1)=5.1$, $p<.05$), but there were no such differences with regard to depression and somatic symptoms.

Support networks

Overall the distribution of network types was similar across the three schemes, although Scheme B showed some differences from A and C which had very similar percentages of residents with each network type. A locally integrated support network was the most common network type among residents (41%) in all three schemes (see Table 7). Local self contained support networks were the next most frequent type in Schemes A and C, whereas in Scheme B family dependent and family dependent / private restricted networks were more frequent and only 1 resident had a local self contained network.

In order to carry out analyses network types were grouped together by putting mixed networks with the least socially supportive network in their combination. Thus the Private group of networks comprised: private restricted, private restricted / family dependent, private restricted / local self contained and private restricted / wider community focused. The Self contained group comprised: local self contained, local self contained / locally integrated and local self contained / wider community focused. The Family dependent and Locally integrated groups only contained those with those

network types respectively. Those with wider community focused, wider community focused / locally integrated and inconclusive network types were removed from the data analysed because of small numbers and outlying scores nor did they fit theoretically with the other combinations (see Table 8). Locally integrated networks were most common in all three schemes, however in B networks in the private group were the next most frequent but in A and C self-contained were. There was no difference in the distribution of network types among married and single people (χ^2 (3) = 1.4 p=.69).

Table 7. The number of residents with each type of support network (PANT).

Type of Support Network	Scheme A (n=23)	Scheme B (n=33)	Scheme C (n=30)	Total (n=86)
Locally integrated	9 (39%)	12 (36%)	14 (47%)	35 (41%)
Locally integrated-local self contained	2 (9%)	0 (0%)	1 (3%)	3 (3%)
Locally integrated-wider community	0 (0%)	1 (3%)	1 (3%)	2 (2%)
Local self contained	5 (22%)	1 (3%)	6 (20%)	12 (14%)
Local self contained-wider community	1 (4%)	1 (3%)	0 (0%)	2 (2%)
Local self contained-private restricted	0 (0%)	2 (6%)	1 (3%)	3 (3%)
Local family dependent	2 (9%)	5 (15%)	1 (3%)	8 (9%)
Local family dependent-private restricted	0 (0%)	4 (12%)	0 (0%)	4 (5%)
Wider community focused	1 (4%)	2 (6%)	2 (7%)	5 (6%)
Wider community focused-private res.	0 (0%)	1 (3%)	1 (3%)	2 (2%)
Private restricted	3 (13%)	3 (9%)	3 (10%)	9 (10%)
Inconclusive	0 (0%)	1 (3%)	0 (0%)	1 (1%)

Table 8. Residents' support networks (as grouped for analysis).

Support Networks	Scheme A (n=23)	Scheme B (n=33)	Scheme C (n=30)	Total (n=86)
Private	3 (13%)	10 (30%)	5 (17%)	18 (21%)
Family dependent	2 (9%)	5 (15%)	1 (3%)	8 (9%)
Self contained	8 (35%)	2 (6%)	7 (23%)	17 (20%)
Locally integrated	9 (39%)	12 (36%)	14 (47%)	35 (41%)

Social Support

Perceived quantity and quality of social support was measured using the OARS. The majority of residents had family and friends providing social support which on the whole they were satisfied with. There was however a minority who had very little social contact and or were often lonely. Ten residents (11%) had not spent any time in the past week with someone who did not live with them, neither going out with anyone nor receiving any visitors other than the brief calls by the warden. In addition twelve (14%) had only spent time with someone once that week. Ten (11%) had not spoken to anyone on the phone that week and a further 11 (13%) had only used the phone once. Fifteen residents (17%) did not know anyone well enough to visit at home, neither family nor friends. A further 24 (28%) knew only one or two people whose homes they could visit. Thirty-nine (45%) did not see family and friends as often as they would like to. Twenty five (29%) residents felt lonely sometimes and a further 14 (16%) felt lonely quite often. Sixteen (18%) said they did not have someone they could trust or confide in, the same number knew no one they could ask for any help at all in the event of illness. For the majority who did have someone they could ask for help this person was almost always their spouse or child, although some residents said it was the warden.

There were no differences between residents of the three schemes with regard to their answers to the social support questions. Women were more likely to use the

telephone daily rather than occasionally or rarely (χ^2 (3) = 16.7, p<.001). Married people (100%) were significantly more likely than single people (71%) to report having someone they could trust and confide in ($\chi^2(1)$ = 11.1, p<.001). They were more likely to have someone to care for them if they became sick ($\chi^2(1)$ = 7.6, p <.01) and to have someone able to care indefinitely rather than for only a short time ($\chi^2(2)$ = 18.1, p<.001). Single people were more likely than married people to report being lonely ($\chi^2(2)$ = 12.6, p<.01).

Residents who had clinical levels of depression were more likely to report being lonely often ($\chi^2(1)$ = 25.7, p <.001 Fisher's exact test-two tail) and more likely to say they did not see their relatives as often as they wanted to ($\chi^2(1)$ = 6.2, p <.05). Residents who had clinical levels of activity limitation were also more likely to report being lonely quite often rather than sometimes or never ($\chi^2(2)$ = 16.5, p<.05) as were those with clinical levels of somatic symptoms ($\chi^2(2)$ = 12.5, p<.01).

Residents with a private support network were more likely to report being lonely often than were residents with a locally integrated network ($\chi^2(1)$ = 5.4, p <.05 Fisher's exact test-two tail). The majority (11, 61%) of those with a private network said they had no-one to trust, this compares with only 2 (25%) of those with family dependent networks, 1 (6%) of those with a self-contained network and 2 (6%) of those with a locally integrated network.

LIVING IN SHELTERED ACCOMMODATION

Seventy eight residents (90%) agreed or strongly agreed with the following statement *'the move to sheltered accommodation has been a success'*. Content analysis of residents responses to the question *"How do you find it living here?"* revealed that overall the majority of residents were positive about living in their sheltered accommodation scheme (see Table 9). Responses included: "wonderful", "I love it", "lovely, peaceful..", "very good, neighbourly", "very good, it prolongs your life, I'm

not hassled by anything" "smashing, put another 10 years on me (life)" and "great, best move I ever made, especially if you're nosy".

A small minority (8, 10%) were very unhappy describing their sheltered accommodation scheme as "dreadful", "terrible....very depressing" or with "lots and lots of room for improvement". Some had specific complaints: "could be cleaner", "filthy lift and corridor". There was no correlation between depression score and rating of response. Residents of the three schemes differed significantly according to how positive they were (Kruskal-Wallis H(2) = 5.8, p=.05); residents in C (m=6.9, sd=1.3) were more positive than residents in A (m=5.7, sd=2.2) and B (m=5.7, sd=2.4). Scheme C had the most residents responding positively and A the least. However in A few were negative, many being neutral. Six of the eight who were negative lived in scheme B (see Table 9). The small numbers made it difficult to draw significant conclusions about these eight who were negative about their scheme. All were single. Four felt lonely often, but six had a confidant. There was a wide range in their length of residency and together they had all four types of support network. Half said the decision to move in had been made by someone else as compared to 34% of the total group. Six of the eight were depressed, and they had a higher than population mean number of needs (7.4 as compared to 4.9) and unmet needs (2.1 as compared to 1.5). (see later for the results of the total samples needs).

Table 9. Resident responses to 'How do you find living here?'
(content analysis rating scale 0=very negative, 4=alright, 8=excellent)

Responses(rated 0-8)	Scheme A	Scheme B	Scheme C	Total
Positive (6-8)	10 (48%)	22 (67%)	23 (76%)	55 (66%)
Neutral (4-5)	9 (43%)	5 (15%)	7 (23%)	21 (25%)
Negative (0-3)	2 (10%)	6 (18%)	0 (0%)	8 (10%)

Sixty four residents (74%) agreed or strongly agreed with *'I have made new friends in sheltered accommodation';* 79% of those in scheme A, 76% in B and 67% in C. Similar percentages of married and single (77%, 71%) and of men and women (75%, 73%) reported making new friends. For the purpose of analysis residents were divided by age into three roughly equal sized groups. People over 83 years i.e. the oldest residents, were significantly less likely to agree they had made new friends since moving in ($\chi^2(2) = 21.3$, $p<.001$). Residents with depression were also significantly less likely than those without to agree they had made new friends ($\chi^2(1) = 11.2$, $p<.001$) as were those with clinical levels of activity limitation ($\chi^2(1) = 6.1$, $p<.05$). Residents with each network type reported making new friends but more residents with locally integrated (32: 91%) and self contained networks (13: 77%) reported making new friends than those with private (7: 39%) or family dependent (3: 38%) networks ($\chi^2(3) = 20.5$, $p<.001$).

Forty-six residents (53%) said they saw more people to talk to since moving. Residents in Scheme B were significantly more likely to report seeing a greater number of people to talk to since moving in ($\chi^2(2) = 8.4$, $p=.01$). Those over 83 years were less likely to report seeing more people to talk to since moving in ($\chi^2(2) = 9.0$, $p=.01$) as were those with clinical levels of activity limitation ($\chi^2(1) = 5.2$, $p<.05$).

No residents see their old friends more since moving, 33 (38%) see them about the same and 54 (62%) see their old friends less. Fifty-one (60%) see their family "about the same" with 15 (18%) seeing them less and 19 (22%) seeing them more. Residents in Schemes A and B were significantly more likely to see more of their family after moving than residents in C ($\chi^2(2) = 9.8$, $p<.01$).

When asked if any loneliness had increased or decreased since their move 49 (56%) felt it was about the same, 20 (23%) were less lonely in sheltered accommodation and 18 (21%) were more lonely. Although many residents in each scheme reported no change in their level of loneliness there was a significant difference between the three schemes ($\chi^2(4) = 10.4$, $p<.05$). Residents of scheme A were fairly evenly divided between those who were less, the same or more lonely; whereas the

majority of residents in C reported no change in their loneliness (see Table 10). Reported change in loneliness was not associated with gender, marital status, social network or age.

Table 10. Residents reported changes in loneliness after moving in.

	Scheme A	Scheme B	Scheme C
More lonely	7 (29%)	6 (18%)	5 (17%)
No change	9 (38%)	17 (52%)	23 (77%)
Less lonely	8 (33%)	6 (18%)	2 (7%)

Warden and Alarm system

Every weekday the warden calls on each resident for a few minutes. Nine (10%) residents reported that the warden regularly helped them, this included changing light bulbs, advising, explaining and filling in official forms, writing birthday cards on behalf of a resident no longer able to write, pushing a resident in a wheelchair to the common room for activities, and collecting prescriptions. Some residents had a more mutual social relationship with the warden and help was both given and received e.g. shopping or lending foodstuffs.

Forty four (51%) residents had called their warden in a emergency in the last year. The usual help provided in such situations was calling emergency services and waiting with the resident until they arrived. There was no significant difference in the number of calls made by residents with the four network types. Fifty five residents (63%) had pulled the emergency cord during their tenancy, on a few occasions this was on behalf of a neighbour in need.

Twelve residents (14%) would like the warden to do more for them (nine of these had private or self contained networks). A few felt their warden was not doing her job well enough in some areas such as cleaning or organising social activities. Most

of those wanting a warden to do more were commenting not on their warden who they felt was too busy to do more, but on what tasks they thought a warden should be able to do for people e.g. shopping, transport, collecting prescriptions, and calling in at weekends.

Common room

Residents tended to be divided into those that attended social activities in the common room e.g. bingo, coffee mornings and keep fit at least once a fortnight and those that never did (see Table 11). Forty seven (54%) attended activities regularly at least once a fortnight, including 33 (38%) who attended at least twice a week. Thirty three (38%) never attended events and only 6 (7%) occasionally attended activities.

There was no significant difference between the number of residents using the common room in the three schemes. However fewer residents in scheme B than in A or C attended events in the common room twice a week or more possibly because in addition to common room activities residents in B ran a social club off site which many of those able to get out attended. This off site club seemed to have been started following a conflict among residents about whether or not events in the common room should include those with significant cognitive or physical impairment.

A significantly greater proportion of residents with locally integrated networks used the common room (27, 77%), than residents with self contained networks (8, 50%), or private networks (3, 28%) ($\chi^2(3) = 12.4$, $p<.01$). Those with family dependent networks (3, 38%) were excluded from the analysis due to low expected values. Residents who were positive about living in their sheltered scheme were more likely to attend the common room ($\chi^2(1) = 5.8$, $p<.05$). Residents offered the following reasons fro not attending events in the common room, men complained there were few other men, some disliked having more disabled people present, others found the activities boring and the other residents uninteresting. Some had an active social life off site. Fifty four residents (62%) used the communal laundry room.

Table 11. Resident attendance in the common room in the three schemes.

Frequency of attendance	Scheme A (n=23)	Scheme B (n=33)	Scheme C (n=30)	Total (n=86)
Never	7 (30%)	17 (52%)	9 (30%)	33 (38%)
Occasionally	3 (13%)	2 (6%)	1 (3%)	6 (7%)
Every week or fortnight	2 (9%)	6 (18%)	6 (20%)	14 (16%)
Twice a week or more	11 (48%)	8 (24%)	14 (47%)	33 (38%)

In summary the majority of residents seemed to be happy living in sheltered accommodation. Many used the common room, the communal laundry, and had called the warden in an emergency or pulled the alarm cord. However a minority did not make use of each of these 'sheltered' features.

WHY PEOPLE MOVED TO SHELTERED ACCOMMODATION

Table 12 gives the reasons for moving, derived from a content analysis of the responses to the question '*Why did you decide to move to sheltered accommodation?*' Problems with the old home, e.g. with stairs, was the reason given most frequently (34, 39%), followed by poor health (29, 34%), desire to have a warden or alarm available (24, 28%) and spouse's poor health (21, 24%). Table 13 gives the ratings of reasons for moving into sheltered accommodation that residents went on to give. The two ways of questioning give very similar responses, with the same four reasons most frequent. Poor health (47%) was the reason most frequently rated as important followed by having a warden (40%) and being unable to manage stairs (34%). Spouse's poor health was an important reason for 24%, half of whom did not themselves have poor health warranting a move. Concern about future needs was important for 23%.

Table 12. "Why did you move to sheltered housing?" - Residents' responses.

Reasons given for moving into scheme	Number of people	
Physical health or disability	24	(28%)
Mental health	5	(6%)
Spouses health	21	(24%)
Bereavement / Divorce	10	(11%)
Concern for future needs	5	(6%)
Finances	1	(1%)
Old home - problems with stairs, damp etc.	34	(39%)
Liked the new home - view, location etc.	11	(13%)
Warden / Alarm	24	(28%)
Company	11	(13%)
Recommended by friends or family	5	(6%)
To move nearer family	9	(10%)
To move out of children's home	6	(7%)
Problems with previous neighbours	14	(16%)
Advised or forced to move to sheltered	15	(17%)
Did not particularly want sheltered	6	(7%)

Table 13. Residents ratings of importance of reasons for moving to sheltered accommodation .

Reasons for moving	important or very important		quite important		slightly or not important	
Physical / Mental health	41	(47%)	4	(5%)	42	(48%)
Spouses health	21	(24%)	0	(0%)	66	(76%)
To continue being independent	15	(17%)	15	(17%)	57	(66%)
Concern for future needs	20	(23%)	6	(7%)	60	(70%)
Old home - unable to manage stairs	30	(34%)	6	(7%)	51	(59%)
Old home too large	10	(12%)	5	(6%)	72	(83%)
Old home needed alterations	10	(12%)	3	(3%)	74	(85%)
Warden	35	(40%)	8	(9%)	44	(51%)
Security	17	(20%)	13	(15%)	55	(65%)
Active social life	13	(15%)	9	(11%)	64	(74%)
Company of other residents	18	(20%)	10	(12%)	59	(68%)
To join friends	3	(3%)	0	(0%)	84	(97%)
To be nearer family	14	(16%)	1	(1%)	72	(83%)
Other (usually problem neighbours)	26	(30%)	3	(3%)	5	(6%)

For the purpose of analysis the rating scores given to the reasons were assigned to two categories: important or very important versus quite or not at all important. There were differences between the schemes in the numbers of residents rating certain reasons as important (see Table 14). Other reasons were important to similar proportions of residents.

Significantly more residents in Scheme C, than in A or B rated poor health as an important reason for their moving to sheltered accommodation ($\chi^2(2)= 6.2$, $p<.05$) (see Table 14). Residents who rated poor health an important reason for moving were

more likely to have environmental needs ($\chi^2(1) = 4.1$, $p<.05$), and there was a trend towards them being more likely to have more physical needs although this was not significant ($\chi^2(1) = 3.3$, $p=.068$). Being unable to manage stairs was important for more residents in A and C than in B ($\chi^2(2)= 9.1$, $p=.01$). Given the higher proportion of married people in Scheme C it is unsurprising that spouse' poor health was important for more residents in C ($\chi^2(2) = 9.4$, $p<.01$).

Significantly more residents rated moving near family as an important reason in B than in C ($\chi^2(1) = 12.1$, $p<.001$), or in A however the difference between B and A was not statistically significant ($\chi^2(1) = 3.3$, $p=.07$). Those who said family were an important reason for moving were significantly less likely to report environmental needs ($\chi^2(1) = 4.9$, $p<.05$).

More residents in Scheme C rated a warden as an important reason for moving to sheltered accommodation than in B or A (8, 33%). This difference approached significance ($\chi^2(2) = 5.2$, $p=.07$). Residents who rated a warden as an important reason to move in were significantly less likely to report social needs ($\chi^2(1) = 4.4$, $p<.05$), or unmet social needs ($\chi^2(1) = 5.9$, $p<.05$)

Social life was important to significantly more residents in A than B ($\chi^2(1) = 5.3$, $p<.05$), although also important to more in A than in C this difference did not reach significance.

In summary health, stairs and a social life were most often important to residents in A, health, stairs, and having a warden to residents in C. Being nearer family was important to more residents in B than in A or C.

Residents for whom concern for future needs was an important reason for moving were less likely to have unmet psychological needs ($\chi^2(1) = 7.9$, or unmet physical needs ($\chi^2(1) = 5.3$, $p<.05$).$p<.01$). Although only approaching significance there was also a trend for them to be less likely to have unmet social ($\chi^2(1) = 3.3$, $p=.068$) or unmet environmental needs ($\chi^2(1) = 4.0$, $p=.06$ Fisher's exact test two-tail). They were also less likely to have psychological needs ($\chi^2(1) = 7.3$, $p<.01$) or social

needs ($\chi^2(1) = 4.2$, $p<.05$). These analyses are exploratory and it is important to bear in mind the possibility of Type I errors.

Table 14. Important reasons for moving - differences between residents of the three schemes.

Reasons for moving	Scheme A	Scheme B	Scheme C
Physical / Mental health	13 (54%)	10 (30%)	18 (60%)
Spouses health	4 (17%)	4 (12%)	13 (43%)
Old home - unable to manage stairs	12 (50%)	5 (15%)	13 (43%)
Warden	8 (33%)	10 (30%)	17 (57%)
Active social life	7 (29%)	2 (6%)	4 (13%)
To be nearer family	3 (13%)	11 (33%)	0 (0%)

Thirty residents (34%) reported that the decision to move from their old home into sheltered accommodation had been mainly someone else's such as family or health and social services however there was no significant difference in depression or dementia scores between those who had and had not made the decision themselves.

In summary the reasons for moving to sheltered accommodation reported most often were because they or their spouse were in poor health, they could not manage in their old home and they wanted a warden or alarm system.

NEEDS

Needs for assistance were investigated using the CANE. The vast majority of residents (79, 91%) had at least one need (m = 4.9, sd = 3.8), two people actually had 14 needs. Eight residents (9%) had no known needs: scheme A had three (13%) such residents, B had four (12%) and C had one (3%). As well as some residents with no needs each

scheme also had some residents with over ten needs. The range in the number of needs per resident was similar in each scheme (see Table 15). This range demonstrated the policy of balance which Harlow Council follows in its allocation of residents to schemes i.e. ensuring residents in any one scheme have a range of dependency levels .

Table 15. Total number of needs of residents in the three schemes.

Number of needs	Scheme A (n=24)	Scheme B (n=33)	Scheme C (n=30)	Total (n=87)
0	3 (13%)	4 (12%)	1 (3%)	8 (9%)
1 - 3	6 (25%)	13 (39%)	11 (37%)	30 (34%)
4 - 6	9 (38%)	7 (21%)	8 (27%)	24 (28%)
7 - 9	3 (13%)	2 (6%)	7 (23%)	12 (14%)
10 -14	3 (13%)	7 (21%)	3 (10%)	13 (15%)

Fifty one residents (59%) had at least one unmet need, 24 (28%) had one unmet need, 27 (31%) had more than one (m = 1.5, sd = 1.9). One person had nine unmet needs (see Table 16). Each scheme had some residents with no unmet needs, and some residents with over six unmet needs. The percentage of residents with at least one unmet need was similar across the three schemes, A (50%), B (61%) and C (63%).

Table 16. Total number of unmet needs of residents in the three schemes.

Number of unmet needs	Scheme A (n=24)	Scheme B (n=33)	Scheme C (n=30)	Total (n=87)
0	12 (50%)	13 (39%)	11 (37%)	36 (41%)
1	8 (33%)	11 (33%)	5 (17%)	24 (28%)
2 - 9	4 (17%)	9 (27%)	14 (46%)	27 (31%)

There were no significant differences between the residents of the three sheltered schemes in their total number of needs ($F(2,84) = 0.06$, $p=.9$) the number of met needs ($F(2,84) = 0.1$, $p=.9$) or the number of unmet needs (Kruskal-Wallis $H(2) = 2.6$, $p=.3$) (see Table 17). There were no significant differences between the three sheltered schemes in the proportions of met and unmet need ($\chi^2(2) = 3.5$, $p=.17$) (see Table 18). In total 426 needs were identified of which 300 (70%) were being met and 126 (30%) were unmet. Numbers of met needs and unmet needs per resident correlated to some degree ($r_S=0.34$, $p<.001$).

Table 17. Number of needs, met needs and unmet needs per resident.

Needs	Scheme A	Scheme B	Scheme C	Total
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Unmet	1.1 (2.1)	1.4 (1.9)	1.7 (1.8)	1.5 (1.9)
Met	3.5 (3.0)	3.5 (3.1)	3.3 (2.3)	3.4 (2.8)
Total	4.7 (4.0)	5.0 (4.3)	5.0 (3.2)	4.9 (3.8)

Table 18. Number of met and unmet needs in the three schemes

Needs	Scheme A	Scheme B	Scheme C	All 3 Schemes
Unmet	27 (24%)	47 (29%)	52 (35%)	126 (30%)
Met	85 (76%)	117 (71%)	98 (65%)	300 (70%)
Total	112	164	150	426

Types of need

All the 24 needs for help covered by the CANE were found in at least one resident (see Table 19). A need for treatment of physical ill health was the most common, with 69 (80%) residents reporting ill health or current need for medication to maintain well-

being. Many residents had needs relating to mobility (51%), looking after the home (48%), shopping and/or cooking (45%), eyesight or hearing (37%), self care (29%) and lack of company (27%) (see Table 19). A sizeable minority also had needs relating to psychological distress (20%), daytime activity (17%), and intimate relationships (14%). Few people (2%) reported needs for help caring for someone although in many couples one spouse was more disabled and so more reliant on the other. Rare needs included psychosis (1%), problematic behaviour (1%), deliberate (3%) or inadvertent self harm (2%) and abuse / neglect (2%).

Physical health needs were almost always met, 64 (93%) of the 69 residents with this need were receiving appropriate treatment. Most needs relating to medication use were also met. Other common needs such as looking after the home, shopping and cooking, managing money and self care were also usually met (see Table 20).

The most common unmet needs in terms of the percentage of residents experiencing them were needs relating to mobility (17%), sight and hearing (12%), company (14%), information regarding treatment (12%), and psychological distress (12%) (Table 20). The latter three were more often unmet than met (see Table 20). Other less common needs were also more often unmet than met: claiming benefits; continence; accommodation; memory; and problems with intimate relationships. Daytime activity was an unmet need for seven (40%) of the 15 residents with the need. None of the four residents with an alcohol intake problem were receiving help. The percentages of residents with each need and the percentages with each need unmet were remarkably similar across the three schemes in almost all cases (see Tables 19 and 20). The only difference was in needs relating to accommodation; no-one in Scheme A reported a need for adaptations to their home whereas eight (27%) in Scheme C did. This was often a need for bath adaptations, a shower or improved wheelchair access.

Table 19. Residents' needs.

Needs	Scheme A (n=23)	Scheme B (n=33)	Scheme C (n=30)	Total (n=86)
Environmental Needs				
Accommodation	0 (0%)	4 (12%)	8 (27%)	12 (14%)
Looking after home	12 (52%)	14 (42%)	15 (50%)	41 (48%)
Food and shopping	10 (43%)	15 (45%)	14 (47%)	39 (45%)
Money	3 (13%)	6 (18%)	5 (17%)	14 (16%)
Benefits	3 (13%)	3 (9%)	8 (27%)	14 (16%)
Caring for someone	1 (4%)	0 (0%)	1 (3%)	2 (2%)
Physical Needs				
Physical health	17 (74%)	29 (88%)	23 (77%)	69 (80%)
Drugs	4 (17%)	6 (18%)	5 (17%)	15 (17%)
Eyesight / hearing	10 (43%)	10 (30%)	12 (40%)	32 (37%)
Mobility	13 (57%)	17 (52%)	14 (47%)	44 (51%)
Self care	7 (30%)	10 (30%)	8 (27%)	25 (29%)
Continence	2 (9%)	8 (24%)	6 (20%)	16 (19%)
Psychological Needs				
Psychological distress	4 (17%)	7 (21%)	6 (20%)	17 (20%)
Memory	4 (17%)	2 (6%)	2 (7%)	8 (9%)
Behaviour	0 (0%)	1 (3%)	0 (0%)	1 (1%)
Alcohol	0 (0%)	3 (9%)	1 (3%)	4 (5%)
Deliberate self harm	1 (4%)	2 (6%)	0 (0%)	3 (3%)
Inadvertent self harm	0 (0%)	1 (3%)	1 (3%)	2 (2%)
Psychotic symptoms	0 (0%)	0 (0%)	1 (3%)	1 (1%)
Social Needs				
Company	8 (35%)	8 (24%)	7 (23%)	23 (27%)
Intimate relationships	3 (13%)	5 (15%)	4 (13%)	12 (14%)
Daytime activities	6 (26%)	6 (18%)	3 (10%)	15 (17%)
Information	3 (13%)	6 (18%)	6 (20%)	15 (17%)
Abuse / neglect	1 (4%)	1 (3%)	0 (0%)	2 (2%)

Table 20. Residents' unmet needs and the percentage of needs unmet overall.

Unmet Need	Scheme A (n=23)	Scheme B (n=33)	Scheme C (n=30)	Total Unmet Needs	Total No. Needs	% of Needs Unmet
Environmental Needs						
Accommodation	0 (0%)	3 (9%)	4 (13%)	7 (8%)	12	58%
Looking after home	0 (0%)	2 (6%)	3 (10%)	5 (6%)	41	12%
Food and shopping	0 (0%)	0 (0%)	0 (0%)	0 (0%)	39	0%
Money	1 (4%)	0 (0%)	0 (0%)	1 (1%)	14	7%
Benefits	3 (13%)	2 (6%)	4 (13%)	9 (10%)	14	64%
Caring for someone	0 (0%)	0 (0%)	1 (3%)	1 (1%)	2	50%
Physical						
Physical health	1 (4%)	4 (12%)	0 (0%)	5 (6%)	69	7%
Drugs	0 (0%)	1 (3%)	1 (3%)	2 (2%)	15	13%
Eyesight / hearing	2 (8%)	3 (9%)	5 (17%)	10 (12%)	32	31%
Mobility	5 (21%)	4 (12%)	6 (20%)	15 (17%)	44	34%
Self care	0 (0%)	2 (6%)	4 (13%)	6 (7%)	25	24%
Continence	1 (4%)	4 (12%)	3 (10%)	8 (9%)	16	50%
Psychological Needs						
Psychological distress	1 (4%)	4 (12%)	5 (17%)	10 (12%)	17	59%
Memory	4 (17%)	1 (3%)	2 (7%)	7 (8%)	8	88%
Behaviour	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1	0%
Alcohol	0 (0%)	3 (9%)	1 (3%)	4 (5%)	4	100%
Deliberate self harm	0 (0%)	1 (3%)	0 (0%)	1 (1%)	3	33%
Inadvertent self harm	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2	0%
Psychotic symptoms	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1	0%
Social Needs						
Company	3 (13%)	5 (15%)	4 (13%)	12 (14%)	23	52%
Intimate relationships	1 (4%)	3 (9%)	3 (10%)	7 (8%)	12	58%
Daytime activities	3 (13%)	1 (3%)	2 (7%)	6 (7%)	15	40%
Information	2 (8%)	4 (12%)	4 (13%)	10 (12%)	15	67%
Abuse / neglect	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2	0%

Needs were grouped according to four types: environmental, physical, psychological and social (Martin, 1998). The number of total needs from each group correlated positively with the number of unmet needs in the same group. Unmet psychological needs had the lowest correlations with other types of need (see Table 21).

Table 21. Spearman's rank-order correlations between the four types of need.

	Total ENV	Total PHY	Total PSY	Total SOC	Unmet ENV	Unmet PHY	Unmet PSY
Total PHY	.71***						
Total PSY	.26*	.21					
Total SOC	.49***	.51***	.45***				
Unmet ENV	.45***	.29**	.37***	.37***			
Unmet PHY	.38***	.51***	.24*	.36**	.32**		
Unmet PSY	.06	.04	.76***	.27***	.22*	.16	
Unmet SOC	.40***	.43***	.40***	.76***	.45***	.31**	.30**

*p<.05, **p<.01, ***p<.001

ENV = environmental needs: accommodation, housework, cooking/shopping, money, benefits, caring

PHY = physical needs: physical health, drugs, eyesight/hearing, mobility, continence, self-care

PSY = psychological needs: distress, behaviour, alcohol misuse, psychosis, memory, deliberate and accidental self harm

SOC = social needs: company, relationships, activity, information, abuse/neglect

Physical needs were most frequently identified (201) followed by environmental needs (122). These were met in the majority of cases (Table 22). Social needs (67) and psychological needs (36) were identified less often, but were only met in the minority of cases. Environmental and physical needs were significantly more likely to be met than were psychological or social needs ($\chi^2(3) = 44.8$, $p<.001$). There were no significant differences between the schemes in terms of the number of environmental, physical, psychological or social needs and whether they were met or not.

Table 22. Comparison between four types of met and unmet need

Type of need	Number of needs				
	Met		Unmet		Total
Environmental	99	(81%)	23	(19%)	122
Physical	155	(77%)	46	(33%)	201
Psychological	14	(39%)	22	(61%)	36
Social	32	(48%)	35	(52%)	67

Who was meeting the needs that were met?

Few residents received help from friends with activities of daily living but the majority (58%) received some help from family (see Table 23). Over half the residents (51%) received help from family with shopping and over a quarter (26%) help with housework. Single residents were more likely to receive help from family members than were married residents ($\chi^2(1) = 4.2$, $p<.05$).

Table 23. Number of residents receiving help from family and friends.

Activity	Help received from			
	Family		Friends	
Laundry	14	(15%)	4	(5%)
Shopping	45	(51%)	3	(4%)
Finances	12	(13%)	0	(2%)
Housework	23	(26%)	3	(3%)
Bathing	5	(6%)	0	(0%)
Other e.g. gardening	12	(13%)	8	(9%)
Any sort of help	51	(58%)	12	(14%)

Some needs were predominantly met by family, some by services and others by both (see Table 24). Most help with needs for managing money, shopping and cooking was provided by family. They also provided more of the help with psychological distress and relationships. Most residents receiving help with company and mobility were receiving the help from family, with some receiving additional help from services. Residents tended to receive help with looking after the home either from family or services but not both. Help with daytime activity, continence, and information about health was usually provided by services only. Help with self care and with drugs was also mainly provided by services but some received help just from their family. Most residents receiving help with physical health, eyesight and hearing were receiving help from services with some receiving additional help from family. Accommodation related needs were only ever met by services.

Table 24. Residents' needs and where their help, if any, comes from.

Need	No. of residents with need	No. of residents receiving help from (% needs helped by)				No. with need unmet
		Family & Friends only	Services only	Family, Friends & Services	No-one despite need	
Environmental needs						
Accommodation	12(14%)	0(0%)	9(75%)	0(0%)	3(25%)	7(8%)
Looking after home	41(48%)	20(49%)	16(39%)	4(10%)	3(7%)	5(6%)
Food and shopping	39(45%)	26(67%)	6(15%)	7(18%)	0(0%)	0(0%)
Money	14(16%)	11(79%)	3(21%)	0(0%)	0(0%)	1(1%)
Benefits	14(16%)	0(0%)	3(21%)	4(29%)	7(50%)	9(10%)
Caring for someone	2(2%)	1(50%)	0(0%)	0(0%)	1(50%)	1(1%)
Physical needs						
Physical health	69(80%)	0(0%)	57(83%)	11(16%)	2(3%)	5(6%)
Drugs	15(17%)	4(27%)	8(53%)	1(7%)	2(13%)	2(2%)
Eyesight / hearing	32(37%)	2(6%)	16(50%)	9(28%)	5(16%)	10(12%)
Mobility	44(51%)	15(34%)	9(20%)	15(34%)	9(20%)	15(17%)
Self care	25(29%)	6(24%)	13(52%)	2(8%)	6(24%)	6(7%)
Continence	16(19%)	1(6%)	9(56%)	1(6%)	5(31%)	8(9%)
Psychological needs						
Psychological distress	17(20%)	8(47%)	4(24%)	3(18%)	6(35%)	10(12%)
Memory	8(9%)	1(13%)	1(13%)	0(0%)	6(75%)	7(8%)
Behaviour	1(1%)	0(0%)	1(100%)	0(0%)	0(0%)	0(0%)
Alcohol	4(5%)	0(0%)	1(25%)	0(0%)	3(75%)	4(5%)
Deliberate self harm	3(3%)	0(0%)	2(67%)	0(0%)	1(33%)	1(1%)
Inadvertent self harm	2(2%)	1(50%)	0(0%)	1(50%)	0(0%)	0(0%)
Psychotic symptoms	1(1%)	0(0%)	1(100%)	0(0%)	0(0%)	0(0%)
Social needs						
Company	23(27%)	11(48%)	14%	10(43%)	9(39%)	12(14%)
Intimate relationships	12(14%)	6(50%)	00%	3(25%)	6(50%)	7(8%)
Daytime activities	15(17%)	1(7%)	853%	1(7%)	5(33%)	6(7%)
Information	15(17%)	1(7%)	747%	0(0%)	7(47%)	10(12%)
Abuse / neglect	2(2%)	0(0%)	150%	1(50%)	0(0%)	0(0%)

Service Use

Table 25 gives details of how many residents received various health and social services. The majority (67%) had visited their GP in the preceding three months and 28% had seen a district nurse in the past month. Many (49%) had attended hospital outpatient appointments in the past year. Few residents had seen a community psychiatric nurse, psychologist, occupational therapist or physiotherapist in the last three months, few had attended a day hospital or day centre. Home Help provided personal care or cleaning services to 29% of residents but few received meals on wheels.

Table 25. Services received by residents in the time period given.

Services received	Number of residents seen		Contacts of those receiving service	
			Mean	Range
In the preceding month				
Home Help[a]	25	(29%)	15.6	4 - 56
Other regular help	5	(6%)	2.3	0.5 - 4
Meals on wheels	4	(5%)	23	8 - 28
Lunch Club	10	(12%)	4.7	3 - 8
Day Centre	3	(3%)	4.7	2 - 8
Day Hospital	3	(3%)	6.3	1 - 16
District Nurse	24	(28%)	2.1	1 - 8
In the preceding three months				
GP	58	(67%)	1.7	1 - 6
Occupational Therapist	7	(8%)	3.3	1 - 16
Community Psychiatric Nurse	3	(3%)	5.7	1 - 12
Physiotherapist	2	(2%)	5.0	4 - 6
Psychologist	1	(1%)	3.0	-
In the preceding year				
Social Worker	13	(15%)	1.4	1 - 4
Hospital Out patient appt.	42	(49%)	4.4	1 - 16

[a] personal care and/or housework

NEEDS AND RESIDENT FACTORS

Marital Status

Single residents (i.e. those living alone) had significantly more needs (m = 5.6, sd = 4.2) than married residents (m = 3.6, sd = 2.5) (U = 647, p<.05) and significantly more met needs (m = 4.0, sd = 3.0) than married residents (m = 2.5, sd = 1.9) (U = 625, p<.05). However there was no difference between single (m = 1.6, sd = 2.1) and married (m = 1.1, sd = 1.4) residents in the number of unmet needs (U = 823, p=.68). Single people therefore had more needs and a greater proportion of their needs met.

Married residents had fewer needs but Scheme C with the most couples resident had a higher mean number of needs and unmet needs than Scheme A which was predominantly single. The total needs and unmet needs of single residents were compared across the three schemes however no difference was found, nor was there any gender difference in number of needs among single residents. Single people had a higher mean number of all four types of need and of unmet social and physical needs than did married people, but the difference only reached significance level for total number of physical needs (single people m=2.6, sd = 1.7; married m=1.7, sd = 0.9; U = 616, p<.05).

There was a non significant trend for people currently single and living alone to be in receipt of services for more needs than married people were (u=666, p=.07). Single people did receive family help with significantly more needs than married people did (t(84.02) = 2.5, p<.05 unequal variances).

Age & Gender

No difference was found between men and women with respect to their total number of needs, nor their number of met and unmet needs. There were no significant

differences between men and women with respect to any type of need or any type of unmet need.

There was no significant correlation between age and number of needs or unmet needs, time resident in sheltered accommodation did not correlate with number of needs or unmet needs either.

Health

As predicted high scores on SHORT-CARE depression, dementia, activity limitation, and somatic symptoms scales were associated with high numbers of needs and of unmet needs (see Table 26). Residents scoring above the cut off on the SHORT-CARE indicating the presence of depression, dementia, or high levels of activity limitation or somatic symptoms had significantly more needs and more unmet needs than those without such health problems (see Table 27).

Having at least one unmet social need was more likely in those with depression ($\chi^2(1) = 15.5$, $p<.001$), clinical levels of activity limitation ($\chi^2(1) = 8.7$, $p<.01$) and clinical levels of somatic symptoms ($\chi^2(1) = 12.5$, $p<.001$). Having at least one unmet psychological need was not any more likely in people with any of these four health problems.

Table 26. Correlations between needs and SHORT-CARE scores.

	Depression	Dementia	Activity limitation	Somatic symptoms
Unmet needs (r_s)	.50***	.41***	.41***	.31**
Met needs (r)	.42***	.47***	.70***	.33**
Total needs (r)	.59***	.54***	.71***	.40***

*p<.05, **p<.01, ***p<.001

Table 27. Comparison of met and unmet needs between residents with and without diagnoses of depression, dementia, serious activity limitation or somatic symptoms.

(*p<.05, **p<.01, ***p<.001)

Depression

	With diagnosis (n=20)		Without diagnosis (n=64)		Significance
	Mean	(SD)	Mean	(SD)	Mann-Whitney (U)
Unmet needs	2.9	(2.5)	1.1	(1.4)	350**
Met needs	5.2	(2.7)	2.8	(2.6)	316***
Total needs	8.1	(4.3)	3.9	(3.1)	281***

Dementia

	With diagnosis (n=7)		Without diagnosis (n=77)		Significance
	Mean	(SD)	Mean	(SD)	Mann-Whitney (U)
Unmet needs	3.2	(3.0)	1.3	(1.7)	145*
Met needs	6.0	(3.0)	3.2	(2.7)	128*
Total needs	9.3	(4.2)	4.5	(3.6)	104**

Activity Limitation

	Above clinical cut off (n=46)		Below clinical cut off (n=38)		Significance
	Mean	(SD)	Mean	(SD)	Mann-Whitney (U)
Unmet needs	2.2	(2.1)	0.7	(1.3)	470***
Met needs	5.0	(2.6)	1.5	(1.4)	171***
Total needs	7.2	(3.4)	2.2	(2.2)	156***

Somatic Symptoms

	Above clinical cut off (n=31)		Below clinical cut off (n=53)		Significance
	Mean	(SD)	Mean	(SD)	Mann-Whitney (U)
Unmet needs	2.4	(2.2)	1.0	(1.5)	496**
Met needs	4.6	(2.7)	2.8	(2.6)	471***
Total needs	6.9	(3.7)	3.8	(3.4)	411***

Social Support

Residents who said they were without a confidant they could trust were more likely than those with a confidant to have at least one unmet environmental need ($\chi^2(1)$ = 6.18, p<.05 Fishers exact test-two tailed) and at least one unmet psychological need ($\chi^2(1)$ = 4.6, p<.05 Fishers exact test-two tailed). Those who said they had nobody to help if they became ill were more likely than those with a potential carer to have at least one unmet social need ($\chi^2(1)$ = 9.7, p<.01 Fishers exact test-two tailed) as were those who reported feeling lonely often rather than sometimes or never ($\chi^2(2)$ = 33.0, p<.001). Residents who did not see their relatives as often as they would like to were more likely than those who were satisfied with the frequency of family visits to have at least one unmet environmental need ($\chi^2(1)$ = 4.7, p<.05) and at least one unmet social need ($\chi^2(1)$ = 8.9, p<.01).

View of sheltered housing

There were small correlations between how positive residents felt about living in sheltered housing and social needs and unmet social needs. Those with more positive views had fewer social needs and fewer unmet social needs (r_S= -.28, p<.01; r_S= -.30, p<.01). Views of sheltered housing did not correlate with numbers of other types of need or unmet need nor with total numbers of need or unmet need. Residents with at least one unmet social need were more likely than those without to feel negative or neutral rather than positive about living in sheltered housing ($\chi^2(2)$ = 14.0, p<.05). They were also more likely to report having less people to talk to since moving in ($\chi^2(1)$ = 5.2, p<.05) and to say they had not made new friends since moving in ($\chi^2(1)$ = 12.0, p<.001). Saying they had not made new friends since moving in was also associated with having one or more unmet environmental ($\chi^2(1)$ = 6.5, p<.05), psychological ($\chi^2(1)$ = 4.6, p<.05), or physical need ($\chi^2(1)$ = 5.9, p<.05).

Summary

No relationship was found between the number of needs or unmet needs and resident gender, age or scheme lived in. Single residents had more needs and more met needs but not more unmet needs. They received services for no more needs than did married people but did receive family help with more needs. Higher levels of activity limitation, somatic symptoms, dementia and depressive symptoms were all associated with higher numbers of needs and of unmet needs. Lack of various types of social support was also associated with having unmet needs.

NEEDS AND SUPPORT NETWORKS

Overall a significant difference between the number of needs experienced by residents with different network types was found ($F(3,74) = 2.8$, $p<.05$). One way analysis of variance with a priori planned contrasts showed that residents with a private or family dependent network had significantly more needs than those with locally integrated or self contained networks (see Table 28). A priori planned contrasts did not show up expected differences between residents with a private and family dependent network or between residents with locally integrated and self contained networks.

As predicted residents with a private network had the highest numbers of unmet needs, and those with a locally integrated network had fewest unmet needs (see Table 28); 50% (8)of those with private networks had at least one unmet need as compared to only 14% (5) of those with locally integrated networks.

Residents with either private or family dependent networks had more of most types of needs and unmet needs and residents with locally integrated networks had fewest of most types of need. These differences only reached significance for physical needs (family dependent most) and unmet social needs (private most) (Table 25).

Unsurprisingly those with a private network needed formal services for the greatest number of needs (m=5.8, sd=3.6) and those with a locally integrated network for the least number of needs (m=2.8, sd=2.4; family dependent m=4.6, sd=3.3; self

contained m=4.4, sd=3.6) (Kruskal-Wallis H(3) = 9.9, p < .05). There was however no significant difference between residents with different types of support network in the number of needs they were receiving services for, although the trend was for those with a private network to be receiving help with the most (m=4.1, sd=3.1) and those with a locally integrated network with the least (m=2.2, sd=2.0). There was no significant difference between residents with different types of support network in the number of needs they were receiving family help with, although the trend was as expected for those with a family dependent network to receive family help with the most needs (family m=3.7, sd=2.5; locally integrated m=2.3, sd=2.7; private m=2.3, sd=3.4; self-contained m=1.9, sd=1.8).

Table 28. Types of need among residents with different support networks.

	Type of support network (n)				Significance
Needs	Private (18)	Family dependent (8)	Self contained (17)	Locally integrated (35)	Kruskal Wallis H (3)
	Mean(SD)	Mean(SD)	Mean(SD)	Mean(SD)	
Unmet	2.7(2.5)	1.8(2.7)	1.4(1.5)	1.0(1.4)	8.1*
Met	4.2(2.8)	4.9(2.3)	3.8(3.0)	3.0(2.7)	1.3[a]
Total	6.8(4.3)	6.8(3.7)	5.1(3.9)	4.0(3.2)	2.8*[a]
Total Environmental	1.8(1.5)	2.1(1.5)	1.2(1.1)	1.3(1.2)	2.9
Total Physical	3.1(1.7)	3.3(1.3)	2.5(1.4)	1.9(1.4)	10.2*
Total Psychological	0.7(1.1)	0.6(0.7)	0.4(0.7)	0.3(0.6)	2.6
Total Social	1.3(1.4)	0.8(1.2)	0.9(1.4)	0.5(0.9)	3.6
Unmet Env.	0.4(0.6)	0.5(1.1)	0.4(0.6)	0.2(0.5)	2.8
Unmet Health	0.9(1.0)	0.8(1.0)	0.3(0.6)	0.4(0.7)	6.6
Unmet Psy.	0.4(0.7)	0.3(0.5)	0.2(0.4)	0.2(0.4)	1.1
Unmet Social	0.8(1.1)	0.4(0.7)	0.5(0.9)	0.2(0.5)	8.7*

[a] = F(3,74) not H. *p<.05, **p<.01

MULTIVARIATE ANALYSIS OF UNMET NEED

In order to investigate the influence of different factors on unmet needs a logistic regression analysis was carried out. The dependent variable was the presence or absence of at least one unmet need. The independent variables entered were chosen as hypothesised predictors of unmet need or because of significant associations found with unmet need in the previous analyses reported here. The independent variables were age, gender, married/single, support network (private/other), presence/absence of a confidant, presence/absence of a helper if sick, whether satisfied or not with family contact, and scores on the SHORT-CARE for depression, dementia, activity limitation and somatic symptoms. All the variables were entered and the relative contributions of each can be found in Table 29. When all the variables were included only dementia score reached statistical significance as a predictor of residents having at least one unmet need.

Table 29. Logistic regression analysis investigating variables associated with having at least one unmet need.

Variable	B	S.E.	Wald	df	signif.	R	Exp (B)
Age	-0.056	0.046	1.501	1	.221	.000	0.95
Gender	0.100	0.674	0.022	1	.882	.000	0.91
Married/single	0.913	0.750	1.481	1	.224	.000	2.49
Private/other network	1.672	1.038	2.593	1	.107	.073	5.32
Having a confidant	0.194	1.129	0.029	1	.864	.000	1.21
Seeing relatives enough	-0.718	0.684	1.099	1	.294	.000	0.49
Having a carer if sick	-1.770	1.068	2.745	1	.098	-.082	0.17
Dementia score	0.645	0.207	9.68	1	.002	.264	1.91
Depression score	0.260	0.158	2.734	1	.098	0.081	1.29
Activity limitation	-0.042	0.064	0.422	1	.516	.000	0.96
Somatic symptoms	0.191	0.161	1.404	1	.236	.000	1.21
Constant	2.763	4.214	0.430	1	.512		

A backwards stepwise selection procedure was used to select out in order those variables which did not make a significant contribution to the goodness of fit of the model. The final results can be seen in Table 30. As a result of this procedure seeing family enough, having a private network, dementia score and depression score remained in the model. Depression was less significant than the others. Seeing relatives enough is a subjective variable and likely to an indication of a person's feelings of isolation. These four correctly classified 80% of the sample according to whether they had any unmet needs.

Table 30. Logistic regression analysis likelihood ratios using backwards stepwise selection procedure for variables associated with having at least one unmet need.

Term removed	Log likelihood	-2 Log L Ratio	df	Significance of Log LR
Seeing relatives enough	-41.8	4.98	1	.026
Private/other network	-41.2	3.65	1	.056
Dementia score	-45.8	12.8	1	.000
Depression score	-40.9	3.15	1	.076

A second logistic regression analysis was carried out without the subjective support or potentially confounding health variables to investigate the influence of having a private support network and demographic variables e.g. age, marital status and gender on the dependent variable of having at least one unmet need. The contributions of these variables in this analysis can be seen in Table 31. Only having a private network was statistically significant as a predictor of having unmet needs.

Table 31. Logistic regression analysis investigating network and demographic variables associated with having at least one unmet need.

Variable	B	S.E.	Wald	df	signif.	R	Exp (B)
Private/other network	1.527	0.684	4.985	1	.026	.160	4.61
Gender	0.074	0.515	0.021	1	.886	.000	1.08
Age	-0.003	0.033	0.006	1	.937	.000	1.00
Married/single	0.258	0.504	0.261	1	.610	.000	1.29
Constant	0.155	2.990	0.003	1	.959		

A backwards stepwise selection procedure was used to select out in order those variables which did not make a significant contribution to the goodness of fit of this model. The final results can be seen in Table 32. As a result of this procedure all variables were selected out except private/other support network. This correctly classified 59% of the sample according to whether they had any unmet needs.

Table 32. Logistic regression analysis likelihood ratios using backwards stepwise selection procedure for variables associated with having at least one unmet need.

Term removed	Log likelihood	-2 Log L Ratio	df	Significance of Log LR
Private/other network	-58.1	5.97	1	.0145

CHAPTER FOUR

DISCUSSION

The present study was a survey of 87 residents of three sheltered accommodation schemes in Harlow with regard to why they had moved in, their health and social needs and their support networks. The most common reasons residents gave for moving to sheltered accommodation were because they or their spouse were in poor health, they could not manage in their old home or they wanted a warden or alarm system. The majority of residents were positive about living in sheltered accommodation. Many but certainly not all made use of 'sheltered' features such as the common room, the communal laundry, the warden and the alarm. A minority of residents were lonely and a small minority were very unhappy with their sheltered accommodation.

Residents had a wide range of needs and varied greatly in the number of needs they had. Environmental and physical needs occurred most frequently and were usually met, psychological and social needs were reported less often but a greater proportion of these were unmet. Needs varied as to whether they were more likely to be met by family, services, either, or both together. Having unmet needs was associated with poor health, and type of social network but not with age, gender, marital status or sheltered scheme.

This chapter starts with a comparison between the residents in the present study and those in previous studies of sheltered housing residents. Residents experience of living in their sheltered scheme and their use of 'sheltered features e.g. warden, alarm and common room is discussed along with the implications of this for sheltered accommodation. The next section explores the needs of the residents and the factors associated with unmet need and draws comparisons with other studies. The implications of the present results for models of the relationship between informal and formal care are discussed. The limitations of the study are then discussed. The chapter concludes with the clinical implication of the results and proposals for further research.

SHELTERED HOUSING

Residents

The mean age of residents (80) in the present study was similar to that found among sheltered residents in Islington (81) (Walker et al, 1998). The majority of Springboard housing association sheltered tenants were also over 75 years (Woolrych, 1998). These ages are higher than those found in earlier studies e.g. 75 (Butler et al, 1983) and 76 (Clapham & Munro, 1988). While not direct evidence this lends support to Anchor Housing Association's findings that the residents of sheltered housing were 'ageing in place' (Riseborough & Ninner, 1994).

The present study found more couples and fewer single households than other studies, 64% lived in single households in the present study as compared to 70% (Butler et al, 1983), 75% (Scottish Office study cited in Fletcher & Minter, 1991), 73% (Woolrych, 1998) and 93% (Walker et al, 1998). The high percentage of single residents in Walker's study may have been because some units were bedsits and less suitable for two people than the flats and bungalows of the present study. The high percentage of singles is also likely to explain their higher percentage of women (77%) as compared to 68% in the present study and 69% in Springboard housing association (Woolrych, 1998). Butler and colleagues found that while 70% were living alone when interviewed only 52% had been living alone prior to moving in (Butler et al, 1983). They reported that sheltered housing was often allocated on the basis of one partner's poor health but because of delays in obtaining a place this frail partner died before or shortly after the move, resulting in many single occupants who were often active and independent and not in need of the extra support sheltered housing is expected to be providing. This was certainly the case for some of the residents in the present study. The present sample may have had more couples because a few couples had recently moved into scheme C following the deaths of single residents.

The mean duration of residence was five years in the present study which is similar to Springboards finding that 55% had lived in their residence for over 5 years. It was a long term housing option. What should happen if residents eventually become

very dependent is an issue debated in the literature (e.g. Fletcher & Minter, 1991). Can people be well supported in sheltered housing, or would a move be more appropriate? The present study did find a few people with a high number of unmet needs. Whether or not these could have been met without a change of residence was not investigated.

Health

The present study found higher rates of depression (24%) than the 12 - 18 % found in many community samples of older people (Copeland et al 1987, Kay et al 1985; Lindesay et al 1989; Livingston et al 1990) possibly due in part to the higher rates of disability than in the rest of the community. This supports Banerjee and MacDonald's (1996) finding that those in sheltered housing were more likely to be depressed than those in the community, however as they only quoted odds ratios their actual prevalence is unknown. The present study's prevalence of depression is lower than the 43% of sheltered residents with depressive symptoms reported by Harrison and colleagues (1990) but they used a measure which may have resulted in an over identification of people with depression. The prevalence of depression reported here was higher than that in the sheltered residents (11%) in Islington (Walker et al, 1998). Their prevalence rate was more similar to that of people living with others although most of the sheltered group lived alone leading the authors to suggest that sheltered housing may have provided a protective effect for people who lived alone, however the present results did not support this hypothesis.

Rates of dementia 8% were similar in the present study to the 9% in the Islington sheltered population (Walker et al, 1998). In the present study mean activity limitation score on the SHORT-CARE was somewhat higher and with a greater variance than in Walkers sample.

Fewer residents in the present study than in other studies reported sight (31%) or hearing problems (23%); in comparison other studies reported: sight 45%, hearing problems 27% (Walker et al, 1998); sight 43%, hearing problems 31% (Butler et al, 1983).

Support networks

According to Wenger (1994) 70% of older peoples networks usually fit into one of the five categories with 25% being borderline between two categories (either genuine borderlines or networks in a state of flux) and 5% are usually inconclusive. The present study found similar percentages, 80% in the five categories, 19% borderline and 1% inconclusive.

The distribution of network types among the residents of the present study was very similar to network distribution in an urban community sample in Liverpool (Wenger, 1994). Slightly more sheltered residents than Liverpool residents had locally integrated or self contained networks, i.e. networks with higher levels of neighbour contact, and slightly fewer had family dependent and private restricted networks which usually have little or no neighbour involvement. It may be that sheltered housing has some impact on type of network with neighbours more accessible, or it may be that people who have contact with neighbours are more likely to chose to move in to sheltered accommodation. It is unknown whether networks where many of the neighbour contacts are themselves elderly function differently to networks where neighbours cover a range of ages. If sheltered accommodation does have an impact on network type this could have important clinical implications as locally integrated networks are associated with fewest risks and private restricted with most risks (Wenger, 1997).

Social Support

No British norms for the OARS exist but there are norms from a large US community sample of people 60 years or over. More of the Harlow sheltered accommodation residents than Americans (*in italics*) had spent time with someone they did not live with at least once in the last week (89%, *70%*) and more had spoken on the phone at least once (89%, *80%*). One the other hand there were more Harlow residents who knew no one well enough to go and visit their home (17%, *3%*) and more felt they did not see there family often enough (45%, *31%*). More Harlow residents were often

lonely (16%, 9%). Aside from the cultural differences there are many other potential differences between the two populations. The Harlow residents were probably older on average and so may have been frailer and have lost more friends which may explain why they knew fewer people well enough to visit and the greater reliance on home based socialising such as the telephone. It may also be why more residents were lonely and felt their family did not visit often enough. The Harlow sample were more likely to live alone which may explain the higher levels of social contact with others outside their household. For most Harlow residents any social contact they have is with people they do not live with and there are opportunities for this on site in the common room, whereas most of the US sample lived with spouses or children and so could potentially have had much social contact with others from their household.

As has been reported here and in other studies (Butler et al, 1983; Williams, 1986) a sizeable minority of sheltered housing residents were lonely despite an increased potential for social contact. There are several potential explanations for this. The move may have broken existing social relations, most reported seeing old friends less since moving. A persons high level of unmet need may make them housebound and isolated (Woolrych, 1998). Social isolation and loneliness may be an integral part of the way a person relates (Williams, 1986), "many people take their isolation with them into old age" (Butler et al, 1983, p192). This hypothesis is supported by the findings of Butler and the present study where the majority reported no change in loneliness upon moving.

In the present study 74% of residents reported making new friends upon moving in. However, while not asked directly, anecdotal evidence was that these were not often friends with whom people met up with in their own homes or outside the unit. Woolrych (1998) comments on the difficulties of making close friends in the sheltered accommodation units he surveyed, because of fears of gossip. Butler and colleagues reported that many maintained earlier friendships but the majority of residents (62%) in the present study reported seeing old friends less. Reasons for this were not asked, it could be due to greater geographical distance between them,

increasing frailty, decreasing finances for travel, or the death of friends. Whether residents still saw friends but less often or saw fewer friends was also unknown.

The maintenance or breaking of old relationships can have important repercussions. A survey of a retirement community in the USA found that the quantity of interaction with friends on site was high but the perceived quality of social support was higher for friends outside the retirement community. Social support from friends in the scheme had no association with levels of depression however social support from friends outside predicted low levels of depression (Potts, 1997). Although it was expected that the beneficial effect of friends in the scheme might increase with time this was not found (Potts, 1997). This is an important factor to consider in making the decision to move, and in planning locations of sheltered schemes.

Residents comments in Young's sheltered housing study (1993) suggested that some families were less involved since their older relative moved to sheltered accommodation. The present results suggest that if this does happen it is only to a small minority; only 18% said they saw their family less since moving and 58% of residents were receiving assistance from their family with tasks such as shopping, cooking and housework. The majority of residents in the present study had family and friends providing social support which most were satisfied with. There were however some residents with very little social contact and a sizeable minority who were often lonely.

Satisfaction with sheltered housing relates as much to what is left behind as to what is now experienced. As found in previous studies (e.g. Butler et al, 1983) the majority of residents were positive about living in sheltered housing. As this was the first question asked there may have been a positive bias to the responses. To counteract this any negative comments made later on were recorded and taken into account in the ratings. However Woolrych (1998) still found marked reluctance to express dissatisfaction despite assurances of confidentiality and independence. In support of the positive rating 90% of residents said the move was a success. As Butler and colleagues (1983) also found a small minority of the present residents were very

negative about living in sheltered accommodation. In the present study too few residents were negative to explore factors significantly associated with feeling this way, but they did have poor health and high levels of need and unmet need. From the comments made some of the negative residents had not wanted sheltered housing and disliked particular sheltered features e.g. having neighbours of a similar age, whereas others had problems with their particular scheme e.g. dirty corridors or a strong smell from an incontinent neighbour.

Alarm

The alarm system had been used by 51% in the last year, occasionally on someone else's behalf. This is more often than other studies, 19% (Butler et al, 1983). The main help provided in the present study was to ring emergency services which would support Butler's assertion that most emergencies could be dealt with without the alarm or warden. Half of Butler's residents reported that the alarm made them feel more secure which is an important function if the case, however they found only 6% recalled increased anxiety when the alarm had been out of action. Butler suggested telephones were what was needed.

Warden

As in previous studies (Butler et al, 1983) few residents reported wanting more help from the warden than they were getting, and wardens were apparently carrying out similar tasks in both studies e.g. occasional shopping, help when ill, posting letters and explaining forms. Twelve residents (14%) wanted the warden to do more for them, nine of them had private or self contained networks. Residents with different types of support networks need different types of social work support (Wenger, 1997), it is likely that they may need different types of help from the warden. Knowledge of support network type which includes location of nearest relatives and level of community involvement could be of use to wardens in predicting the amount and type

of help likely to be requested, it is also the sort of information many residents would be happy to give.

In both the present study and Butlers study 40% of residents reported using the common room more than once a week, in both 62% attended events at least occasionally and 38% never attended activities. It would be interesting to know why non attendees do not go since this is an important distinguishing feature between sheltered accommodation and support to stay at home. It is particularly important if some want to go but feel unable for some reason e.g. unmet needs. In the Springboard study some residents had stopped going because of hearing difficulties as there was no hearing loop system in the common room (Woolrych 1998).

Why people moved to sheltered housing

Butler's study (Butler et al, 1983) found that people living in sheltered housing had formerly occupied older and poorer housing than their contemporaries. Their results supported the idea that these people released larger properties into the housing stock. The present study did not ask where residents had lived before and so the impact of previous housing quality on the reasons given for moving is unknown.

Butler and colleagues (1983) found that the decision to move to sheltered accommodation was often complex and the stories told to researchers in the present study would support that. There were often several reasons for moving, sometimes independent of one another, sometimes interdependent. Sometimes a whole series of reasons arose none of which alone would prompt a move but which together provided the impetus to move (Butler et al, 1983). One man in the present study took the decision to move to sheltered following a medical accident which disabled his wife, because he could not care for her in their old home in the context of his poor mental health, his isolation and their long term estrangement from his children. Occasionally the move to sheltered was one in a long series of moves, the original decision to move lying in the past when the chain of events was set in place, not immediately prior to the most recent move (Butler et al, 1983). One woman in the present study had been

admitted to hospital seriously ill during which time her husband died. Upon discharge it was decided she should live with her daughter in another town, however this did not work out and the woman returned to her old home. She felt unable to cope and moved to a bedsit near her daughter. This she hated and so she returned home again before finally moving into sheltered housing near her daughter.

There is much similarity between the present and previous findings of why people moved to sheltered housing. As Butler summarised it sheltered residents main reasons for moving were housing, health and personal relations. Housing was the reason given by the most (40%) Springboard housing association residents, 37% mentioned moving to make management of their health or disability easier currently or in the future and 23% moved to be closer to their relatives (Woolrych, 1998). In both the present study and the York study of those moving into mixed tenure housing association sheltered accommodation (Oldman, 1990) residents most common reasons for moving were housing problems (39% in both) and poor health or disability (28% in both). In the present study 28% mentioned a warden or alarm as a reason for moving and 13% company of other older people which are similar to the York figures of 30% moving to gain such 'sheltered' features (Oldman, 1990). This is in contrast to Butler and colleagues who found few mentioning 'sheltered' features as reasons, their residents were younger and perhaps in better health. In both the present and the York study problems with previous neighbours or the neighbourhood were cited (16%, 18%). Residents in the present study mentioned spouse's health (24%) as a separate reason to their health. The York residents mentioned finances (22%) and to move nearer family (17%) more often than the present study (finance 1%, family 10%). Seven percent of residents in the present study and 5% in Butler et al's (1983) study moved to stop living with their children.

NEEDS

Such a wide ranging needs assessment has not previously been carried out in sheltered housing but studies which looked at needs for help with activities of daily life reported

similar levels of these needs to those found in the present study. Butler et al (1983) reported that 40% of their sample couldn't shop and 18% could not cook for themselves, in the present study 45% reported a need for help with shopping and or cooking. 44% as compared to 48% of the present sample could not manage the housework. Butler reported slightly higher rates of mobility problems, 59% had problems getting around the flat as compared to 51% needing help with mobility either inside or outside.

Overall 91% of the present study needed help with something. Woolrych (1998) found 51% of sheltered residents in need of help with activities of daily living, but this does not include many of the areas of need covered in the present study and is similar to the percentage with such needs in the present study.

Comparison of needs between sheltered housing and residential care

The present study found that on average sheltered residents had considerably fewer needs than had been found in residential care or continuing care residents in Harlow (Martin, 1998). However there was some overlap in the total number of needs of those most in need in sheltered housing and least in need in residential care. There were a greater percentage of residential care residents than sheltered housing residents with most types of need. However more sheltered than residential care residents (80%, 41%) reported needs for physical health (usually prescription medication) and sight / hearing (37%, 21%). Perhaps people whose difficulties are primarily physical health related move to sheltered and those primarily with mental health or cognitive impairment causing difficulties go to residential care?

Almost all residential or çontinuing care residents (96%) had one or more unmet need (Martin, 1998); only 59% of sheltered housing residents did. The mean number of unmet needs per resident however, were not that different: 1.5 in sheltered housing; 2.6 in residential care; 2.3 in continuing care. Common unmet needs experienced by residents in both sheltered housing and residential care included mobility (17% of residents in sheltered housing, *24% in residential care*), company

(14%, *24%*), psychological distress (12%, *24%*), and daytime activity (10%, *33%*). Common unmet needs in sheltered housing but not residential care included sight / hearing (12%) and information about treatment (12%). The following needs were often unmet in both settings; psychological distress (59% of these needs unmet in sheltered housing and *57%* in residential care); company (52%, *35%*); intimate relationships (58%, *23%*); activity (40%, *56%*); sight / hearing (31%, *43%*); mobility (34%, *25%*). Many residents of residential care also had an unmet need for help with their memory (*85%*), no one with this need had it met. In sheltered housing only one of the 8 with this need had it met.

In summary the populations of sheltered housing and residential care were different in terms of number of need per resident. However in both types of provision physical and environmental needs were identified most often and greater proportions of these needs were met than of psychological and social needs. With regard to residential care Martin (1998) hypothesised that physical and environmental needs are considered more important or easier to meet than social and psychological needs e.g. company, activity and that the perceived more difficult to meet needs are neglected in a form of informal rationing. In sheltered housing there may be the assumption that the presence of the warden and neighbours nearby, and the social activities on site would meet social needs. This was the case for some, one lady previously living alone and housebound with agoraphobia still had such difficulties following her move but felt fine within the confines of the building which gave her over 30 neighbours with whom she could potentially have contact without causing herself distress. Her social needs had been met and she was very happy with her new life. Others clearly did not receive satisfactory social support from within the scheme and had unmet social needs.

Factors associated with need and unmet need

The present study found that married people had fewer needs overall than single people but there was no significant difference between them in the mean number of unmet needs. This is probably because needs met by spouses are often invisible as

needs e.g. company, housework. Couples often seemed to compensate for each others difficulties and were able to do more together than either could alone e.g. if only one could manage money and planning and the only the other could carry heavy bags then together they could shop which neither could have done alone. It may only be when a partner becomes unable to maintain their role that needs become apparent. The only type of unmet need that single residents did have significantly more of than married people was unmet physical health needs. There are a number of potential explanations. It could have been a gender difference as most single people were women but no gender difference was found. The mean number of physical health needs for married people could have been lowered by healthy spouses who moved in with frailer partners which was the case for some of the residents interviewed. The very old were usually single women likely to have more unmet physical health needs and they may have skewed the mean. Many of the physical needs related to taking medication and being monitored by GPs; it may be that married people benefited from a spouse to remind them to take medication, notice side effects and accompany them to the GP.

Surprisingly increasing age was not associated with increasing numbers of needs or unmet needs. Anecdotal evidence suggested that people under 70 only moved in to sheltered accommodation if they were severely disabled or had a life-threatening chronic illness. This is likely to have obscured the effect of increasing need with increasing age which might be expected on an individual level.

Residents with depression, dementia, and serious activity limitation were more likely to have more needs, more met needs and more unmet needs than those without. Badger (1998) found depression was a significant predictor of need for mental health services, and financial assistance. Depressed older adults used and needed more medical services but used less social and recreational services than those without depression (Badger, 1998) because of the common association of depression and physical ill health. Allen and Mor (1997) also found high depression scores were associated with having unmet needs for help with ADL and IADL. They suggested that even seemingly minor unmet needs such as a messy house or infrequent baths might

have serious quality of life implications e.g. it may be possible to cope with such things in the short run but having to live with them longer term may trigger depression which in turn may exacerbate poor physical health. As well as a consequence of unmet needs, depression could have been a cause of unmet needs as it influenced relationships and self meeting of needs. It is most likely however, to be both consequence and cause. Teasing this out was not possible in this study and other factors are also likely to have been part of the equation.

Depression, activity limitation and somatic symptoms were all significantly associated with having at least one unmet social need. Surprisingly the present study did not find associations between any of the four health problems and having at least one unmet psychological need. This may have been because psychological needs were reported less often; perhaps reflecting greater reluctance to tell a stranger about these than other types of need.

The findings of the present study lend support to Wenger's (1997) work linking network type and health outcomes and risk. The present hypotheses, based on her work, were supported by the results: residents with a private or family dependent network did have more needs than those with a locally integrated network, and only those with a private network had more unmet needs as those with a family dependent network had family around to identify and meet many needs. Private networks were expected to be associated with high levels of need because: residents with these networks often have long-standing personality disorders or mental health problems; and private networks can result from shifts in other types of network in the event of the older persons increasing dependency (Wenger, 1997). Private networks and not family dependent networks were expected to be associated with high numbers of unmet needs because needs tend to only be identified when there is a crisis due to the social isolation of the older people with private networks. As people with locally integrated networks usually have local family and regular contact with family, friends and neighbours they are associated with least risk (Wenger, 1997); as expected they

had fewest needs overall and fewest unmet needs, presumably because family and friends could help identify and meet needs.

Logistic regression analysis found that depression scores, dementia scores, having a private support network and being satisfied with frequency of contact with relatives were the only predictors of residents having one or more of their needs unmet. This suggests that people in sheltered accommodation with mental health problems are particularly likely to have unmet needs. In addition the absence of an adequate support network and lack of satisfactory contact with relatives is also associated with needs remaining unmet.

There was a small positive correlation between the numbers of met needs and the numbers of unmet needs however logistic regression analysis found that number of met needs was not a significant predictor of unmet needs. Having more met needs might be expected to be associated with having more unmet needs if both were a function of total number of needs, alternatively high numbers of met needs might be associated with low numbers of unmet needs if a range of needs had been identified simultaneously or if those meeting some needs identified and helped meet other needs as they arose.

Allen & Mor (1997) uncovered a number of negative consequences of unmet ADL and IADL needs which included missed doctors appointments and social activities, hunger, falls, infrequent bathing, wetting and soiling and distress, all of which highlight the importance of understanding factors associated with unmet needs, and the need for further research on how to ensure a greater proportion of needs are met.

Who was meeting the needs that were met?

Many residents (58%) in the present study were receiving family help, e.g. 51% with shopping and 26% with housework. Fewer residents in Springboard housing association sheltered schemes received family help (25%); their other sources of help with ADL were Social Services (15%), Private services (15%) and Springboard (4%)

(Woolrych, 1998). In the present study single residents received help from their family with more needs than married people did, but they did not receive help from services with more needs which supports previous findings that adult children and other close family are more involved when there is no spouse present (Wenger, 1997).

The present study found similar levels of GP contact to other studies; 67% of the residents in Harlow sheltered schemes had seen their GP in the last three months, this compares to 55% of the residents of sheltered schemes in Islington who had seen their GP in the last month (Walker et al, 1998). Despite higher levels of depression and activity limitation the present study found lower levels of home help (29%) and meals on wheels (5%) use than in other studies, levels which are closer to community levels for home help (15%) and meals on wheels (5%), rather than sheltered housing levels of 71% and 34% respectively reported by Walker et al (1998). Watson reported that 79% received home help and 13% meals on wheels (Watson et al, 1990); Butler reported that 34% used home help and 16% meals on wheels (Butler et al, 1983). Although there was no community comparison it does not seem likely that the preferential allocation to sheltered residents was happening in Harlow to the same extent as suggested by others (e.g. Walker et al, 1998). Harlow may have different priorities for service provision, but this is unknown. Butler and colleagues (1983) reported that many residents received help from family, as did the present study, which might be another explanation for lower use of home help and meals on wheels. The number receiving family help in Walker's and Watson's studies is unknown and so comparison cannot be made.

Several different models have been put forward to explain the links between informal care from family and friends and formal care from health, social and private services (for a review see Denton, 1997). The task specific model (Litwak, 1985 cited in Denton, 1997) suggests that the task determines the source of care. The substitution model suggests that as formal services are provided there is a decrease in informal care. The majority of relevant studies do not support either of these models (Denton, 1997). The compensatory model (Cantor, 1991 cited in Denton, 1997) argues that only

if assistance is not available from the informal network do older people chose to use formal care. Formal care has been found to compensate for absence of a spouse or child carer but not other informal sources of help (Denton, 1997). The supplementary model of care hypothesises that formal services supplement informal care when needs exceed informal resources. The complementary model includes both compensatory and supplementary functions of formal services. Formal care is accessed when crucial elements of informal care are missing or when need is great (Denton, 1997).

Denton's (1997) findings supported the complementary model. Most help with ADL was provided by informal helpers. Formal help was most common with housework and personal care, these were also the areas where a small minority of people were receiving help from both sources. Another study found that when in need most older people accessed informal help, although a few accessed formal services and a few, those in poorest health, used both (Peek et al, 1997).

The findings of the present study discount the task specific model as described above but certain needs were more likely to be met by particular sources of help. The majority of needs in the present study were met in some cases by family, in others by services and in others by both together. There were however, certain needs which were more likely to be met by family e.g. money, shopping / cooking, psychological distress and relationships; others were more likely to be met by services e.g. accommodation, activity, and continence. The present study did not test the other models directly as it was cross-sectional and did not ask which source of help people preferred or why they used services if they did. There was however some support for the compensatory and supplementary functions of the complementary model. Comments made by residents suggested that certain needs were met by services because they had no family able to meet them e.g. caring for the home tended to be met by either by services or family but not both. Some needs were usually met by a combination of family and services where the need had wide repercussions on daily life e.g. sight / hearing, physical health and taking medication. As Denton (1997) also found the extent of formal care varied with the task.

The linkages between informal and formal care are obviously complex. Most studies in this area have only looked at environmental and physical needs. In addition to these the present study looked at social and psychological needs, but the numbers were small for many of these needs and so the results must be interpreted with caution. There may be different models for the linkages between sources of help for such needs and this is an area for further research.

While not addressed in the present study other studies have found that once older people started receiving care they continued to do so for a long time but the composition of the care-giving network changed over time with respect to the use of informal care, formal care or both (Peek et al, 1997). Women had a greater likelihood of using formal care exclusively. Race and place of residence, urban or rural, influenced the likelihood of using exclusively informal care. Older and frailer people were more likely to use a mix of sources of care (Peek et al, 1997). In the present study as expected those with a private network required formal services for the greatest number of needs and those with a locally integrated network for the least number of needs. This fits in with previous findings that older people with private restricted networks were over represented on social services' caseloads (Wenger, 1994; 1997).

LIMITATIONS OF THE STUDY

The present study had both strengths and limitations. It had an excellent response rate (98%) and the use of cluster analysis to choose three schemes that differed from one another mean the results should generalise to other sheltered schemes with wardens in Harlow and beyond. The similar results in terms of needs, unmet needs and social networks support this. While the present study is the only one known into needs and networks in sheltered housing the many similarities between the present studies and others with overlapping areas of investigation in both local authority and housing association sheltered accommodation lend support to the generalisability of its findings.

The similarity in common needs and unmet needs between sheltered and residential care supports the validity of the present results. The similar distribution of support networks and their relationship to service use in another urban sample also lends supports to the validity and generalisability of the present results. Overlapping questions were used in the present study as recommended, to improve reliability of results (Reviere et al, 1996) e.g. who helps with each need and what help do your family give you. However a balance must be struck as it can become too time-consuming for participants. Asking the questions about health and social support first, improved the quality of information collected by the CANE.

The sample was a homogeneous sample with respect to ethnicity, education, socio-economic status, age and housing provider. While advantageous for looking at relationships between the variables it does potentially limit the generalisability of the results. The present study was cross sectional and measures were taken at one time point so no consideration could be taken of the dynamic relationship between needs and network type. Thus the present results reveal only associations and not causal links.

Self report as a way of obtaining information brings its own benefits and disadvantages. In the case of the present sample residents were the people most knowledgeable and available to discuss their needs. However ideally staff, carer and the person's view of needs should be assessed separately as they have been found to differ, with the person themselves reporting least needs (Reynolds et al, 1999). Therefore the present results are likely to be an underestimate of the overall number of needs and unmet needs. Some residents did have obvious cognitive impairment or other conditions likely to have decreased the reliability of their responses. A few residents felt some of the questions were too personal and declined to answer them, it may be that some needs e.g. environmental ones were easier to admit to than others e.g. psychological ones. Most residents however, were willing to answer all questions. Unmet needs may alter a persons perceptions of the magnitude of other problems and the reporting thereof. Many interviews were carried out with spouses present. This

may have both increased and decreased reliability. On questions about social support, caring, low mood or testing orientation of the second spouse reliability may have decreased if people felt less free to speak openly. One married man who was interviewed without his wife cried for much of the interview about his fears for his wife's health and how he did not want to burden her with the knowledge of the seriousness of her condition. He was unlikely to have spoken so freely had she been there. In other instances a spouses presence improved reliability especially where someone had cognitive impairment or was deaf and communication difficult. When it came to remembering contacts with services and who helped with what two heads were often better than one.

Although the CANE's wide coverage should have minimised this, residents may not have reported problems for which they knew of no intervention that could help e.g. accommodation adaptations to ameliorate housing and mobility problems.

There will always be some differences between researchers in the use of a semi structured interview such as the CANE, but this was minimised by training and discussion about ambiguities. In some cases the distinction between no need, met and unmet need became blurred. These were discussed and consensus between the interviewers was almost always achieved. However, sometimes the distinction could be difficult e.g. at what point does loneliness, despite family visits, move from (partially) met need to unmet need. The heuristic used was would this merit intervention if this was our patient.

Seriousness of need was not recorded beyond reaching the threshold for a need e.g. someone who needs meals provided has a greater need than someone only able to shop for a small amount at a time and unable to buy heavy things such as cleaning materials. Seriousness could be important for providers prioritising the meeting of unmet needs following identification. There can be overlap of need for example someone's psychological distress may be met by direct intervention, or by meeting a need for activity or company or intimate relationships. Some needs may only be identified as such if they are unmet, for example a need for company met by family may

not be identified as a need. This may partly explain why there were fewer social needs reported but more were unmet than physical or environmental needs. Social and psychological needs are also less visible than needs such as food or housework and this may be why they are less met, there may also be lack of knowledge of ways of meeting needs or some stigma with requesting such help. It may also be informal rationing (Martin, 1998). Needs were defined as requirements for help from others, this meant residents were not asked about needs they were meeting themselves e.g. buying their own walking stick or incontinence pads. This may be important information as a difficulty in one area e.g. mobility could have a knock on effect on people's ability to meet their other needs. Needs being self met are probably the most likely problems people will eventually need help with.

The exploratory nature of the analysis into factors associated with unmet needs of different types and the small numbers with some types of need does mean some of the results must be interpreted with caution and the possibility of Type I errors must be borne in mind.

Some residents had recently moved into sheltered housing and so the reasons they gave are likely to be fairly valid, others however had moved in several years previously and may have forgotten some of the contributing factors to their decision to move. Their experience of living in sheltered accommodation is also likely to have affected their response particularly in terms of their rating of the importance of sheltered features such as the warden and social activity.

CLINICAL IMPLICATIONS

Orford (1998) presents the task of community clinical psychology as understanding the connection between the social and economic reality of people's lives and their states of health and well-being; with others giving voice to this understanding; and engaging in collective action to change these realities. The present results have added to the knowledge about the connection between people's health, needs and their social reality

and they have several implications for clinical psychology practice. Only one resident had seen a clinical psychologist in the preceding year, despite 24% having a diagnosis of depression and 8% dementia. Individual approaches focusing on private distress make up much of the work of clinical psychologists but alone these will never be able to meet the psychological needs of the community. For this reason, clinical psychologists are frequently involved in working in a consultative role with others aiming to meet people's psychological needs. The present results highlight several areas in which clinical psychologists could provide a useful psychological consultancy service to wardens and sheltered housing providers.

Clinical psychologists could provide training to wardens in recognising possible depression, anxiety or dementia and equip them with the skills and knowledge to help residents access appropriate services. Other professionals could provide information to wardens on when and how to encourage residents to access other health, housing or social services.

Loneliness was commonly reported by sheltered housing residents. Psychological and social needs were often unmet. Clinical psychologists have the skills to assess psychological and social needs, plan interventions and evaluate the outcomes. They could support wardens in assessing the current level of social participation and the barriers preventing participation when it is desired. People may not attend for social reasons e.g. too many women and too few men, class differences (Young, 1993) or different interests. Disability may also make it difficult e.g. wheelchair access, deafness (Woolrych, 1998) or cognitive impairment. Interventions to raise participation in activity with recently bereaved or disabled older people have shown that increased engagement significantly decreased distress (Reich & Zautra, 1989) and so clinical psychologists could work with wardens to develop ways of increasing participation in social activities. It would be particularly important to monitor participation and to check why regular attendees stop attending. Psychologists' research skills would also be useful in evaluating outcome in terms of social participation and psychological distress.

Training wardens in dealing with difficult group dynamics is another potentially useful area of input from clinical psychologists. Resident groups are a potentially complex mix of people and sensitive support of the residents' committees, where in existence, is important. Considerable bad feeling arose in one of the schemes studied when some residents said they did not want the more disabled residents to come to activities and so set up a club off site which those disabled were unable to walk to. Not an easy situation for a warden to deal with. Splits in resident groups have also been reported elsewhere (Young, 1993).

Group interventions while valuable are not the way to meet all social and psychological needs. A clinical psychologist working with older adults in Nottingham found that many of those on his caseload basically needed companionship but did not want to or feel able to attend group activities (Jewell, Wurr & Zadik, 1997). In collaboration with the voluntary sector he set up Kindred Spirits, a project to help isolated older people. Older people are put in touch with an other who shares a similar interest (Jewell, Wurr & Zadik, 1997). Company and activity were common needs among residents of sheltered housing and clinical psychologists could have a role in helping develop projects similar to Kindred Spirits in sheltered housing schemes, with the warden putting residents in contact with others who share the same interests. As Rook (1991) puts it 'friendships may emerge more easily from shared activities and projects than from interactions focused overtly on friendship formation' (cited in Potts, 1997). Although never a goal over time Kindred Spirits found that those people who had made contacts to share interests with, became more interested in meeting in groups (Jewell, Wurr, Zadik, 1997). Making acquaintances with shared interests could mean residents become more likely to attend social events in the common room, thus having individual and group contact which may help meet their needs even more comprehensively.

Clinical psychologists could also make a valuable contribution to the assessment processes used to select residents for sheltered housing by disseminating and interpreting relevant research findings e.g. that maintaining contact with old friends

influences severity of depression (Potts, 1997) and therefore issues of friendship and social contact should be explored during assessment for a move to sheltered housing. Areas covered in assessment could include interest in maintaining contact, preferred means of doing so, transport links and the ability to use them and the proximity of friends. Unless a request for a move to a new location is made people should stay as close as possible to their social network as distance becomes increasingly important with increased frailty. Maintenance of social links also has implications for town planning to site schemes and bus routes close together.

The present results also have implications for clinical psychologists' practice with individual older adult clients and not just sheltered residents. Those in this sample had a range of functional abilities and a variety of difficulties making them not unlike the general population of older people in many ways, and probably not that different from many of those on psychology caseloads. Private restricted support network are associated with long-standing personality problems and are common on social workers caseloads, and probably psychology case lists too Private support networks and diagnoses of depression and dementia were variables associated with having unmet needs of various types. Therefore many clinical psychology clients are likely to have one or more unmet needs. Given the potentially serious consequences of unmet needs and the links between social support deficits, physical ill health, environmental problems and psychological distress Clinical psychologists need to assess network type and unmet needs, environmental, physical, and social as well as psychological needs. Clients can then be helped to meet unmet needs through joint problem solving and facilitating access to services. Jackson and Mittelmark (1997) suggested screening older people for unmet needs when they come into contact with services e.g. primary care, day centres and emergency services.

The present study supports Riseborough & Ninner's (1994) finding that the population in sheltered accommodation schemes is now older (cf. Butler et al, 1983) but did not address whether this means increasing dependency. The population in residential and continuing care have apparently become more dependent over time

(Martin 1998) and so it is likely that this has happened in sheltered housing also. If this is the case there are implications for allocation policy and the warden's role and training.

While not at immediate risk of institutionalisation the population in sheltered housing do have important unmet needs that could compromise their ability to remain independent. Wardens could be provided with information about common unmet needs among residents.

Springboard housing association residents felt there was not enough going on in their schemes (Woolrych, 1998). They identified a number of potential obstacles: lack of leadership and staff time, increasing age and frailty among the residents, lack of interest from other residents, and changing times with more passive individualised entertainment available e.g. television. Others reported that it was the active and able who did not attend activities on site, but rather socialised elsewhere (Clapham & Munro, 1988); they also found that schemes with more dependent older people were just as lively and sociable as those with a less disabled resident group. The impression gained from the present study was that the most active and well residents did socialise off site rather than with fellow residents. Woolrych (1998) said that the common rooms were underused and suggested they be made available for outside use such as a luncheon club for older people. Butler and colleagues (1983) found places where this was happening and in these schemes residents were generally in favour. In schemes where this did not happen opinion was more divided. There are certainly potential benefits for residents with more going on although this would need to be carefully managed.

Others ideas for wardens include facilitation of taxi share schemes and joint shopping trips for those wanting more social contact or lacking the confidence or finances to go alone.

In common with many local authority schemes the ones selected in the present study had resident wardens although Harlow also has schemes visited by wardens resident elsewhere. Springboard housing association no longer have wardens on site,

instead they have project managers and a support line alarm system which residents can contact and whose staff visit the scheme regularly. As the present study was only of residents living in sheltered accommodation schemes which had a warden resident on site comment cannot be made on the issue of on site wardens or non residential project managers. Most of the suggestions above could be carried out by either. It is also important to remember the role of management in supporting any changes in a warden's role. The present study only asked what the warden did for people on an individual level and it may be that the wardens already carry out some of the suggestions given above.

Butler (1983) found that few residents had had the warden's role explained and suggested this would be useful for residents. Family and service providers would also benefit from such information as wardens in the present study commented that the expectations placed on them by those outside were often beyond their job description. In such situations wardens had to knowingly leave needs unmet or do more than they were employed or even allowed by their employer to do.

The present results thus have implications for clinical psychology practice with individuals and in providing consultancy services to others. The present results also have implications for the warden's role and housing provision policies and practice.

FURTHER RESEARCH

The present study highlights several areas in need of further research: the determinants and consequences of met and unmet need particularly social and psychological needs, and longitudinal investigation of the interactions over time between different types of unmet need and of interactions between unmet need and network type. A number of current policy issues would benefit from being informed by research e.g. allocation of places, wardens role, support of frail older people, apparent increasing age and dependency in the sheltered population, and the cost implications.

Exploration of potential determinants of different unmet needs is necessary e.g. health, support network, social support received, availability and affordability of formal services, personality, age, gender, marital status, socio-economic status, educational background and knowledge of services and of preventative health measures.

Needs are likely to change over time as people become ill or recover from illness or other life events befall them and those close to them. Exploration of the impact of unmet needs on the development of other needs would be of interest. It is easy to imagine how an unmet mobility need could lead to psychological distress or need for company. Associations have been found between unmet needs and transportation problems as these make it difficult to meet personal needs and access community services (Jackson & Mittelmark, 1997). Woolrych (1998) found that some residents in sheltered housing were housebound and isolated because of unmet needs. Further research on links between different types of need and common comorbidity of needs would be interesting. Martin (1998) suggests some needs may be mutually exclusive, e.g. someone with severe dementia in residential care would probably not have access to alcohol to abuse. Understanding how and why needs change over time is important if needs are to be met. Understanding the links with network type would hopefully produce ways of supporting the different networks so they function well and meet the needs of older people.

A residents support network has a large influence on service use (Wenger, 1997). Further exploration of associations between network type, who meets needs and the type of help wanted from the warden would be useful. Longitudinal research is needed to investigate causal links between needs and networks. Networks affect who is available to provide help. It may be that the type of network a resident has makes them more or less vulnerable to needs, or alternatively that needs affects network type and the sorts of relationships a person is able to maintain. Both could be happening. A small percentage of networks do change every year, usually in predictable ways, and often in response to the older person's increased dependency (Wenger, 1994).

Some residents had very little social contact and a sizeable minority were often lonely. Social and psychological needs were frequently unmet. The present study found a trend for residents with a private network to be less likely to report making friends in the scheme, the small numbers however mean this must be interpreted cautiously, but it would be an area worthy of further exploration. Further research into how this group of residents fare in sheltered housing would be useful, such older people have been reported to make poor adjustment to residential care (Wenger, 1997) and they may have similar problems in sheltered housing. Alternatively given the common problems in residential care it may be that supporting them in sheltered housing is a good option.

Development and evaluation of interventions to meet needs in sheltered housing would benefit residents e.g. how is it possible to shift support networks to a more supportive type e.g. from private restricted to wider community focused? Can networks be strengthened and isolation decreased? Can wardens have an impact on the numbers of unmet social and psychological needs?

The relationship between needs and whether they remain unmet and the following physical and social environmental factors would also be worthy of research: the layout and location of the scheme, the type of housing e.g. flats or bungalows, access, lighting, public rooms, activity level and policies concerning allocation, resident participation in organisation ,dealing with problem behaviour, and dependency. This would be of use to town planners, architects the local council and those managing sheltered housing schemes:

Housing need was one of the most common reasons residents gave for their move and some openly expressed that they would have preferred a better home but not a sheltered one. Others did not mind but were not looking for the features found in sheltered schemes. Thus able residents were living in the scheme who were not in need of support. This fits with the policy of maintaining a balance of dependency levels in the schemes. However this means people may be receiving services they are not in need of, and that some of those in need of sheltered housing are having to wait a long time for it. Clapham and Munro (1988) research concluded that the policy of balance

should be abandoned as the arguments for it were no longer valid. The issue of warden workload could be met by increasing staff; and there was no evidence of active tenants helping the more dependent or contributing more to the social life of the scheme. Further research is needed into whether the policy of balance is most effective and efficient or whether increasing staff and only taking in less able residents is a better option

Sheltered residents are ageing so it is important to monitor levels of dependency, needs and unmet needs as there are potential implications for allocation policy and the wardens role. A related issue is care of the frail elderly, including those who become more dependent after moving in to sheltered accommodation. Are these people's need best met by a further move or can they generally be well supported in situ and up to what point? Will meeting physical and environmental needs be at the expense of psychological and social needs? Investigation of the reasons people move out of sheltered housing would inform this debate. Do they move out of choice or necessity? Woolrych (1998) found that no sheltered residents wanted to go to residential care if they became too frail, but some would consider extra care sheltered housing.

The relationship between needs and people's decision to move in originally would be of interest to service planners and providers in housing health and social services. Some of the present residents had recently moved in ,others had lived there for years. While the present study gives a snapshot of needs it does not reveal the needs that may have prompted people to move in, and whether certain needs were better met in sheltered housing and others less well met than before, nor does it plot the development of needs once there and how these are met if they are.

The homogeneity of the present sample limited generalisability. It would be interesting to assess needs and networks in inner city and rural areas and in sheltered accommodation of providers other than local authorities e.g. housing associations and private schemes. Comparisons could also be made between schemes with different tenures such as rented or owner occupied. A study of needs and networks in extra care

or very sheltered and in sheltered housing for particular ethnic groups would add to the present study.

CONCLUSION

The present study aimed to explore why people moved to sheltered housing, what their experiences of living in sheltered housing were, and what use they made of sheltered features e.g. warden, alarm and common room. It found that older people reported moving to sheltered housing most often because of their or their spouses poor health, because they were having problems with their old home no longer being suitable e.g. stairs, and because they wanted to have a warden or alarm system available should the need arise. Most residents were positive about their experience of living in sheltered housing.

The present study also aimed to explore needs and investigate those factors associated with unmet needs. Residents of sheltered housing were generally found to have the majority of their physical and environmental needs met, but psychological and social needs, although less frequently reported, often remained unmet. A number of factors were associated with having unmet needs e.g. mental health problems, aspects of social support and type of support network. These findings have implications for the practice of those working in sheltered housing and their management, as well as for the practice of those working in mental health and social services. Although there is a need for further research to improve our understanding of the needs of older people and how they can best be met the present results do suggest ways psychological and social needs may be better met and the quality of life improved for older people in sheltered housing.

REFERENCES

Abraham, I.L., Buckwalter, K.C., Snustad, D.G., Smullen, D.E. (1993). Psychogeriatric outreach to rural families: The Iowa and Virginia models. *International Psychogeriatrics, 5,* 203-211.

Age Concern (1998). *Older People in the United Kingdom: Some basic facts.* Age Concern England.

Allen, S.M. & Mor, V. (1997). The prevalence and consequences of unmet need: Contrasts between older and younger adults with disability. *Medical Care, 35(11),* 1132-1148.

Andersson, L. (1985). Intervention against loneliness in a group of elderly women: An impact evaluation. *Social Sciences and Medicine, 20,* 355-364.

Arnetz, B.B. (1985). Gerontic occupational therapy - psychological and social predictors of participation and therapeutic benefits. *American Journal of Occupational Therapy, 39,* 460 - 465.

Asada, T., Kariya, T., Kitajima, E., & Kakuma, (1994). Falls among community dwelling psychogeriatric patients. *International Journal of Geriatric Psychiatry, 9,* 17-23.

Auslander, G.K. & Litwin, H. (1991). Social networks, social support and self ratings of health among the elderly. *Journal of Aging and Health, 3 (4),* 493-510.

Badger, T.A. (1998). Depression, physical health impairment and service use among older adults. *Public Health Nursing, 15 (2),* 136-145.

Baldwin, S. (1986). Problems with Needs - where theory meets practice. *Disability, Handicap & Society, 1 (2),* 139 - 145.

Banerjee, S. & MacDonald, A. (1996). Mental disorder in an elderly home care population: Associations with health and social service use. *British Journal of Psychiatry, 168,* 750-756.

Barker, J.C., Mitteness, L.S., & Wood, S.J. (1988). Gate-keeping: Residential managers and elderly tenants. *The Gerontologist, 28,* 610-619.

Bebbington, P.E. (1990). Population surveys of psychiatric disorder and the need for treatment. *Social Psychiatry and Psychiatric Epidemiology, 25,* 33-40.

Bebbington, P. (1992). Assessing the need for psychiatric treatment at the district level: The role of surveys. In G. Thornicroft, C.R. Brewin, and J. Wing (Eds), *Measuring Mental Health Needs.* London: Gaskell.

Black, B.S., Rabins, P.V., German, P., McGuire, M. & Roca, R. (1997). Need and unmet need for mental health care among elderly public housing residents. *The Gerontologist, 37,* 717-728.

Blazer, D.G. (1982). Social support and mortality in an elderly commmunity population. *American Journal of Epidemiology, 115,* 684-694.

Blazer, D. & Williams, C. D. (1980). Epidemiology of dysphoria and depression in an elderly population. *American Journal of Psychiatry, 137,* 439-444.

Bowling, A. (1994). Social networks and social support among older people and implications for emotional well-being and psychiatric morbidity. *International Review of Psychiatry, 6 (1),* 41-58.

Bradshaw, J. (1972). A taxonomy of social need. In G.McLachlan (Ed.) *Problems and Progress in Mental Health Care, 7th Series.* London: Oxford University Press.

Brewin, C.R., Wing, J.K., Mangen, S.P., Brugha, T.S., MacCarthy, B. & Lesage, A. (1988). Needs for care among the long term mentally ill: A report from the Camberwell high contact survey. *Psychological Medicine,* 18, 457-468.

Brewin, C.R. (1992). Measuring individual needs for care and services. In G.Thornicroft, C.R. Brewin & J. Wing *Measuring Mental Health Needs*, pp220-236. Gaskell.

Brown, K., Williams, E.I. & Groom, L. (1992). Health checks on patients 75 years and over in Nottinghamshire after the new GP. contract. *British Medical Journal, 305,* 619-621.

Brugha, T., Bebbington, P.E., MacCarthy, B., Sturt, E. & Wykes, T. (1987). Social networks, social support and the type of depressive illness. *Acta Psychiatrica Scandinavica, 76,* 664-673.

Butler, A., Oldman, C. & Greve, J. (1983). *Sheltered Housing for the Elderly: Policy Practice and the Consumer.* London: Allen & Unwin.

Caring for people: Community Care in the next decade and beyond. (1989) DH/DSS/Welsh Office/Scottish Office. London: HMSO.

Cassel, C.K. (1994). Researching the health needs of elderly people. *British Medical Journal, 308,* 1655-1656.

Chapell N.L. & Badger, M. (1989). Social isolation and well-being. *Journals of Gerontology, Social Sciences, 44,* S169-176.

Clapham, D. & Munro, M. (1988). *A Comparison of Sheltered Housing and Amentity Housing for Older People.* Edinburgh: Scottish Office.

Cohen, C.I., Teresi, J. & Holmes D. (1985). Social networks, stress, adaptation, and health. *Research on Aging, 7,* 409-431.

Copeland, J.R.M., Dewey, M.E., Wood, N., Searle, R. & Davidson, I.A. (1987). Range of mental illness among the elderly in the community: Prevalance in Liverpool using the GMS-AGECAT package. *British Journal of Psychiatry, 150,* 815-823.

Denton, M. (1997). The linkages between informal and formal care of the elderly. *Canadian Journal on Aging, 16,* 30-50.

Department of Health Social Services Inspectorate (1991). Care Management and Assessment: Practitioners Guide. London: HMSO.

Donabedian, A. (1974). The assessment of need. In *Aspects of Medical Care Administration.* Harvard University Press. Cited in Hamid, Howard & Silverman, 1995.

Dykstra, P.A. (1990). *Next of nonkin:The importance of primary relationships for older adults' well-being.* Amsterdam: Swets & Zeitlinger.

Fennell, G. (1986). *Anchor's Older People: What Do They Think?* Anchor Housing Association.

Fillenbaum, G. (1978). Multidimensional Functional Assessment: The OARS methodology. A Manual. Durham, North Carolina: Duke University Centre for the Study of Aging and Human Development.

Fillenbaum, G. & Smyer (1981). The development, validity and reliability of the OARS Multidimensional Functional Assessment questionaire. *Journal of Gerontology, 36 (4),* 428-434.

Fitzpatrick, C, McGee, H.M., Browne, J.P., McLauglin, B. (1993). Quality of life in an elderly urban female population at risk for nutritional deficiency. *Irish Journal of Psychology, 14 (1),* 164-175.

Fleiss, A. (1985). *Home Ownership Alternatives for the Elderly*. London:HMSO.

Fletcher, P., & Minter, J. (1991). *The future of sheltered housing - who cares?* National Federation of Housing Associations and Anchor Housing Association. London: NFHA.

Gale, B.J. & Erikson, J.R. (1997). How race affects health service use by older women. *Health Care for Women International, 18,* 221-232.

George, L.K., Blazer, D.G. Hughes, D.C. & Fowler, N. (1989). Social Support and the outcome of major depression. *British Journal of Psychiatry, 154*, 478-485.

Golden, R.R., Teresi, J.A. & Gurland, B.J. (1984). Development of indicator scales for the Comprehensive Assessment and Referral Evaluation (CARE) interview schedule. *Journal of Gerontology, 39,* 138-146.

Gordon, D.S., Spicker, P., Ballinger, B.R., Gillies, B. et al (1997). A population needs assessment profile for dementia. *International Journal of Geriatric Psychiatry, 12 (6),* 642-647.

Goudie, F. & Richards, G (1993). The psychological needs of older adults and their carers in primary care settings. Unpublished report, Community Health, Sheffield.

Grant, G. & Wenger, G.C. (1993). Dynamics of support networks: Differences and similarities between vulnerable groups. Special Issue: Psychological aspects of ageing: Well-being and vulnerability. *Irish Journal of Psychology, 14 (1),* 79-98.

Green, B.H., Copeland, J.R., Dewey, M.E., Sharma, V., Saunders, P.A, Davidson, , I.A., Sullivan, C. & McWilliam, C. (1992). Risk factors for depression in elderly people: a prospective study. *Acta Psychiatrica Scandinavica, 86,* 213-217.

Gurland, B., Golden, R.R., Teresi, J.A. & Challop, J. (1984). The Short-CARE: An efficient instrument for the assessment of depression, dementia, and disability. *Journal of Gerontology, 39,* 166-169.

Hamid, W., Howard, R. & Silverman, M. (1995). Needs assessment in old age psychiatry: A need for standardisation. *International Journal of Geriatric Psychiatry, 10 (7),* 533-540.

Hanson, B.S., Isacsson, S.O., Janzon, L. & Lindell, S.E. (1990). Social Network and social support influence on mortality in elderly men. *Advances, 7,* 16-18.

Harrison, R., Savla, N. & Kafetz, K. (1990). Dementia, depression, and physical disability in a London borough: A survey of Elderly people in and out of residential care and implications for future developments. *Age and Ageing, 19,* 97-103.

Henderson, S. (1981). Social Relationships, adversity and neurosis: An analysis of prospective observations. *British Journal of Psychiatry, 138,* 391-398.

Henwood, M. (1991). *Excess winter mortallity: International comparisons 1976 - 84.* UK: Family Policy Studies Centre.

Heumann L. & Boldy, D. (1982). *Housing for the Elderly.* London: Croom Helm.

Holshouser, W.L (1988). *Aging in Place: The demographics and service needs of elders in urban public housing.* Boston: Citizens Housing and Planning Association.

Holland, W.W. (1983). Concepts and meaning in evaluation of health care. In W.W. Holland (Ed) *Evaluation of Health Care.* Oxford: Oxford University Press.

Holloway, F. (1994). Need in community psychiatry: A consensus is required. *Psychiatric Bulletin, 18,* 321-323.

Hopton, J.L. & Hunt, S.M. (1996). Housing conditions and mental health in a disadvantaged area in Scotland. *Journal of Epidemiology and Community Health, 50,* 56-61.

Jackson,S. & Mittelmark, M.B. (1997), Unmet needs for formal home and community services among african american and white older adults: The Forsyth County aging study. *The Journal of Applied Gerontology, 16 (3),* 298-316.

Jewell, M., Wurr, S. & Zadik, T. (1997). Kindred Spirits. *PSIGE Newsletter, 59.*

Kamis-Gould, E. & Minsky, S. (1995). Needs assessment in mental health service planning. *Adminisrtation and Policy in Mental Health, 23(1),* 43-58.

Katona, C.L.E., Manela, M.V., Livingston, G.A. Comorbidity with depression in older people: The Islington study. *Ageing & Mental Health, 1,* 57-61.

Katz, S., Ford, A.B., Moskowitz, C., Jackson, B.A., Jaffe M.W. & Cleveland, M.A. (1963). Studies of illness in th eaged. The index of ADL: A standardised measure of biological and psychosocial function. *JAMA, 185,* 914.

Kay, D.W.K., Henderson, A.S., Scott, R., Wilson, J., Rickwood, D. & Grayson. D.A. (1985). Dementia and depression among the elderly living in the Hobart community: The effect of diagnostic criteria on the prevalence rates. *Psychological Medicine, 15,* 771-788.

Kaye, L. & Monk, A. (1991). Social relations in enriched housing for the aged: A case study. *Journal of Housing For the Elderly,* 9, 111-126.

Kitwood, T., Buckland, S. & Petre, T. (1995). *Brighter Futures. A report on research into provision for persons with dementia in residential homes, nursing homes and sheltered housing.* Anchor Housing Association.

Lam, D.H. & Power, M.J. (1991). Social support in a general practice elderly sample. *International Journal of Geriatric Psychiatry, 6,* 89-93.

Lawton, M.P. & Brody, E. (1969). Assessment of older people: Self-maintaing and and instrumental activities of daily living. *Gerontology, 9,* 179.

Lee, G.R. (1985). Kinship and social support of the elderly: The case of the United States. *Ageing and Society, 5,* 19 - 38.

Linden, M., Horgas, A.L., Gilberg, R. & Steinhagen-Thiesen, E. (1997). Predicting health cae utilisation in the very old: The role of physical health, mental health, attitudinal and social factors. *Journal of Aging and Health, 9,* 3-27.

Lindesay, J. Briggs, C. & Murphy, E. (1989). The Guy's/Age Concern survey. Prevalance rates of cognitive impairment, depression and anxiety in an urban elderly community. *British Journal of Psychiatry, 155,* 317-329.

Livingston, G.A., Hawkins, A. Graham, N., Blizzard, B. & Mann, A. (1990). The Gospel Oak Study: Prevalence rates of dementia, depression and activity limitation among elderly residents in Inner London. *Psychological Medicine, 20,* 137-146.

MacCarthy, B., Benson, J. & Brewin, C. (1986). Task motivation and problem appraisal in long-term psychiatric patients. *Psychological Medicine, 16,* 431-438.

Mackintosh, S. Means, R. & Leather, P. (1990). *The Housing Finance Implications of the Ageing Society.* School of Advanced Urban Studies, Bristol: University of Bristol.

Manton, D.M. (1989). Epidemiological, demographic and social correlates of disability among the elderly. *Millbank Q, 67,* 13.

Martin, M., Pehrson, J. & Orrell, M. (1997). A National Survey of Needs Assessmnet. Unpublished. Department of Psychiatry and Behavioural Sciences, University College London Medical School.

Martin, M (1998). *Can continuing care settings provide for the needs of their elderly residents?* MSc Dissertation. University College London.

McCrone, P. & Strathdee, G. (1994). Needs not diagnosis: Towards a more rational approach to community mental health resourcing in Britain. *International Journal of Social Psychiatry, 40,* 79-86.

McEwan, E. (1992). The consumer's perception of need. In *Long-term Care for Elderly People.* London: HMSO.

McLean, K.A. Austin, C.A. Neal, K.R. & Channer, K.S. (1994). Integration between general and geriatric medecine: A needs related policy. *Journal of the Royal Colllege of Physicians London, 28,* 415-418.

McWalter, G., Toner, H., McWalter, A., Eastwood, J., Marshall, M. & Tuvey, T. (1998). A community needs assessment: The care needs assessment pack for dementia (CARENAPD) - its development, reliability aand validity. *International Journal of Geriatric Psychiatry, 13,* 16-22.

Middleton, C. (1987). *So Much for So Few: A view of Sheltered Housing, 2nd ed.* Liverpool: Institute of Human Ageing, University of Liverpool.

Ministry of Housing and Local Government Design Bulletin (1958). Flatlets for Older People. London: HMSO.

Ministry of Housing and Local Government / Ministry of Health (1961). Services for Older People. London: HMSO.

Ministry of Housing and Local Government (1969). Housing standards and costs: accommodation specially designed for old people. Circular 82/69. London: HMSO.

Mor-Barak, M.E., Miller, L.S. & Syme, L.S. (1991). Social Networks, life events, and health of the poor, frail elderly: A longitudinal study of the buffering versus the direct effect. *Family and Community Health, 14 (2),* 1 - 13.

Morgan, D.L., Neal, M.B. & Carder, P. (1996). The stability of core and peripheral networks over time. *Social Networks, 19,* 9-25.

Murphy, E. (1982). Social origins of depression in old age. *British Journal of Psychiatry, 141,* 135-142.

Murphy, E. (1992). A more ambitious vision for residential long term care (editorial). *International Journal of Geriatric Psychiatry, 7,* 851-852.

NHS and Community Care Act. (1990). London: HMSO.

Noelker, L.S., Ford, A.B., Gaines, A.D., Haug, M.R., Jones, P.K., Stange, K.C. & Mefrouche, Z. (1998). Attitudinal influences on th eelderly's use of assisstance. *Research on Aging, 20,* 317-338.

Oldman, C. (1988). More than bricks and mortar: a critique of the Griffiths and Wagner reports. *Housing, 24 (5),* 13-15.

Oldman, C. (1990). *Moving in Old Age: New Directions in Housing Policies.* London: HMSO.

Orrell, M. & Bebbington, P. (1995). Social factors and psychiatric admissions in senile dementia. *International Journal of Geriatric Psychiatry, 10,* 313-323.

Orford, J. (1998). Have we a theory of community psychology? *Clinical Psychology Forum, 122,* 6-10.

Oxman, T.E., Freeman, D.H. & Manheimer, E.D. (1995). Lack of social participation or religious strength and comfort as risk factors for death after cardiac surgery in the elderly. *Psychosomatic Medicine, 57,* 5-15.

Peek, C.W. Zsembik, B.A. & Coward, R.T. (1997). The changing caregiving networks of older adults. *Research on Aging, 19,* 333-361.

Phelan, M., Slade, M., Thornicroft, G., Dunn, G. Holloway, F., Wykes, T., Strathdee, G., Loftus, L., McCrone, P. & Hayward, P. (1995). The Camberwell Assessment of Need: The validity and reliability of an instrument to assess the needs of people with severe mental illness. *British Journal of Psychiatry, 167,* 589-595.

Phillipson, C. (1997). Social Relationships in Later Life: A review of the research literature. *International Journal of Geriatric Psychiatry, 12,* 505-512.

Potts, M. (1997). Social support and depression among older adults living alone: The importance of friends within and outside of a retirement community. *Social Work, 42,* 348-362.

Prince, M.J., Harwood, R.H., Thomas, A. & Mann, A.H. (1997). Social support deficits, lonliness and life events as risk factors for depression in old age. The Gospel Oak Project VI. *Psychological Medicine, 27,* 323-332.

Reich, J.W. & Zautra, A.J. (1991). Experimental measurement approaches to internal control in at-risk older adults. *Journal of Social Issues, 47,* 143-158.

Reviere, R. Berkowitz, S., Carter, C.C & Ferguson, C.G. (1996). *Needs Assessment: A creative and practical guide for social scientists.* Washington DC, USA: Taylor & Francis.

Reynolds, T., Thornicroft, G., Woods, R., Abas, M., Hoe, J. & Orrell, M. (1999). The development, validity and reliability of the Camberwell Assessment of Need for the Elderly. (submitted).

Reynolds, T., Thornicroft, G., Woods, R., Abas, M. & Orrell, M. (1998). The validity and reliability of the Camberwell Assessment of Needs for the Elderly. Short Paper presented at the winter meeting of the Royal College of Psychiatrists.

Riseborough,M. & Ninner, P. (1994). *I Didn't Know You Cared: A survey of Anchor's Sheltered Housing Tenants.* Oxford: Anchor Housing Trust

Rook, K.S. (1998). Investigating the positive and negative sides of personal relationships: Through a lens darkly? In B.H. Spitzberg & W.R.Cupach (Eds.) *The dark side of close relationships,* pp369-393. Mahwah, NJ, USA: Lawrence Erlbaum Associates.

Russell, D.W. & Cutrona, C.E. (1991). Social support, stress and depressive symptoms among the elderly: Test of a process model. *Psychology & Ageing, 6 (2),* 190-201.

Schultz, A.A. (1997). Identification of needs and utilization of resources by rural and urban elders after hospital discharge to the home. *Public Health Nursing,* 14, 28-36.

SPSS (1993). Spss for Windows version 6.0. Statistical Package for the Social Sciences. Chicago:SPSS Inc.

Stewart, R. (1979). The nature of needs assessment in community mental health care. *Community Mental Health Journal, 15,* 287-295.

Stoller, E.P. (1984). Self-assessments of health by the elderly: The impact of informal assisstance. *Journal of Health and Social Behaviour, 25,* 260-270.

Struyk, R.T. (1987). The economic behaviour of elderly people in housing markets. *Housing Studies, 2(4),* 221-236.

Tennstedt, S. & Chang, B.H. (1998). The relative contribution of ethnicity versus socioeconomic status in explaining differences in disability and receipt of informal care. *Journals of Gerontology: Series B - Psychological Sciences and Social Sciences, 53B (2),* s61-s70.

Thaper, K. & Rowland, L. (1989). Quality of life perspectives in long term care: Staff and patient perspectives. *Acta Psychiatrica Scandinavica, 80,* 267-271.

Tideiksaar, R. (1993). Mechanisms of falls in community residing older persons. *Pride Institute Journal of Long Term Home Health Care, 12(3),* 3-11.

Tinker, A. (1984). *Staying at Home: Helping Elderly People.* London: HMSO.

Tinker, A. (1989). *An evaluation of very sheltered housing.* Department of the Environment, London: HMSO.

Walker, M. Orrell, M., Manela, M., Livingston, G. & Katona, C. (1998). Do health and use of services differ in residents of sheltered accomodation? A pilot study. International Journal of Geriatric Psychiatry, 13 (9), 617-624.

Watson, P.E., Catty, E.J., Oyebode, J.R. & Fairburn, A.F. (1990). The characteristics of female residents living alone in sheltered housing accomodation compared with those living in the community. *Care of the Elderly, 2(5),* 207-209.

Wenger, G.C. (1990). Change and adaptation in informal support networks of elderly people in Wales 1979 - 87. *Journal of Aging studies, 4,* 375-389.

Wenger, G.C. (1994). *Support Networks of Older People: A Guide for Practioners.* Bangor: University of Wales Centre for Social Policy Research & Development.
Wenger, G.C. (1996). Social networks and gerontology. *Reivews in Clinical Gerontology, 6,* 285-293.

Wenger, G.C. (1997). Social networks and the prediction of elderly people at risk. Ageing and Mental Health, 1(4), 311-320.

Wenger, G.C. & Shahtahmasebi, S.(1990). Variations in Support Networks: Some Policy Implications. In J.Mogey (Ed.) Aiding and Ageing: The Coming Crisis, pp255-277. Westport CT; Greenwood Press.

Wenger, G.C. & Shahtahmasebi, S.(1991). Survivors: Support network variation and sources of help in rural communities. *Journal of Cross Cultural Gerontology, 6 (1),* 41-82.

Wilcox, J., Jones, B. & Alldrick, D. (1995). Identifying the support needs of people with dementia and older people with mental illness on a joint community team: A preliminary report. Special section: Dementia care. *Journal of Mental Health, 1995, 4 (2),* 157-163.

Williams, G. (1986). *Meeting the Housing Needs of the Elderly: Private Initiative or Public Responsibility?* Department of Town & Country Planning Occassional Paper No. 17. Manchester: University of Manchester.

Woolrych, R. (1998). *Springboard Housing Association Report on Sheltered Housing Schemes.* London: Springboard Housing Association.

Young, S. (1993). Private tenanted sheltered accommodation and the elderly: A study into independence, security and social relationships. Unpublished BSc thesis, University of Surrey.

Appendix 1

Letter from West Essex Local Research Ethics Committee.

WEST ESSEX
LOCAL RESEARCH ETHICS COMMITTEE

Parndon Hall, The Princess Alexandra Hospital NHS Trust, Hamstel Road, Harlow, Essex CM20 1QX

Tel: 01279 827082
Fax: 01279 429371

Our ref: JT/dt

6 March 1998

Dr M H Walker
Senior Registrar
Department of Psychiatry
Princess Alexandra Hospital

Dear Dr Walker

1186 HEALTH, DISABILITY AND SOCIAL SUPPORT IN SHELTERED ACCOMMODATION

Thank you for complying with the Local Ethical Research Committee's request for an amended Information and Consent Form. This project has now been approved by way of Chairman's action.

The Chairman would like to take this opportunity to wish you luck with this project.

Yours sincerely

Jane Thomas
Secretary to the West Essex Local Research Ethics Committee

Appendix 2

Warden Questionnaire derived from the Multiphasic Environmental Assessment Procedure (MEAP Moos & Lemke, 1992)

Preliminary Questionnaire for Sheltered Accommodation Wardens

notes:

1) We use "facility" to mean the sheltered accommodation complex, including individual flats and any outlying bungalows or houses, and its management structure.

2) Throughout this questionnaire, please circle the appropriate answer or answers if there is a choice or, where there is a line, please fill in quantities. Please try to answer every question.

3) If you do not know the answer or it does not seem relevant to your facility please fill in "DK" (meaning "don't know") beside the alternatives or above the line.

4) Some questions ask about numbers of residents in a certain category (eg with impaired vision), we would like you to make an estimate from your knowledge of the residents and not spend a lot of time checking these things. This is quite a long questionnaire, but we think it should not take you very long if you do it this way.

examples:

are meals provided?	yes	no
number of residents using a chiropodist	_____	
is there a sitting room in each unit or a shared one?	shared	each unit

General information about the facility

Private or Local Authority run	Private	LA
Approximate cost of a unit (if applicable)	_____	
Rent (per month)	_____	
Any other charges (per month)	_____	
Is there a minimum age?	yes	no
if yes, what is it?	_____	
What is the maximum possible number of residents?	_____	
How many residents currently?	_____	
How many units are occupied by more than one person?	_____	

What kind of warden cover is there? (please circle a cross)

Resident warden only	x
Mobile warden only	x
Resident warden with 24-hour mobile cover	x
24-hour resident wardens (i.e. a shift system)	x

Are there any other regular staff members?	yes	no
if yes, how many	_____	

Which of these facilities are shared or present in each unit? (circle both if appropriate)

Kitchen	shared	each unit
Bathing facilities	shared	each unit
Sitting room	shared	each unit
Dining room	shared	each unit
Mailbox	shared	each unit
Front door (and address)	shared	each unit

How many of each of these kinds of unit are there in your facility?

Type of units:	number
studio (i.e. one room)	_____
one bedroom	_____
two or more bedrooms	_____
bungalows	_____
flats	_____
houses	_____

How many units are accessible by wheelchair from outside? _____

Is there a handbook for residents?	yes	no
Is there a handbook for staff?	yes	no
Is there an orientation programme for new residents?	yes	no
Are there visits from volunteers?	yes	no
Are the units let furnished or unfurnished?	furnished	unfurnished
Does the warden have a key to all the units?	yes	no

In what year was the facility built or converted? _____

How many years have you been a warden in total? _____

How long have you been at your present facility? _____

Residents who have left

In the last 5 years how many residents have left the complex? _____

Of these, how many -	died?	_____
	went into a residential or nursing home?	_____
	went into hospital?	_____
	went to live with family?	_____
	went into independent accommodation?	_____
	other	_____

Residents' functional abilities

How many residents:	do this unaided	do this with some help	cannot do this
take care of their own appearance (eg comb hair and shave)	_____	_____	_____
eat their meals?	_____	_____	_____
cook?	_____	_____	_____
dress/undress themselves?	_____	_____	_____
walk?	_____	_____	_____
get in and out of bed?	_____	_____	_____
bath or shower?	_____	_____	_____
get to the lavatory on time?	_____	_____	_____
make their needs or wishes clearly understood?	_____	_____	_____
handle their own money (eg paying bills)	_____	_____	_____
use the telephone?	_____	_____	_____
go shopping?	_____	_____	_____
do the housework?	_____	_____	_____

How many residents:

are currently on prescribed medication? _____

do not see well enough to read a (normal print) newspaper or book (even with glasses)? _____

use a hearing aid (or should do)? _____

do not know what day and year it is? _____

attend a day centre _____

Policies about functional ability

In this section we want to know about the general policies of the facility, this is not about individual residents. Please circle the appropriate cross.

allowed	=	this behaviour is expected, it is no problem
tolerated	=	the behaviour is seen as a minor problem, but active attempts to discourage it are not necessary
discouraged	=	active attempts would probably made to discourage this behaviour
intolerable	=	if continued, the resident would have to move out

	allowed	tolerated	discouraged	intolerable
inability to make one's bed	x	x	x	x
inability to clean room/flat	x	x	x	x
inability to feed oneself	x	x	x	x
inability to wash oneself	x	x	x	x
inability to dress	x	x	x	x
incontinence (urine or faeces)	x	x	x	x
confusion or disorientation	x	x	x	x
depression	x	x	x	x

Problem Behaviours

refusing to participate in activities	x	x	x	x
refusing to take medication	x	x	x	x
excessive use of medication	x	x	x	x
being drunk	x	x	x	x
wandering around the complex at night	x	x	x	x
wandering and getting lost	x	x	x	x
going out in the evening without telling anyone	x	x	x	x
refusing to wash	x	x	x	x
creating a disturbance or noise	x	x	x	x
stealing others' belongings	x	x	x	x
damaging others' property	x	x	x	x
verbally threatening another resident	x	x	x	x
physically attacking a resident	x	x	x	x
physially attacking a member of staff	x	x	x	x
suicide attempts	x	x	x	x
indecent exposure to other residents	x	x	x	x

Resident Participation

do any of the residents do unpaid work in the unit? yes no

if so, how many participate? _____

are any residents paid for jobs within the unit? yes no

if so, how many participate? _____

Is there a residents council or committees for specific purposes (eg entertainment committee)? yes no

if so, how often do they meet? (please circle the appropriate cross)

x - twice a month or more
x - once a month
x - less than once a month
x - only when needed

Are there regular "house meetings" open to all residents? yes no

if so, how often? (please circle the appropriate cross)

x - twice a month or more
x - once a month
x - less than once a month
x - only when needed

Is there a newsletter? yes no

if so, do residents contribute? yes no

Is there a bulletin board? yes no

if so, is it regularly used by residents? yes no

Decision making

Who makes decisions in these areas? (please circle appropriate cross)

	mainly staff	staff and residents	mainly residents
planning entertainment (eg outings or parties)	x	x	x
planning educational activities	x	x	x
planning menus	x	x	x
making rules	x	x	x
deciding on the decor of the public areas	x	x	x
selecting new residents	x	x	x
moving a resident within the complex	x	x	x
deciding when a resident must leave	x	x	x
changes in staff	x	x	x

Services

Are the following services provided by the facility?

note - please circle "no" if they are provided on an individual basis by an outside agency, eg Social Services or the GP, unless there is a specific contract for the service

			approximate number of residents who use this service at least once in a typical week
scheduled doctor's hours	yes	no	_____
doctor on-call	yes	no	_____
scheduled nurse's hours	yes	no	_____
assistance in using prescribed medications	yes	no	_____
physiotherapy	yes	no	_____
assistance with housework	yes	no	_____
assistance with meals or meals-on-wheels	yes	no	_____
assistance with personal care	yes	no	_____
visiting hairdresser	yes	no	_____
assistance with laundry	yes	no	_____
assistance with shopping	yes	no	_____
assistance with money-handling	yes	no	_____
day centre	yes	no	_____

Are meals provided? yes no

which meals? please circle cross(es)	how many people attend this meal?
x - breakfast	_____
x - lunch	_____
x - evening meal	_____

Is there a time after which residents must be inside the unit in the evening? yes no

if so, what is this time? _____

Is each resident checked every day? yes no

Activities that take place in the facility

	rarely or never	a few times a year	at least monthly	at least weekly	number of participants
keep fit / exercise	x	x	x	x	_____
visiting entertainment (eg singer, musician)	x	x	x	x	_____
discussion group	x	x	x	x	_____
reality orientation group	x	x	x	x	_____
self-help group	x	x	x	x	_____
films	x	x	x	x	_____
drama or musical group	x	x	x	x	_____
classes or lectures	x	x	x	x	_____
games (eg bingo, cards)	x	x	x	x	_____
parties	x	x	x	x	_____
religious services	x	x	x	x	_____
social meeting (eg coffee)	x	x	x	x	_____
arts and crafts	x	x	x	x	_____
other	x	x	x	x	_____

Are there any comments you would like to add about matters we have not covered in the questionnaire?

Appendix 3

Letter to the wardens of Harlow Council sheltered housing schemes.

13

Essex & Herts
Community NHS Trust

Princess Alexandra Hospital
Hamstel Road, Harlow, Essex CM20 1QX
Telephone 01279 444455 ext.

Direct Line 01279 827260

DEPARTMENT OF PSYCHIATRY OF THE ELDERLY

14 August 1997

Dear Warden

We are writing to ask for your help in a research project being carried out in sheltered accommodation in Harlow. The project is being carried out by Dr Mike Walker and Dr Martin Orrell from Princess Alexandra Hospital with help from Chris Hazelhurst from the Housing Department.

We plan to investigate the mental health of people living in sheltered accommodation in London and Essex and to explore possible causes of mental health problems. We also want to find out more about the residents in general, for example, how their network of friends and family has been affected by moving to sheltered housing and how much their expectations have been fulfilled.

We have been involved in a survey in Islington, in London, where we found that, if anything, there might be less depression in residents of sheltered housing than in other accommodation, especially when looking only at those people who live alone. There was a higher level of mild dementia in sheltered residents and a higher rate of problems with vision, hearing and mobility.

The next stage is to compare how people are in different types of sheltered accommodation complexes. This is where we need your help. In order to compare different types, we need to know more about the units and residents in Harlow. We hope that you will be able to fill in a questionnaire about your complex and its residents. To discuss and hear your comments on the questionnaire we are going to hold a meeting at 2.00 pm on Thursday 25th September 1997 . We would be most grateful if you could attend.

Yours sincerely

DR M H WALKER
SENIOR REGISTRAR IN PSYCHIATRY OF THE ELDERLY

DR M W ORRELL
SENIOR LECTURER IN PSYCHIATRY OF THE ELDERLY

Appendix 4

Letter to the wardens of the three selected sheltered housing schemes.

St. Luke's Hospital
Woodside Avenue
Muswell Hill
London
N10 3HU

Dear Warden,

My name is Dr Mike Walker. You may remember me from the meeting at Fountain's Farm in September where myself and Dr Orrell explained that we were hoping to undertake a research project in sheltered. You and your colleagues had kindly filled in our questionnaires about your units.

After performing a statistical analysis of the results of the questionnaire, we picked four units (yours and three others) as typical of four groups of sheltered accommodation, based on the type of accommodation, activities, health of the residents, etc. I would now be most grateful if you could help us by posting the letters which I enclose, one to each resident. These letters explain that we hope to visit each resident within the next two weeks. If residents are not in when we call, we will come again. If residents do not want to be interviewed, they just have to say so when we visit and we will ask them no further questions. I also enclose a sample letter so that you can see what we are asking the residents.

I would be grateful if you could post the letters as if they were ordinary mail, in the resident's post-box. I would rather you used this technique than, say, handing them out at a meeting, since residents may then become concerned about the study without adequate time to digest the contents of the letter. If residents do have concerns they can contact me at the above address (which is in their letters).

Yours Sincerely

Dr Michael Walker

tel: 0181 219 1815
email: MikeWalker@Compuserve.com

Appendix 5

Letter to the residents of the three selected sheltered housing schemes.

Essex & Herts
Community NHS Trust

Princess Alexandra Hospital
Hamstel Road, Harlow, Essex CM20 1QX
Telephone 01279 444455 ext.

Dear Resident,

We are conducting a survey of residents of sheltered accommodation in the local area and we would like to ask for your help. One of us (Dr Walker or Ms Field) will visit in the next few weeks. We will both have official identification.

If you agree to see us, we would like to ask you a number of questions about your health and your social life. The interview should last a maximum of an hour. We will be asking everyone the same questions. Mr Hazlehurst from the Housing Department and your warden are helping us with this project and have allowed us to approach the residents. Your answers will be kept in the strictest confidence so that no-one other than Dr Walker and Ms Field will know what an individual person has said.

We hope to find out about the health and social needs of residents of sheltered accommodation. This research may be useful in guiding developments in health and social care and in the planning of new sheltered accommodation complexes.

You do not have to see us if you don't want to, although it will be very helpful to us if you do. If you do not want to see us, just explain this when we call. Whether you agree to see us or not and what answers you give will not affect your tenancy in any way.

If you have any questions, we will be happy to answer them when we visit, but if you would like to speak to us before this please contact Dr Walker.

Dr Michael Walker - Senior Registrar
St. Luke's Hospital, Woodside Avenue, Muswell Hill, London, N10 3HU
tel: 0181 219 1815

Ms Elizabeth Field - Clinical Psychologist in Training, University College, London.

Dr Martin Orrell
Consultant
Princess Alexandra Hospital, Harlow.

Appendix 6

Consent form

Essex & Herts
Community NHS Trust

Princess Alexandra Hospital
Hamstel Road, Harlow, Essex CM20 1QX
Telephone 01279 444455 ext.

Information and consent form

Dear Resident

This is a short note to explain why we called on you and why we are asking residents of sheltered accommodation to help us.

Sheltered accommodation has been in existence in the UK for around 40 years. Despite this there hasn't been a great deal of research on the health needs, physical needs and social life of people who live in sheltered accommodation.

The answers you give to the questions will be kept in the strictest confidence and not be passed on to your wardens or the housing department. We hope to publish the results of the survey, but no individuals will be identified.

We would like to ask you about various aspects of your health and social life. The interview should not last longer than about an hour and may be quicker. You can stop the interview at any point. The study is purely for information and no treatment is being proposed. The researchers may want to contact you on a second occasion.

The purpose and nature of this study has been explained to me
by _____ on _____(date)

Signed _____

Date _____

Appendix 7

Camberwell Assessment of Needs for the Elderly (CANE)
(Reynolds,Thornicroft, Woods, Abas & Orrell, 1998).

CAMBERWELL ASSESSMENT OF NEED FOR THE ELDERLY

(CANE)

Revised Version (II)

CODE	

INTERVIEWEE	DATE	interview time
USER		
STAFF		
CARER		

1 ACCOMMODATION

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE AN APPROPRIATE PLACE TO LIVE? ☐ ☐ ☐

What kind of home do you live in? Do you have any problems with accommodation?

0 = NO PROBLEM	e.g.	Has an adequate and appropriate home (even if currently in hospital).
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g	Home undergoing adaptation/redecoration
2 = SERIOUS PROBLEM	e.g	Homeless, inappropriately housed or home lacks basic facilities such as water, electricity, heating or essential alterations.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 2

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH THEIR ACCOMMODATION? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasionally does odd jobs or minor redecorations.
2 = MODERATE HELP	e.g.	Substantial help with improving accommodation such as organising redecoration or specific adaptions.
3 = HIGH HELP	e.g.	Living with relative because own accommodation is unsatisfactory.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES WITH THEIR ACCOMMODATION? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES WITH THEIR ACCOMMODATION? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Minor redecoration; referral to housing agency/assisted housing.
2 = MODERATE HELP	e.g.	Major improvements; actively pursuing change in accommodation.
3 = HIGH HELP	e.g.	Being rehoused; living in supported accommodation, residential care, nursing home or continuing care hospital ward.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH THEIR ACCOMMODATION? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH ACCOMMODATION? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

2 LOOKING AFTER THE HOME

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE DIFFICULTY IN LOOKING AFTER THEIR HOME? ☐ ☐ ☐

Are you able to look after your home?
Does anyone help you?

0 = NO PROBLEM	e.g.	Home may be untidy but kept basically clean.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Limited in looking after home and has regular domestic help.
2 = SERIOUS PROBLEM	e.g	Unable to do any housework. Home is a potential health/fire/escape hazard.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 3

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH LOOKING AFTER THE HOME? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Prompts or helps tidy up or clean occasionally.
2 = MODERATE HELP	e.g.	Prompts or helps clean at least once a week.
3 = HIGH HELP	e.g.	Does most or all of the household tasks.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES WITH LOOKING AFTER THE HOME? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES WITH LOOKING AFTER THE HOME? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g	Prompting/supervision by staff.
2 = MODERATE HELP	e.g.	Some assistance with household tasks.
3 = HIGH HELP	e.g.	Majority of household tasks done by staff.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH LOOKING AFTER THE HOME? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH LOOKING AFTER THE HOME? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

3 FOOD

ASSESSMENT
USER STAFF CARE

DOES THE PERSON HAVE DIFFICULTY IN GETTING ENOUGH TO EAT? ☐ ☐ ☐

Are you able to prepare your own meals and do your own shopping?
Are you getting the right sort of food?

0 = NO PROBLEM	e.g.	Able to buy and prepare adequate meals.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Unable to prepare food and has some meals provided
2 = SERIOUS PROBLEM	e.g	Very restricted diet; culturally inappropriate food; unable to do shopping or prepare any food.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 4

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH GETTING ENOUGH TO EAT? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional meal provided and/or occasional help with shopping.
2 = MODERATE HELP	e.g.	Help with weekly shopping and/or meals provided more than weekly but not daily.
3 = HIGH HELP	e.g.	Meal provided daily
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES WITH GETTING ENOUGH TO EAT? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES WITH GETTING ENOUGH TO EAT? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	1-4 meals a week provided or assisted for one meal a day.
2 = MODERATE HELP	e.g.	More than 4 meals a week provided or assisted for all meals. Weekly shopping.
3 = HIGH HELP	e.g.	All meals provided.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH GETTING ENOUGH TO EAT? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH GETTING ENOUGH TO EAT? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

4 SELF CARE

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE DIFFICULTY WITH SELF CARE? ☐ ☐ ☐

Do you have any difficulty with personal care like washing, cutting your nails or dressing?
Do you ever need help?

0 = NO PROBLEM	e.g.	Appropriately dressed and groomed.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Needs and gets help with self care.
2 = SERIOUS PROBLEM	e.g	Poor personal hygiene, unable to dress or wash.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 5

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH SELF CARE? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Prompts (e.g. to change clothes) or helps occasionally.
2 = MODERATE HELP	e.g.	Regular assistance e.g. weekly or more often.
3 = HIGH HELP	e.g.	Daily assistance with care e.g. dressing, bathing: Weekly laundry.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES WITH SELF CARE? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES WITH SELF CARE? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g	Occasional prompting by staff.
2 = MODERATE HELP	e.g.	Supervise weekly washing and some other aspects of self-care.
3 = HIGH HELP	e.g.	Supervise most aspects of self care; assist most days.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH SELF CARE? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH SELF CARE? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

5 CARING FOR SOMEONE ELSE

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE DIFFICULTY CARING FOR ANOTHER PERSON? ☐ ☐ ☐

Is there anyone that you are caring for?
Do you have any difficulty in looking after them?

0 = NO PROBLEM	e.g.	No-one to care for or no problem in caring.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Difficulties with caring and receiving help.
2 = SERIOUS PROBLEM	e.g.	Serious difficulty in looking after or caring for the person.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 6

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH LOOKING AFTER SOMEONE ELSE? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional help less than once a week.
2 = MODERATE HELP	e.g.	Help most days.
3 = HIGH HELP	e.g.	Cared-for person goes to stay with friends or relatives.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES WITH CARING? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES WITH CARING? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Day care; weekly assistance at home.
2 = MODERATE HELP	e.g.	Nearly daily assistance at home; on-going carer support/training programme.
3 = HIGH HELP	e.g.	Respite care, 24-hour care package or plans for residential care.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH CARING? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR CARING FOR SOMEONE ELSE? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

6 DAYTIME ACTIVITIES

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE DIFFICULTY WITH REGULAR, APPROPRIATE DAYTIME ACTIVITIES? ☐ ☐ ☐

How do you spend your day? Do you have enough to do?

0 = NO PROBLEM	e.g.	Adequate social, work or leisure activities.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Some limitation in occupying self, attending organised activities e.g. day centre.
2 = SERIOUS PROBLEM	e.g	No adequate social, work or leisure activities.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 7

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES IN FINDING OR KEEPING REGULAR AND APPROPRIATE DAYTIME ACTIVITIES? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional help in arranging activities.
2 = MODERATE HELP	e.g.	Help at least weekly.
3 = HIGH HELP	e.g.	Daily help with arranging activities.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES IN FINDING OR KEEPING REGULAR AND APPROPRIATE ACTIVITIES? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES IN FINDING OR KEEPING REGULAR AND APPROPRIATE ACTIVITIES? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g	Adult education. Weekly day activity.
2 = MODERATE HELP	e.g.	Day centre 2-4 days a week. Day Hospital attendance.
3 = HIGH HELP	e.g.	Attends day hospital or day centre 5 or more days a week.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH ACTIVITIES? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH ACTIVITIES? ☐

(0 = NOT SATISFIED 1 = SATISFIED

COMMENTS

7 MEMORY

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE A PROBLEM WITH MEMORY? ☐ ☐ ☐

Do you often have a problem remembering things that happened recently?
Do you often forget where you've put things?

0 = NO PROBLEM	e.g	Occasionally forgets but remembers later.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Some problems but having investigations/assistance.
2 = SERIOUS PROBLEM	e.g.	Clear deficit in recalling new information; loses things; becomes disorientated in time and/or place.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 8

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR MEMORY LOSS? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Prompting, occasional notes, reminders. Weekly visit.
2 = MODERATE HELP	e.g.	Assistance/supervision most days.
3 = HIGH HELP	e.g.	Living with relative. Constant supervision.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES FOR MEMORY LOSS? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES FOR MEMORY LOSS? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Some advice.
2 = MODERATE HELP	e.g.	Undergoing investigations. Regularly sees health care professional, e.g. Memory Clinic, Day Hospital. Specialist day facility.
3 = HIGH HELP	e.g.	Residential/inpatient care.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR MEMORY LOSS? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR MEMORY LOSS? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

8 EYESIGHT/HEARING

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE ANY PROBLEM WITH SIGHT OR HEARING? ☐ ☐ ☐

Do you have any difficulty hearing what someone says to you in a quiet room?
Do you have difficulty in seeing newsprint or watching television?

0 = NO PROBLEM	e.g.	No difficulties (may wear corrective lenses or hearing aid).
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g	Some difficulty but aids help to some extent.
2 = SERIOUS PROBLEM	e.g	A lot of difficulty seeing or hearing.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 9

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH EYESIGHT/HEARING? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Help making appointments for sight/hearing problems.
2 = MODERATE HELP	e.g.	Regular help with difficult tasks e.g. reading correspondence.
3 = HIGH HELP	e.g.	Help with most tasks that are difficult because of hearing/vision problem.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES WITH EYESIGHT/HEARING? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES WITH EYESIGHT/HEARING? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g	Advice.
2 = MODERATE HELP	e.g.	Investigations/treatment. Aids provided. Regular assistance with tasks.
3 = HIGH HELP	e.g.	Assistance several days a week. Hospital appointments/specialist services or specialist day facilities.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH EYESIGHT/HEARING? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH EYESIGHT/HEARING? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

10 CONTINENCE

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE INCONTINENCE? ☐ ☐ ☐

Do you ever have accidents/find yourself wet if you can't get to the toilet quickly?
(How much of a problem? Ever any soiling? Are you getting any help?)

0 = NO PROBLEM	e.g.	No incontinence.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g	Some incontinence. Receiving appropriate help/investigations.
2 = SERIOUS PROBLEM	e.g	Regularly wet or soiled.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 11

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR INCONTINENCE? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Prompts to maintain continence.
2 = MODERATE HELP	e.g.	Regularly assists with laundry, hygiene and use of aids.
3 = HIGH HELP	e.g.	Full assistance with continence (laundry, hygiene, aids).
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES FOR INCONTINENCE? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES FOR INCONTINENCE? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g	Prompts to maintain continence and provision of aids.
2 = MODERATE HELP	e.g.	Investigations/treatment. Regular help with laundry, hygiene and aids.
3 = HIGH HELP	e.g.	Planned medical intervention (e.g. surgery). Constant care and assistance (eg. in residential care or nursing home).
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR INCONTINENCE? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR INCONTINENCE? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

9 MOBILITY

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE RESTRICTED MOBILITY, FALLS OR ANY PROBLEMS USING PUBLIC TRANSPORT?

Do you have any difficulty getting about outside or inside your home? Do you have falls? Can you use the bus or train?

0 = NO PROBLEM	e.g.	Physically able and mobile.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g	Some difficulty walking , climbing steps or using public transport but able with assistance (e.g. walking aids). Occasional fall.
2 = SERIOUS PROBLEM	e.g	Very restricted mobility even with walking aid. Several falls in a month.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 10

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR MOBILITY PROBLEMS?

0 = NONE		
1 = LOW HELP	e.g.	Occasional help e.g. with transport.
2 = MODERATE HELP	e.g.	Regular help with mobility/public transport. Help organising home alterations.
3 = HIGH HELP	e.g.	Daily help and supervision with mobility/transport.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES FOR MOBILITY PROBLEMS?

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES FOR MOBILITY PROBLEMS?

0 = NONE		
1 = LOW HELP	e.g	Advice; one or more aids.
2 = MODERATE HELP	e.g.	Currently undergoing investigations and/or O.T./Physiotherapy assessments. Regular transport, e.g. to day centre.
3 = HIGH HELP	e.g.	Fully appropriate home alterations and aids. Assistance most days.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR MOBILITY PROBLEMS?

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR MOBILITY PROBLEMS?

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

11 PHYSICAL HEALTH

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE ANY PHYSICAL ILLNESS? ☐ ☐ ☐

How well do you feel physically?
Are you getting any treatment from your doctor for physical problems?

0 = NO PROBLEM	e.g.	Physically well.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Physical ailment such as high blood pressure under control, receiving appropriate treatment.
2 = SERIOUS PROBLEM	e.g	Untreated serious physical ailment. Terminal illness. Awaiting major surgery.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 12

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR PHYSICAL HEALTH PROBLEMS? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Arranging appointments to see doctor.
2 = MODERATE HELP	e.g.	Accompanied regularly to doctor/clinics.
3 = HIGH HELP	e.g.	Daily help with condition arising out of physical health problems. e.g. Living with relative while convalescing or ill.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES FOR PHYSICAL HEALTH PROBLEMS? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES FOR PHYSICAL HEALTH PROBLEMS? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g	Given dietary or health advice. Occasional visit to GP.
2 = MODERATE HELP	e.g.	Prescribed medication. Regularly seen by health care professional (GP, nurse, day hospital staff, out-patient clinic).
3 = HIGH HELP	e.g.	Inpatient admissions. 24-hour nursing care.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR PHYSICAL HEALTH PROBLEMS? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR PHYSICAL HEALTH PROBLEMS? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

12 DRUGS

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE PROBLEMS WITH MEDICATION OR DRUGS? ☐ ☐ ☐

Do you have any problems (eg. side effects) with medication? How many different tablets are you on?
Has your medication been recently reviewed by your doctor? Do you take any drugs that are not prescribed?

0 = NO PROBLEM	e.g.	No problems with compliance, side effects, drug-abuse or dependancy.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Regular reviews, advice. District Nurse/CPN administers medication. Dosette boxes/aids.
2 = SERIOUS PROBLEM	e.g.	Poor compliance, takes too much or too little. Dependency or abuse of prescribed or non-prescribed drugs.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 13

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH THEIR MEDICATION? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional prompt. Advice about drug misuse.
2 = MODERATE HELP	e.g.	Collection, regular reminding and checking of medication. Advice about helping agencies.
3 = HIGH HELP	e.g.	Administers and holds medication. Support during drug withdrawal programme.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES WITH THEIR MEDICATION? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES WITH THEIR MEDICATION? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Advice from G.P. Prompts to take medication.
2 = MODERATE HELP	e.g.	Supervision by District Nurse/CPN/Day Hospital.
3 = HIGH HELP	e.g.	Daily administration of medication. Supervised withdrawal programme for drug dependancy.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH MEDICATION? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH THEIR MEDICATION? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

13 PSYCHOTIC SYMPTOMS

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE SYMPTOMS SUCH AS DELUSIONAL BELIEFS, HALLUCINATIONS, FORMAL THOUGHT DISORDER OR PASSIVITY? ☐ ☐ ☐

Do you ever hear voices, see strange things or have problems with your thoughts? Are you on any medication for this?

0 = NO PROBLEM	e.g	No definite symptoms. Not at risk or in distress from symptoms and not on medication for psychotic symptoms.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Symptoms helped by medication or other help.
2 = SERIOUS PROBLEM	e.g.	Currently has symptoms or is at risk.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 14

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR THESE PSYCHOTIC SYMPTOMS? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Some support.
2 = MODERATE HELP	e.g.	Carers involved in helping with coping strategies or medication compliance.
3 = HIGH HELP	e.g.	Constant supervision of medication and help with coping strategies.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES FOR THESE PSYCHOTIC SYMPTOMS? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES FOR THESE PSYCHOTIC SYMPTOMS? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Mental state and medication reviewed three monthly or less often. Support group.
2 = MODERATE HELP	e.g.	Mental state and medication reviewed more frequently than three monthly. Frequent specific therapy e.g. day hospital, high CPN input.
3 = HIGH HELP	e.g.	Active treatment/ 24 hour hospital care, daily day care or crisis care at home.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR THESE SYMPTOMS? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR THESE SYMPTOMS? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

14 PSYCHOLOGICAL DISTRESS

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON SUFFER FROM CURRENT PSYCHOLOGICAL DISTRESS? ☐ ☐ ☐

Have you recently felt very sad or fed up? Have you felt very anxious, frightened or worried?

0 = NO PROBLEM	e.g	Occasional or mild distress.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Needs and gets ongoing support.
2 = SERIOUS PROBLEM	e.g.	Distress affects life significantly, e.g. prevents person going out.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 15

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR THIS DISTRESS? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Some sympathy and support.
2 = MODERATE HELP	e.g.	Has opportunity at least weekly to talk about distress and get help with coping strategies.
3 = HIGH HELP	e.g.	Constant support and supervision.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES FOR THIS DISTRESS? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES FOR THIS DISTRESS? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Assessment of mental state or occasional support.
2 = MODERATE HELP	e.g.	Specific psychological or social intervention for anxiety. Counselled by staff at least once a week e.g. at Day Hospital.
3 = HIGH HELP	e.g.	24 hour hospital care, or crisis care at home.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR THIS DISTRESS? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR THIS DISTRESS? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

15 INFORMATION (ON CONDITION & TREATMENT)

ASSESSMENT
USER STAFF CARE

HAS THE PERSON HAD CLEAR VERBAL OR WRITTEN INFORMATION ABOUT THEIR CONDITION AND TREATMENT?

Have you been given clear information about your condition, medication or other treatment? Do you want such information? How helpful has the information been?

0 = NO PROBLEM	e.g	Has received and understood adequate information. Has not received but does not want information. Advanced stage of dementia precludes need.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Has not received or understood all information.
2 = SERIOUS PROBLEM	e.g.	Has received inadequate or no information.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 16

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES IN OBTAINING SUCH INFORMATION?

0 = NONE		
1 = LOW HELP	e.g.	Some advice.
2 = MODERATE HELP	e.g.	Given leaflets/fact-sheets or put in touch with self-help groups.
3 = HIGH HELP	e.g.	Regular liaison with mental health staff or voluntary groups (e.g. Alzheimer's Disease Society) by friends or relatives.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES IN OBTAINING SUCH INFORMATION?

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES IN OBTAINING SUCH INFORMATION?

0 = NONE		
1 = LOW HELP	e.g.	Brief verbal or written information on illness/problem/treatment.
2 = MODERATE HELP	e.g.	Given details of self-help groups. Long verbal information sessions e.g. during Day Hospital attendance.
3 = HIGH HELP	e.g.	Has been given specific personal education with or without detailed written information.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP IN OBTAINING INFORMATION?

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING IN OBTAINING INFORMATION?

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

16 SAFETY TO SELF (DELIBERATE SELF-HARM)

ASSESSMENTS
USER STAFF CARER

IS THE PERSON A DANGER TO THEMSELVES? ☐ ☐ ☐

Do you ever think of harming yourself or actually harm yourself?

0 = NO PROBLEM	e.g	No thoughts of self-harm or suicide
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Suicide risk monitored by staff; receiving counselling.
2 = SERIOUS PROBLEM	e.g.	Has expressed suicidal intent, deliberately neglected self or exposed self to serious danger in the last month.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 17

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVESTO REDUCE RISK OF DELIBERATE SELF-HARM? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Able to contact friends or relatives if feeling unsafe.
2 = MODERATE HELP	e.g.	Friends or relatives are usually in contact and are likely to know if feeling unsafe.
3 = HIGH HELP	e.g.	Friends or relatives in regular contact and are very likely to know and provide help if feeling unsafe.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES TO REDUCE THE RISK OF DELIBERATE SELF-HARM? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES TO REDUCE THE RISK OF DELIBERATE SELF-HARM? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Someone to contact when feeling unsafe.
2 = MODERATE HELP	e.g.	Staff check at least once a week; regular supportive counselling.
3 = HIGH HELP	e.g.	Daily supervision; inpatient care.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP TO REDUCE RISK OF DELIBERATE SELF-HARM? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING TO REDUCE RISK OF DELIBERATE SELF-HARM? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

17 SAFETY TO SELF (INADVERTENT SELF-HARM)

ASSESSMEN.
USER STAFF CAI

IS THE PERSON AT INADVERTENT RISK TO THEMSELVES? ☐☐☐

Do you ever do anything that accidentally puts yourself in danger (e.g. leaving gas taps on, leaving fire unattended or getting lost)?

0 = NO PROBLEM	e.g.	No accidental self-harm..
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Specific supervision or help; e.g. memory notes or prompts.
2 = SERIOUS PROBLEM	e.g.	Frequent dangerous behaviour; e.g. getting lost, gas/fire hazard.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 18

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES TO REDUCE THE RISK OF INADVERTENT SELF-HARM? ☐☐☐

0 = NONE		
1 = LOW HELP	e.g.	Periodic supervision; weekly or less.
2 = MODERATE HELP	e.g.	Supervision on 3-5 days a week.
3 = HIGH HELP	e.g.	Almost constant supervision/24-hour care.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES TO REDUCE THE RISK OF INADVERTENT SELF-HARM? ☐☐☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES TO REDUCE THE RISK OF INADVERTENT SELF-HARM? ☐☐☐

0 = NONE		
1 = LOW HELP	e.g.	Check on behaviour weekly or less.
2 = MODERATE HELP	e.g.	Daily supervision.
3 = HIGH HELP	e.g.	Constant supervision e.g. residential care.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP TO REDUCE RISK OF INADVERTENT SELF-HARM? ☐☐☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING TO REDUCE RISK OF INADVERTENT SELF-HARM? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

18 SAFETY TO SELF (ABUSE / NEGLECT)

ASSESSMENTS
USER STAFF CARER

IS THE PERSON AT RISK FROM OTHERS? ☐ ☐ ☐

Has anyone done anything to frighten or harm you, or taken advantage of you?

0 = NO PROBLEM	e.g.	No abuse/neglect.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Needs and gets ongoing support or protection.
2 = SERIOUS PROBLEM	e.g.	Regular shouting, pushing or neglect. Financial misappropriation. Physical assault.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 19

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES TO REDUCE RISK OF ABUSE? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional advice.
2 = MODERATE HELP	e.g.	Regular support and protection.
3 = HIGH HELP	e.g.	Constant support; very regular protection; negotiation.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES TO REDUCE THE RISK OF ABUSE? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES TO REDUCE THE RISK OF ABUSE? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Someone to contact when feeling threatened or unsafe.
2 = MODERATE HELP	e.g.	Regular support; occasional respite.
3 = HIGH HELP	e.g.	Constant supervision; legal involvement via services; separation from abuser.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP TO REDUCE RISK OF ABUSE? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING TO REDUCE RISK OF ABUSE? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

19 BEHAVIOUR

ASSESSMEN
USER STAFF CAR

IS THE PERSON'S BEHAVIOUR DANGEROUS, THREATENING, INTERFERING OR ANNOYING TO OTHERS?

Do you come into conflict with others e.g. by interfering with their affairs, frequently annoying, threatening or disturbing them? What happens?

0 = NO PROBLEM	e.g.	No history of disturbance to others.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Under supervision because of potential risk.
2 = SERIOUS PROBLEM	e.g.	Recent violence, threats or seriously interfering behaviour.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 20

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?

0 = NONE		
1 = LOW HELP	e.g.	Help/supervision weekly or less.
2 = MODERATE HELP	e.g.	Help/supervision more often than weekly.
3 = HIGH HELP	e.g.	Almost constant help/supervision due to persistently disturbing behaviour.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?

0 = NONE		
1 = LOW HELP	e.g.	Check on behaviour weekly or less.
2 = MODERATE HELP	e.g.	Daily supervision or night-sitting service.
3 = HIGH HELP	e.g.	Constant supervision; behaviour management programme.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING TO REDUCE ANNOYING OR DISTURBING BEHAVIOUR?

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

20 ALCOHOL

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON DRINK EXCESSIVELY OR HAVE A PROBLEM CONTROLLING THEIR DRINKING? ☐ ☐ ☐

Do you drink alcohol? How much? Does drinking cause you any problems?
Do you ever feel guilty about it? Do you ever wish you could cut down your drinking?

0 = NO PROBLEM	e.g.	Doesn't drink or drinks sensibly.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g	At risk from alcohol abuse and receiving help.
2 = SERIOUS PROBLEM	e.g	Current drinking harmful or uncontrollable.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 21

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES FOR THEIR DRINKING? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Advised to cut down.
2 = MODERATE HELP	e.g.	Advised about helping agencies, e.g. Alcoholics Anonymous.
3 = HIGH HELP	e.g.	Constant support and/or monitoring of alcohol intake.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES FOR THEIR DRINKING? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES FOR THEIR DRINKING? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Given information and told about risks.
2 = MODERATE HELP	e.g.	Given support and details of helping agencies.
3 = HIGH HELP	e.g.	Attends alcohol clinic, supervised withdrawal programme.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP FOR THEIR DRINKING? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING FOR THEIR DRINKING? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

21 COMPANY

ASSESSMENTS
USER STAFF CA

DOES THE PERSON NEED HELP WITH SOCIAL CONTACT?

Are you happy with your social life?
Do you wish you had more social contact with others?

0 = NO PROBLEM	e.g.	Able to organise enough social contact, has enough contact with friends.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	May be lonely at night but attends appropriate drop-in or day centre or other eg. Lunch Club.
2 = SERIOUS PROBLEM	e.g.	Frequently feels lonely and isolated. Very few social contacts.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 22

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH SOCIAL CONTACT?

0 = NONE		
1 = LOW HELP	e.g.	Social contact/visit less than weekly.
2 = MODERATE HELP	e.g.	Social contact weekly or more often.
3 = HIGH HELP	e.g.	Social contact at least four times a week.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES IN ORGANISING SOCIAL CONTACT?

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES IN ORGANISING SOCIAL CONTACT?

0 = NONE		
1 = LOW HELP	e.g.	Occasional visits from befriender or voluntary worker. Referral to day centre.
2 = MODERATE HELP	e.g.	Regular attendance at day centre; regular luncheon club, organised social activity.
3 = HIGH HELP	e.g.	Day centre attendance or social home visits 3 or more times a week.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH SOCIAL CONTACT?

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH THEIR SOCIAL CONTACT?

(0 = NOT SATISFIED 1 = SATISFIED

COMMENTS

22 INTIMATE RELATIONSHIPS

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE A PARTNER, RELATIVE OR FRIEND WITH WHOM THEY HAVE A CLOSE EMOTIONAL/PHYSICAL RELATIONSHIP? [ ] [ ] [ ]

Do you have a partner, relative or friend you feel close to? Do you get on well? Can you talk about your worries or problems? Do you lack physical contact/intimacy?

0 = NO PROBLEM	e.g.	Happy with current relationships or does not want any intimate relationship.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Counselling/advice which is helpful.
2 = SERIOUS PROBLEM	e.g.	Desperately lonely. Lack of confidant.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 23

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES WITH INTIMATE RELATIONSHIPS OR LONELINESS? [ ] [ ] [ ]

0 = NONE		
1 = LOW HELP	e.g.	Occasional emotional support.
2 = MODERATE HELP	e.g.	Regular support.
3 = HIGH HELP	e.g.	Help contacting counselling services (e.g. bereavement/marriage counselling) and possibly accompanying the person there.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES WITH INTIMATE RELATIONSHIPS OR LONELINESS? [ ] [ ] [ ]

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES WITH INTIMATE RELATIONSHIPS OR LONELINESS? [ ] [ ] [ ]

0 = NONE		
1 = LOW HELP	e.g.	Some support/advice.
2 = MODERATE HELP	e.g.	Regular support/advice.
3 = HIGH HELP	e.g.	Intensive support. Specific therapy, e.g. marital or bereavement counselling.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP WITH RELATIONSHIPS? [ ] [ ] [ ]

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING WITH RELATIONSHIPS? [ ]

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

23 MONEY

ASSESSMENTS
USER STAFF CARER

DOES THE PERSON HAVE PROBLEMS MANAGING OR BUDGETING THEIR MONEY? ☐ ☐ ☐

Do you have any difficulty managing your money?
Are you able to pay your bills?

0 = NO PROBLEM	e.g.	Able to buy essential items and pay bills.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Benefits from help with managing affairs or budgeting.
2 = SERIOUS PROBLEM	e.g.	Often has no money for essential items or bills. Unable to manage finances.
9 = NOT KNOWN		

IF RATED 0 OR 9 GO TO QUESTION 24

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES IN MANAGING THEIR MONEY? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional help sorting out household bills.
2 = MODERATE HELP	e.g.	Calculating weekly budget. Collecting pension.
3 = HIGH HELP	e.g.	Complete management of finances. Power of Attorney.
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES IN MANAGING THEIR MONEY? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES IN MANAGING THEIR MONEY? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional help with budgeting.
2 = MODERATE HELP	e.g.	Supervised in paying rent; given weekly spending money.
3 = HIGH HELP	e.g.	Virtual or complete management of finances; Court of protection; Enduring Power of Attorney.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP IN MANAGING THEIR MONEY? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING IN MANAGING THEIR MONEY? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

24 BENEFITS

ASSESSMENTS
USER STAFF CARER

IS THE PERSON DEFINITELY RECEIVING ALL THE BENEFITS THAT THEY ARE ENTITLED TO? ☐ ☐ ☐

Are you sure that you are getting all the money that you are entitled to?

0 = NO PROBLEM	e.g.	Has no need of benefits or receiving full entitlement of benefits.
1 = NO/MODERATE PROBLEM DUE TO HELP GIVEN	e.g.	Receives appropriate help in claiming benefits.
2 = SERIOUS PROBLEM	e.g.	Not sure/not receiving full entitlement of benefits.
9 = NOT KNOWN		

IF RATED 0 OR 9 FINISH OR GO TO CARER'S SECTION OVERLEAF

HOW MUCH HELP DOES THE PERSON RECEIVE FROM FRIENDS OR RELATIVES IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasionally asks whether person is getting any money.
2 = MODERATE HELP	e.g.	Make enquiries about entitlements and help fill in forms.
3 = HIGH HELP	e.g.	Has ensured full benefits are being received..
9 = NOT KNOWN		

HOW MUCH HELP DOES THE PERSON *RECEIVE* FROM LOCAL SERVICES IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT? ☐ ☐ ☐

HOW MUCH HELP DOES THE PERSON *NEED* FROM LOCAL SERVICES IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT? ☐ ☐ ☐

0 = NONE		
1 = LOW HELP	e.g.	Occasional advice about entitlements.
2 = MODERATE HELP	e.g.	Help with applying for extra entitlements.
3 = HIGH HELP	e.g.	Comprehensive evaluation of current entitlement.
9 = NOT KNOWN		

DOES THE PERSON RECEIVE THE RIGHT TYPE OF HELP IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT? ☐ ☐ ☐

(0 = NO 1 = YES 9 = NOT KNOWN)

OVERALL, IS THE PERSON SATISFIED WITH THE AMOUNT OF HELP THEY ARE RECEIVING IN OBTAINING THEIR FULL BENEFIT ENTITLEMENT? ☐

(0 = NOT SATISFIED 1 = SATISFIED)

COMMENTS

Appendix 8

Practitioner Assessment of Network Typology (PANT)
(Grant & Wenger, 1993).

Network assessment instrument*

*This form should only be used in conjunction with the appropriate training package devised by Dr.G. Clare Wenger, Centre for Social Policy Research and Development, University of Wales, Bangor

Instructions

1. Ask all questions and circle code
2. Circle same code across all boxes on same line
3. Count (do not add) circled codes for each network column and enter number at bottom of column
4. Highest number on bottom line will be in column of respondent's network type

Question	Response categories	Code	Family dependent	Locally integrated	Local self-contained	Wider community focused	Private
1. How far away, in distance, does your nearest child or other relative live? *Do not include spouse*	No relatives	A					
	Same house/within 1 mile	B	B				
	1-5 miles	C		C			
	6-15 miles	D		D	D		
	16-50 miles	E			E	E	E
	50+ miles	F				F	F
2. If you have any children, where does your nearest child live?	No relatives	A			A		A
	Same house/within 1 mile	B	B	B			
	1-5 miles	C	C	C			
	6-15 miles	D		D	D		
	16-50 miles	E			E		
	50+ miles	F				F	F
3. If you have any living sisters or brothers, where does your nearest sister or brother live?	No sisters or brothers	A				A	A
	Same house/within 1 mile	B	B	B			
	1-5 miles	C	C	C	C		
	6-15 miles	D		D	D		
	16-50 miles	E			E		
	50+ miles	F				F	F
4. How often do you see any of your children or other relatives to speak to?	Never/no relative	A					A
	Daily	B	B	B			
	2-3 times a week	C	C	C			
	At least weekly	D			D		
	At least monthly	E			E	E	
	Less often	F				F	F
5. If you have friends in this community/neighbourhood, how often do you have a chat or do something with one of your friends?	Never/no friends	A					A
	Daily	B		B		B	
	2-3 times a week	C		C		C	
	At least weekly	D		D		D	
	At least monthly	E	E		E		
	Less often	F	F		F		F

Question	Response categories	Code	Family dependent	Locally integrated	Local self-contained	Wider community focused	Private
6. How often do you see any of your neighbours to have a chat with or do something with?	No contact with neighbours	A	A				A
	Daily	B		B			
	2-3 times a week	C		C			
	At least weekly	D		D	D	D	
	At least monthly	E	E		E	E	
	Less often	F	F				F
7. Do you attend any religious meetings?	Yes, regularly	A		A		A	
	Yes, occasionally	B	B		B	B	
	No	C			C		C
8. Do you attend meetings of any community/ neighbourhood or social groups, such as old people's clubs, lectures or anything like that?	Yes, regularly	A		A		A	
	Yes, occasionally	B	B		B		
	No	C	C		C		C
NETWORK TYPE (highest number)							

Information received from:	All from client/patient	1
(code as appropriate)	Some or all from proxy	2

Network type:

Appendix 9

Older Americans Resources and Services (OARS)
Social Resources Section (Fillenbaum, 1978).

Social Resources - from the OARS Multidimensional Functional Assessment Questionnaire
(See Fillenbaum and Smyer, 1981)

Now I'd like to ask you some questions about your family and friends.

1. Are you single, married, never married, widowed, divorced or separated?
   1 Single (never married)
   2 Married
   3 Widowed
   4 Divorced
   5 Separated
   - Not answered

2 Who lives with you?

(Tick "yes" or "no" for each of the following.)

yes	no	
___	___	No one
___	___	Husband or wife
___	___	Children
___	___	Grandchildren
___	___	Parents
___	___	Grandparents
___	___	Brothers and sisters
___	___	Other relatives
___	___	Friends
___	___	Non-related paid helper
___	___	Other (*Specify*) _____

3. How many people do you know well enough to visit with them in their homes?

   3 Five or more
   2 Three to four
   1 One or two
   0 None
   - Not answered

4. About how many times did you talk to someone - friends, relatives, or others on the telephone in the past week (either you called them or they called you)? [*If subject has no phone, question still applies.*]

   3 Once a day or more
   2 2-6 times
   1 Once
   0 Not at all
   - Not answered

5. How many times during the past week did you spend some time with someone who does not live with you; that is you went to see them or they came to visit you, or you went out to do things together?

   3 Once a day or more
   2 2-6 times
   1 Once
   0 Not at all
   - Not answered

6. Do you have someone you can trust and confide in?

1 Yes
0 No
- Not answered

7. Do you find yourself feeling lonely quite often, sometimes, or almost never?

0 Quite often
1 Sometimes
2 Almost never
- Not answered

8. Do you see your relatives and friends as often as you want to, or not?

1 As often as wants to
0 Not as often as wants to
- Not answered

9. Is there someone who would give you any help at all if you were sick or disabled, for example your husband/wife, a member of your family, or a friend?

1 Yes
0 No one willing and able to help
- Not answered

[*If "no" ignore the remainder*]

a. Is there someone who would take care of you as long as needed, or only for a short time, or only someone who would help now and then (for example, taking you to the doctor, or making lunch occasionally, etc.)?

3 Someone who would take care of Subject indefinitely
2 Someone who would take care of subject for a few weeks (up to six months)
1 Someone who would help the subject now and then
- Not answered

b. Who is this person?

Name _____
Relationship _____
Code :
1 Spouse
2 Sibling
3 Offspring
4 Grandchild
5 Other family member
6 Friend
7 Other

Appendix 10

Extra questions for residents of sheltered accommodation

Extra questions for residents of sheltered accommodation.

How do you find living here? _____

_____

_____

How long have you lived here? ___ ___

Why did you decide to move to sheltered accommodation?_____

_____

What were the features of sheltered accommodation which most attracted you?

_____

_____

In your decision to move, how important were the following? :
Please circle circle the most appropriate number (from 1 to 5).

	Not at all important		Quite important		Very important
Having a warden	1	2	3	4	5
Company of other residents	1	2	3	4	5
An active social life	1	2	3	4	5
Security	1	2	3	4	5
Poor health	1	2	3	4	5
No longer able to manage stairs at home	1	2	3	4	5
Previous home was too large	1	2	3	4	5
Previous home would have needed alterations (eg to bathroom)	1	2	3	4	5
To be nearer the family	1	2	3	4	5
To join friends already there	1	2	3	4	5
To continue being independent	1	2	3	4	5
Concerns about your future needs	1	2	3	4	5
Other (please specify) _____	1	2	3	4	5

_____

Was the move mainly someone else's decision? yes no

If so, whose? _____

How do you feel about the following statements?
Please circle circle the most appropriate number (from 1 to 5).

	strongly agree	agree	uncertain	disagree	strongly disagree
The move to sheltered accommodation has been a success	1	2	3	4	5
My expectations have been fulfilled	1	2	3	4	5
I have made new friends in sheltered accommodation	1	2	3	4	5

Since I have moved:-	much less	less	about the same	more	much more
the number of people I see to talk to is	1	2	3	4	5
I see my family	1	2	3	4	5
I see the friends I knew before I moved	1	2	3	4	5
I have feelings of lonliness	1	2	3	4	5

How often do you see the warden? _____

For how long on average? _____

Has the warden helped you in an emergency? yes no

If so, what help was given? _____

how often has this occurred in the last year? _____

Does the warden help you in any tasks regularly? yes no

If so, what help is given? _____

how often has this occurred in the last month? _____

Would you like the warden to do more for you than she/he currently does? yes no

Which of the following facilities do you use?:

	yes	number of times per week	no	facility not provided
Common room	___	___	___	___
Communal laundry	___	___	___	___
Alarm	___	___	___	___

Please go on to fill in the three sheets "Roles and Goals", "OARS Social Resources" and "Network assessment instrument".

Appendix 11

Health problems questionnaire

Q1: Do you have any health problems? Yes ☐ No ☐

If Yes: Can you tell me what they are?

_____

_____

_____

Q2: Do you take any medicines at all, either from your doctor or from any other source (eg. chemist, health shop, homeopath) ?

Yes ☐ No ☐

If Yes: Could you tell me what medicines you take, what dose and how often?

_____

_____

_____

_____

Q3: Do you have any problems with your sight? Yes ☐ No ☐

If Yes:	Corrected with glasses?	Yes ☐	No ☐
	Cannot see satisfactorily?	Yes ☐	No ☐
	Limited (large print books read)	Yes ☐	No ☐
	Blind	Yes ☐	No ☐

Q4: Do you have any problems with your hearing? Yes ☐ No ☐

If Yes :	Corrected with hearing aid?	Yes ☐	No ☐
	Inadequate hearing?	Yes ☐	No ☐
	Interviewer has to shout?	Yes ☐	No ☐
	Deaf: Communications impossible?	Yes ☐	No ☐

Q5: Have you ever smoked?

No	☐
Yes, in the past	☐
Yes, now	☐

If Yes: What age did you first start smoking? _____

What age did you stop smoking? _____

How much do/did you smoke?

Pipe or cigars only	Yes ☐	No ☐
Smokes very occasionallly	Yes ☐	No ☐
1-3 per day	Yes ☐	No ☐
4-9 per day	Yes ☐	No ☐
10-19 per day	Yes ☐	No ☐
20-29 per day	Yes ☐	No ☐
30+ per day	Yes ☐	No ☐

Appendix 12

Service use questionnaire

SERVICES QUESTIONNAIRE

Have you seen in the last **3 months**:

A GP?

yes no

number of times (in 3/12) ___

What was the reason? _____

A CPN?

yes no

number of times (in 3/12) ___

What was the reason? _____

A Physiotherapist?

yes no

number of times (in 3/12) ___

What was the reason? _____

A Psychologist?

yes no

number of times (in 3/12) ___

What was the reason? _____

An Ocupational Therapist?

yes no

number of times (in 3/12) ___

What was the reason? _____

IN the last **year** have you:

Seen a Social Worker?

yes no

number of times (in a year) ___

What was the reason? _____

Been to a hospital outpatient appointment?

yes no

number of times (in a year) ___

What was the reason? _____

In the last **month** (4 weeks) have you:

Seen a District Nurse?

yes no

number of times (in 4/52) ___

What was the reason? _____

Had Home Help?

yes no

number of times (in 4/52) ___

What was the reason? _____

Had Meals on Wheels?

yes no

number of times (in 4/52) ___

What was the reason? _____

Had other services at home?

yes no

number of times (in 4/52) ___

What was the reason? _____

Been to a Day Hospital?

yes no

number of times (in 4/52) ___

What was the reason? _____

Been to a Day Centre?

yes no

number of times (in 4/52) ___

What was the reason? _____

Been to a Lunch Club?

yes no

number of times (in 4/52) ___

What was the reason? _____

Had help at home from your family?

yes no

number of times (in 4/52) ___

did that include? (please circle):

laundry shopping finances housework

bathing/washing other _____

Had help at home from friends or neighbours?

yes no

number of times (in 4/52) ___

did that include? (please circle):

laundry shopping finances housework

bathing/washing other _____