Suicide prevention

Collaborating with older people in independent living units

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WESLEY mission

WESTERN SYDNEY UNIVERSITY

About Wesley Mission

Wesley Mission supports people from all walks of life through more than 120 community service programs. Over 50 years ago Wesley Mission established the first Lifeline service, and today we continue to provide crisis support to people most in need by operating Lifeline Sydney & Sutherland. We offer support through our clinical mental health hospitals in southern and inner western Sydney and provide national suicide prevention and community mental health services under Wesley LifeForce.

In collaboration with Western Sydney University and residents and managers of Wesley Retirement Living villages independent living units, Wesley Mission has conducted an intensive piece of high specification social and psychological action research. This research will aid the development of a suite of services to support mental health wellbeing and to help prevent suicide amongst older people living independently in the community. The research elicits key social, psychological and environmental risk factors older people may face as the result of key life transitions and proposes a range of practical solutions to help older people meet these challenges and maintain their independence.

Contents

1   Introduction

The Suicide prevention – Collaborating with older people in independent living units paper[1] covers new ground for Wesley Mission and is a practical example of the use of expertise in research, caring for older people, mental health service provision and in suicide prevention to develop integrated care.

Wesley Mission uses evidence from its expertise and experience and, crucially, from this research to develop a stepped model of care to improve people's lives – in this case, addressing the mental health and wellbeing of older people.

The approach is consistent with Wesley Mission's vision to do all the good you can.[i]

This research was motivated by Wesley Mission's concern for the wellbeing of older residents living independently, including at Wesley Retirement Living villages and in the wider community.

The decision to initiate research was prompted by direct evidence that the highest age-specific suicide rate in Australia is men aged 85 years and over, compared to all other age and gender groups – 32.9 per 100,000 persons. This group rate accounted for 2.7 per cent of all male intentional self-harm deaths in 2018, while comprising less than 1.6 per cent of the male population.[ii] Older adults in Australia are also exposed to a range of risk factors, which can increase vulnerability to suicide.

This research sought to identify and address the risk factors in poor mental health and suicide among older people living in retirement villages, such as loneliness, chronic illness, bereavement and environmental issues. It has accessed a quality sample of residents with sufficient data to accurately represent the risks and needs directly from the experiences of people living independently in Wesley Retirement Living villages.

In addition to collecting information about key demographic factors, the survey elicited responses from residents about their living environment, their social lives in and out of the villages, including their activities and sociability, their bereavement status and any other factors which can impact their wellbeing.

Through the survey, Wesley Mission gathered the evidence to identify and develop strategies and services to address the risks and needs for older people's mental health and wellbeing. Research fieldwork resources were made available, in the form of social work students on research placements from Western Sydney University, to support all respondents completing three scales for wellbeing to measure loneliness, anxiety/depression and suicidality, along with other questions. Due to the quality of collection, extensive data was made available for analysis across key items in the dataset.

The Independent Living and Wellbeing Research was designed and conducted to provide data of sufficient quantity and quality to create representative and generic evidence about the mental health of older people living independently. The research originated with Wesley Mission's mental health services and Wesley LifeForce, Wesley Mission's suicide prevention service, as well as Wesley Retirement Living villages and the Department of Social Work and Community Welfare in the school of Social Sciences at Western Sydney University.

By presenting key survey results and some new service proposals as part of a model of care, the paper represents an endpoint of the research. However, as the size and quality of the data set

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[1] For brevity, it is referred to as the paper throughout the document.

lends itself to more complete, intensive and extensive analyses, the paper overviews the research and provides some guidance to further analyses and research reporting.

The paper presents results from high specification survey research. The quality and robustness of the research was enhanced by the work of Western Sydney University social work students who did extensive doorknocking as research fieldworkers to support questionnaire administration.

Consultation with residents resulted in a very positive response to involvement with the survey, which strongly supported the research.

Consultation also accessed residents' views and advice about mental health, wellbeing and suicide prevention and elicited recommendation for the most suitable methods to communicate with village residents to optimise data gathering.

The paper shines a light on the mental health and wellbeing of older people living independently in village communities, providing representative information about the impacts of key transitions that may occur with ageing. The resulting robust data set allows rigorous analyses of key issues and investigation of their relationships across the issues alluded to in the questionnaire.

The research evidence informs the development of a robust model of care that considers Wesley Mission's current progressive service mix of community strategies and activities, community 'gatekeeper' suicide prevention training and the Mental Health and Resilience Program.

The research outcomes highlight a range of key environmental and health transitions, which can challenge older adults. Each transition experienced can have an impact on the quality of residents' lives and threaten their independence, considered essential to their quality of life. The model of care seeks to provide stepwise care to match the mental health and wellbeing needs of people as they age. The services proposed recognise the challenges confronted by transitions such as the loss of loved ones, changing life circumstances and diminishing physical or mental health.

By seeking to help a person to adapt to these changes, the model of care also aims to directly address the negative impacts of transitions on an individual's social and emotional wellbeing through activities and services designed to raise sociability, mood and the ability to cope.

The research results were shared in summary form with village residents for their input into the findings and new service proposals. The results of this feedback will also be provided to government and other funding agencies responsible for the provision of proposed services for older people to enhance social and emotional wellbeing and suicide prevention.

It is hoped that the data from this paper will allow and encourage ongoing research on the challenges faced by an increasing older population, even more essential due the impact of the COVID-19 pandemic.

2 Overview

This section outlines the research purposes, presents the results and briefly suggests services for funding within a model of care consistent with the findings to improve older village residents' wellbeing.

2.1 Purposes

The purposes of the survey research were:

- to elicit a wellbeing profile of residents living in the villages
- to create representative quantitative and qualitative evidence about people living independently in retirement
- to elicit sufficiently good quality data to drive the development of a range of new services to improve the lives of people living independently in the community and improve their mental health and wellbeing and prevent suicide.

The research will enable the coordinated development and promotion of new services, by supporting and driving work with:

- residents, staff and managers from Wesley Retirement Living villages
- the Mental Health and Resilience Program
- Community Development Co-ordinators (CDCs) from the suicide prevention arm of Wesley Mission, Wesley LifeForce
- students and staff from our partner organisation, Western Sydney University.

2.2 Results overview

All statistical relationships reported in the findings are statistically significant at least at the .05 level.

Moderate to strong correlations existed between scores on the loneliness scale, the depression/anxiety scale and on suicidality scale. A negative correlation means if one variable goes up the other variable will tend to go down. With a positive correlation, both variable scores will tend to head in the same direction.

2.2.1 Demography

A moderate negative relationship existed between married status and loneliness: married people were less likely to be lonely, depressed or anxious or experience suicidal ideation than others.

Divorced residents were found to be more likely to be depressed or anxious.

Female respondents showed no significant relationship between key mental health factors or suicidality and age.

Men were generally less lonely and less depressed or anxious as they aged.

2.2.2 Activities

Arguably the most important finding was the significant relationship discovered between the activity 'volunteering' and suicidality. Respondents, describing one activity by ticking the box for 'volunteering', were significantly less like to experience suicidal thinking.

Volunteering was also positively correlated with four questions about sociability and with the sum of the sociability questions.

Involvement with 'medical or professional appointments or therapies' was associated:

- with loneliness and loneliness is associated with suicidal ideation
- with being less likely to 'have made friends I share a bond with'
- with being less likely to have agreed with any statements about sociability statements.

Participation in 'medical or professional appointments or therapies' and its impact on sociability can be interpreted in several ways, the sum of which suggests a person in transition. Their sociability could be inhibited as this activity would compete for time and focus with other more social activities. An older person's increasing focus upon their illness or their partner's illness could be potentially life threatening and also presage the loss of a partner.

This evidence outlines an experience of transition through unsought restrictions heralding a new stage in one's life due to illness. From the perspective of one half of a couple, it may presage the loss of their sick partner and future challenges to mental health wellbeing.

There is another interpretation of the positive correlations between loneliness and suicidal ideation scores and 'medical or professional appointments or therapies'. Older people are seeking help by acting upon a mental health threat, by participating in 'medical or professional appointments or therapies'.

There were no relationships between most activities and depression/anxiety, with one exception, a negative relationship with 'visiting a friend or friends'.

There were also positive correlations between loneliness and two activities, participation in 'general community activities' and 'attend a self-help or support group'.

Attendance at a 'self-help or support group' can be interpreted as help seeking behaviour. Self-help or therapeutic groups could be provided either within the village by Wesley Mission's Mental Health and Resilience Program or externally through other auspices.

2.2.3 Sociability

Statistically significant negative relationships were found between sum scores of the questions relating to sociability and all the mental health wellbeing scales. Moderate negative or inverse correlations were found to exist between the sum of sociability scores and scores for loneliness and suicidality.

All the sociability questions were negatively correlated with scores for loneliness and suicidality.

Negative or inverse relationships existed between agreement with two sociability statements and depression/anxiety scale scores.

Men were more likely to agree they were "satisfied with the opportunities in the village for social activities", whereas women were more likely to disagree.

There were correlations between the number of activities respondents nominated and all the sociability questions.

Participation in the activity 'music performance' was correlated with three of the sociability statements.

2.2.4 Environment

Respondents who were not satisfied with the natural lighting in their unit were statistically more likely to be depressed or anxious.

Residents living alone who ventured an estimate for the internal floor area of their unit, demonstrated the strongest relationships between depression/anxiety and suicidality, between depression/anxiety and loneliness and between loneliness and suicidality.

While 'green spaces' appear to be effective resources for activities that can improve health and psychological wellbeing, there is no direct relationship evident between 'green spaces' and mental health wellbeing.

2.2.5 Religion

'Strength of faith' showed a weak correlation with depressive and anxiety symptoms.

2.2.6 Services proposed for funding

Wesley Mission's model of care proposes the following linked services be funded from external sources.

Two voluntary assessment tools are proposed to identify signs that a resident may be experiencing some challenges to their mental health and wellbeing.

- In the immediate living environment, a lack of natural light or fresh air could lead to a feeling of confinement. Such a tool could be used to link the resident directly to support or care as required or to support planning and renovations to improve unit living.
- In response to transitions in their lives, which could impact on mental wellbeing, such a tool could be used to link the resident directly to support or care as required when changes occur or are in prospect.

Activities support: proposes funding a professional to investigate and work with residents to support the development of activities that address loneliness and deficits in social life that can arise.

Community wellbeing networks: a program to facilitate development of resident groups within retirement villages in Australia that provide and support volunteering opportunities for residents to develop community activities. This would have twin purposes:

- to promote sociability and connection in older age
- to address and improve mental health and wellbeing and prevent suicide.

Wesley Mission Mental Health and Resilience Program should be allocated the resources for ongoing trained psychological and other counselling resources. As the research suggests, the program promotes both mental health wellbeing directly and help seeking behaviour that supports mental health wellbeing, the resources should be allocated for it to become an ongoing program and to expand it nationally to serve older people living independently in retirement villages generally.

By driving action for new projects with these results and bringing together stakeholders from the community, Wesley Mission and Western Sydney University make a clear case for resource allocations for new services needed to improve the mental health and wellbeing of older people living independently in the community.

By eliciting factual answers to key questions and analysing relationships between key influences identified in the environment and in the lives of residents, Wesley Mission is contributing to foundational knowledge about the mental health wellbeing and suicide prevention needs of older people in our community, which underpins the network future development of the services required with strong and appropriate evidence.

3   Methodology

This research project was granted approval from Western Sydney University Human Research Ethics Committee. It was important to ensure principles of voluntary consent, anonymity, perceived benefit to the participants and amelioration of risk, through support for participants who may have experienced distress during the data collection phase. Prior to construction and distribution of the survey, consultations with residents were held about appropriate language and dissemination processes.

This approach was an outworking of the action research framework within which the research was conducted. Action research is a framework that enables researchers to gather information and data from the perspectives of those being researched, while simultaneously beginning to effect some change relating to the major issues identified. In practice, this allowed the methodology to be framed in a way that Wesley LifeForce was able to interact with participants in all aspects of the research project, from gathering and analysing information to testing and delivering a tangible outcome that seeks to directly impact on, and align with, future activities that would benefit the residents.

The 'mixed method action research' employed the most sophisticated and representative information collection structures and processes to provide high specification representative evidence about the wellbeing of older people living independently in Wesley Retirement Living villages.

The research originated with literature reviews around the key topics of:

- factors in suicidality among older people including
  – distress/anxiety and depression– loneliness and social isolation
  – social and emotional connection
  – support needs for connection and social engagement activities to maintain independence

- environmental and sociocultural factors
  – proximate and accessible green space(s)
  – natural light access in units
  – sufficiency of space and perceptions of sufficiency of space in living units

- bereavement as a risk factor for suicide
- belongingness and its antecedents as protective factors against suicide
- religious faith and suicide.

The literature reviews sought to explore the relationships among these topics across psychological factors, social interaction and living environment and with depression, loneliness and suicidality for the development of the survey requirements.

3.1   Hypotheses

Twelve hypotheses were proposed from the literature reviews.

Hypothesis 1: residents who report more symptoms of depression report higher rates of suicidal ideation.

Hypothesis 2: residents experiencing loneliness report more depression.

Hypothesis 3: lower levels of depression will be reported by residents perceiving themselves to have good social connections.

Hypothesis 4: lower levels of depression will be reported by residents engaging in meaningful activities.

Hypothesis 5: poor psychological states, poor social interaction and poor living environment are linked with feelings of unhappiness and loneliness.

Hypothesis 6: residents living in larger apartments will experience fewer symptoms of depression.

Hypothesis 7: residents who perceive that their unit has adequate sunlight and air would report feeling fewer symptoms of depression.

Hypothesis 8: green spaces act as a resource to improve health and psychological wellbeing.

Hypothesis 9: accessible green spaces improve mood for people living in independent living units.

Hypothesis 10: residents who are recently bereaved experience more suicidal ideation.

Hypothesis 11: belongingness and its key antecedents, are likely protective factors against suicide.

Hypothesis 12: religious factors such as participation in religious activities and strength of faith:

- reduce suicidal ideation
- influence attitudes to suicide
- increase the likelihood of help-seeking behaviours.

More information is provided beyond that required by the hypotheses to extend the value of the results by providing a basic respondent profile to better inform the reader about a community living independently in a village. Where certain information indirectly informs or backgrounds those variables relating directly to testing the hypothesis in question, additional information and analysis may be found in the hypothesis discussion.

3.2   Research Model

Diagram 1: provides a more detailed overview of the whole of the research model and the services, the pilot proposal and the consultations into the results and about the proposed services and their feasibility.

Diagram 1: research model and prospective proposals for model of care.
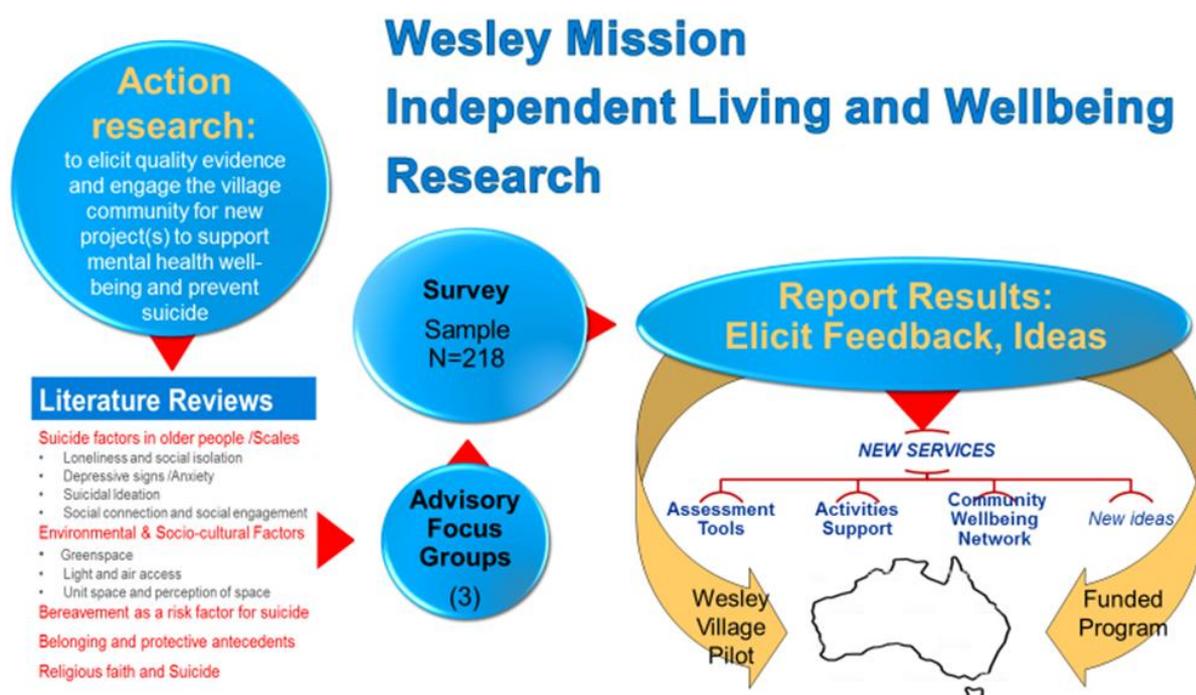
3.3 Advisory Focus Groups

Village managers and residents had input to the development and delivery of the survey research in Wesley Retirement Living villages. In the first instance, village managers were consulted and residents were informed about the Advisory Focus Group and the oncoming survey in general meetings with residents and with Resident Executive Committees. There was discussion about the purposes of the advisory focus groups and how to promote participation in them.

All residents were letter boxed with invitations to ask them to participate in an 'advisory focus group' in their village. Because of its small size with just 29 residents at the time, Wesley Taylor Village was doorknocked to recruit sufficient numbers to run a small group.

The aims of the 'advisory focus group' were to inform the language around mental health, wellbeing and suicide prevention, and to support a communication strategy to support the delivery and best possible completion of the questionnaire. This was done by promotion of the survey to residents, honing communication strategies and improving the clarity of messaging for increased survey response rates.

Information gathered from the literature reviews and from the advisory focus groups was used to construct the Wesley Retirement Living villages Residents' Wellbeing Research Survey.

3.4 Resident support for the survey research

The findings of the focus groups were presented directly to the residents either through a residents' general meeting, and/or to the Residents Executive Committee to seek residents' feedback and support. This consultation yielded support from residents for doorknocking to improve the sufficiency and quality of the survey sample and for the most representative results.

Residents were also made aware of key outcomes of the action research in prospect – services to improve community mental health and wellbeing, to address mental health issues and to support suicide prevention.

A communication strategy was developed following consultation with advisory focus groups and resident executive committees.

The Wesley Retirement Living villages Residents' Wellbeing Prospective Research Survey was conducted within three Sydney Wesley Retirement Living villages:

- Frank Vickery Village at Sylvania (222 residents)
- Alan Walker Village at Carlingford (230 residents)
- Wesley Taylor Village at Narrabeen (29 residents).

Data was collected by Western Sydney University Social Work students who interviewed village residents. There was a response rate of 82 per cent of the random sample of 265 residents who were asked to complete a survey, with all key questions being answered by 218 respondents or approximately 41 people of all people living in Wesley Retirement Living villages.

3.5 Key strength

On a methodological note, the reader should be aware of the special circumstances and the effort required to reach a quality, sufficient sample as the key strength of the research that enabled it to stand on its own as high specification social research.

The key strength has been arrived at and has included:

- access to, and availability of, most residents living independently in Wesley Retirement Living villages, which was supported by the Village Executive Committees, ensuring a good quality quantitative survey
- access to multiple social work students for research placements from Western Sydney University
- consultation and initial Advisory Focus Group research to develop an effective communication strategy to promote the delivery of the survey research in the villages
- the design and the labour-intensive conduct of fieldwork, which required two students over a four-month period in mid-2019 to exhaustively door knock for the sample in each village.

All these factors have enabled the collection of a random, resilient, robust and representative sample.

As a result, Wesley Retirement Living villages Residents' Wellbeing Prospective Research Survey is more representative, well-structured and rigorous and at a higher specification than is usual with social research. This provides a real opportunity for its results to be considered and analysed more intensely due to the rigour and representativeness of the research outputs. The robustness of the sample construction and the integrity of the collection justifies the focus in the results upon relationships or correlations between the variables.

Most of the results are sufficiently well-founded to stand on their own without needing to be triangulated with external information, were that information available. Indeed, the limited references to external data in the paper can be explained as the result of an abundance of quality data available from the survey itself.

The quality and abundance of the data goes some way to explaining the intensity of the analysis it has enabled, including most importantly the exploration of relationships between the various factors and the promotion of these analyses on their own. It also explains why limited amounts of additional data from other sources and communities have been included.

Taken together, the strength of the research design and the intensity of the fieldwork conducted have created a sufficiency and quality of data that also encourages revisitation for further, deeper and more nuanced analyses and to help inform future research and the provision of new services.

While some opportunities for revisiting the data set or for more research based upon it are suggested as part of the interpretations of the various results is open to the reader to find more.

By using the dataset to elicit further understandings beyond these current analyses, Wesley Mission continues to generate the best possible immediate local evidence to enable us to grasp the future challenges to the mental health and wellbeing of older people living independently. In this way and by making this information available generally, Wesley Mission has created foundational knowledge as a contribution to the field of older people's mental health wellbeing for all to use.

Wesley Mission will continue to lead contributions to improvements in service provision based upon the findings reported here and by making the dataset available for further future analyses.

3.6   Analytical notes

The purpose of the analysis was to provide quantitative evidence about relevant relationships between the various elements of the research, to inform the need and to more adequately describe the issues in the demographic social, physical and psychological environment, which underpin the lives, mental health and wellbeing of residents of Wesley Retirement Living villages.

These relationships have been analysed using the questionnaire software IBM SPSS Statistics to analyse ordinal scales such using the Spearman's Rho or Kendal's Tau statistics. On some occasions, non-parametric tests such as Chi Squared were used.

Reliability tests for all the questions on each wellbeing scale were conducted using the Cronbach alpha scale reliability test for the sample, which seeks to ensure that each question in a scale is measuring the same thing. The analyses yielded standardised values of .913 for the loneliness scale and .822 for the depression/anxiety scale and .784 for the sum of all parts of Question 15 that were used as a sociability measure.

The Cronbach alpha score of .596 for the suicidality scale, Question 25, was only able to be brought within the reliable range (>.700) by removing two questions from this scale, which yielded a standardised Cronbach alpha of .751.

4 Findings

A random sample of 265 residents was surveyed over the period July to October 2019. The number of respondents completing a questionnaire[2] was 218 or 82 per cent. Initially sent a self-completion paper questionnaire, exhaustive doorknocking promoted with the support of each Resident Executive Committee was employed to support questionnaire administration. It was the key factor in the high response rate and in the quality of answers.

This support led to both an improved response rate lifting from about 23 per cent for self-completion to 82 per cent with enhanced follow up relying on student field workers to achieve full completion of key questions[3].

As the researchers recognised that there would be a natural reluctance to answer key questions, fieldworkers doorknocked seeking completion of these questions, in priority order:

1. Those that contained scales that related to potentially dependent variables about loneliness (Question 23), depression/anxiety (Question 24) and suicidal thinking (Question 25).
2. The activity participation and popularity Question 16, which was a difficult and complex question.
3. Question 15 that included five parts (a, b, c, d, e) that related to sociability.
4. Questions related to living in the unit, the environment and greenspace (Questions 10, 11 and 12).
5. "Your village and the time living in it" (Questions 1 and 2).
6. All the demographic questions.

Question 9, requesting the respondent guess an estimate of the floor area of their unit was not revisited with the respondents by fieldworkers.

On most occasions, when seeking information about depression/anxiety, we also conducted the analyses using the loneliness scales and the suicidality scales.

Over the period of quantitative research delivery, the fieldworkers were responsible for eight confidential referrals of residents to the Mental Health and Resilience Program.

Eliciting answers about bereavement was left to the discretion of the fieldworker as there were concerns about triggering.

Other significant relationships peripherally related to the hypotheses may also be described to supplement the information provided in the direct analyses to enable the development of broader picture of the issues in their local social and environmental contexts.

4.1 Basic Respondent Profile

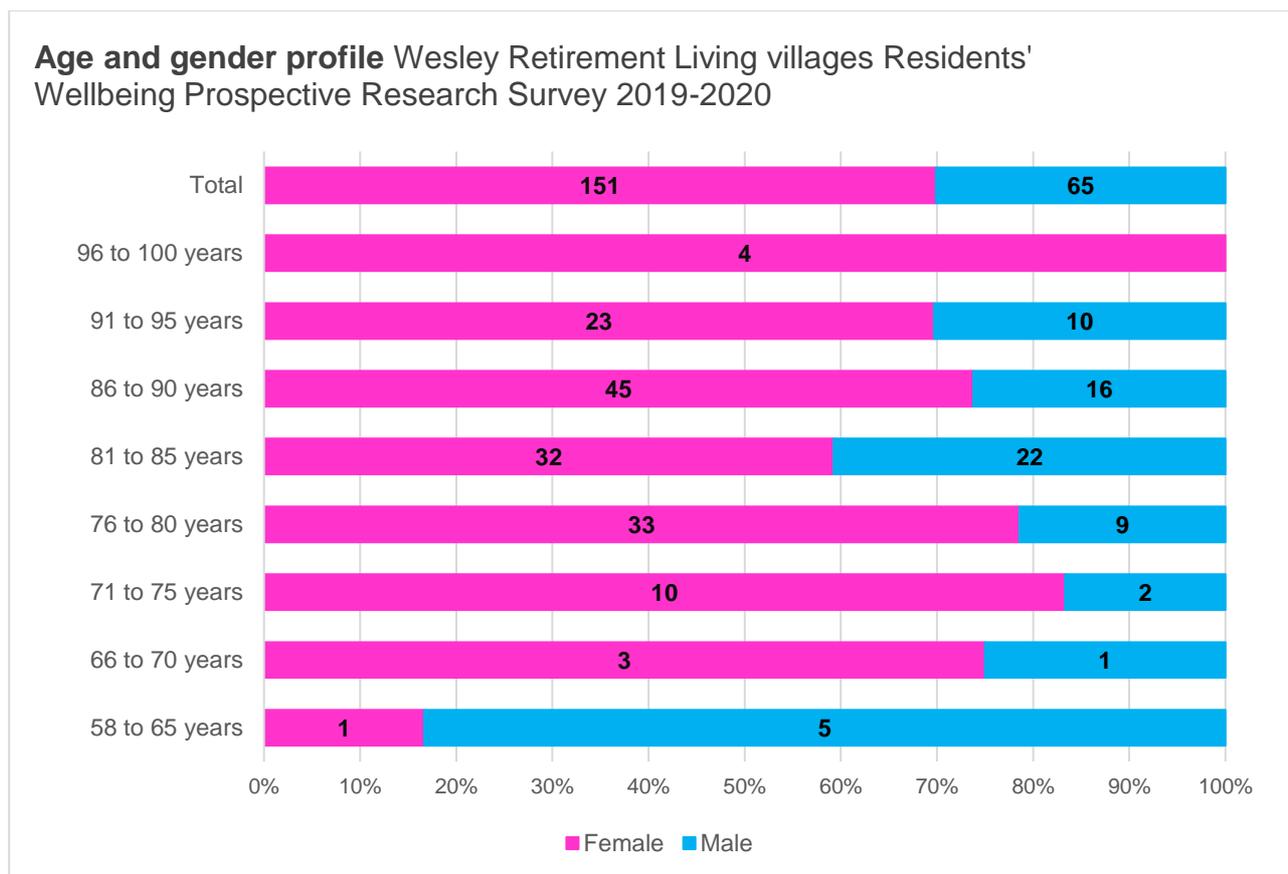Resident respondent demographics:

- seventy per cent (151) were female and 30 per cent (65) male
- sixty percent of men were 81 years or over compared to 52.3 per cent of women
- over 58 per cent of men were in the cohort 76 to 85 year of age compared with just 43 per cent of women
- the average age of women was 84 years and five months and of men 82 and eleven months
- fifty-two per cent of males (34) compared with 81 per cent of females (122) were living alone.

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[2] A full copy of the questionnaire is available at Appendix 8.6 pages 47 to 53.
[3] A detailed explanation of the sample completeness for the survey research is in Appendix 8.5. Glossary, page 46.

Graph 1: Age and gender profile

Age and gender profile Wesley Retirement Living villages Residents'
Wellbeing Prospective Research Survey 2019-2020

Age group	Female	Male
Total	151	65
96 to 100 years	4	
91 to 95 years	23	10
86 to 90 years	45	16
81 to 85 years	32	22
76 to 80 years	33	9
71 to 75 years	10	2
66 to 70 years	3	1
58 to 65 years	1	5

■ Female ■ Male

4.1.1 Differences in mental health and wellbeing between older men and women

Female respondents showed no significant relationships between key factors of mental health and wellbeing and age while men were less lonely and less depressed or anxious with age.

While a weak negative correlation existed between age and depression/anxiety scores - .188 (p<.01) for the whole sample population (N0=218), for men (n=65) there were moderate negative correlations between age and scores for depression/anxiety at -.460 and for loneliness at - .367 (p<.01).

Women showed no significant correlations between depression/anxiety and loneliness with age.

4.1.2 Patterns of sociability and ageing and mental health wellbeing

In terms of the sociability element (Q15C) – satisfaction with the opportunities in the village for social activities – the correlations as they aged for male and female residents were completely opposite and of similar magnitude.

Men were less inclined to agree with the statement, "I am satisfied with the opportunities in the village for social activities" (Q15C) with age.

There was a moderate negative correlation -.248 between levels of agreement and age compared with women who were more inclined to agree with the statement with age, correlated + .253 at p< .01.

4.1.3 Sociability differences between men and women and impacts on the mental health wellbeing scales

The sample demonstrated weak to moderate negative correlations between all the elements of the sociability questions[4] and some of the three mental health wellbeing scales -the loneliness scale, the depression/anxiety scale and the suicidality scale.

Female responses were moderately negatively correlated. For female residents, the more sociable they were, the more likely they were to exhibit better mental health and wellbeing.

With some exceptions, males' responses were not significant. For men sociability appeared to have no relationship with loneliness. On the 'loneliness scale' (Q23) males showed no correlations with any of the sociability questions (Q15a, b, c, d, e) or the sum of the responses.

However, on the 'depression/anxiety scale' there was a moderate negative correlation for male respondents with levels of agreement with the statement, "Wesley Mission activities have engaged me socially" (Q15e) at - .344 (p<.01).
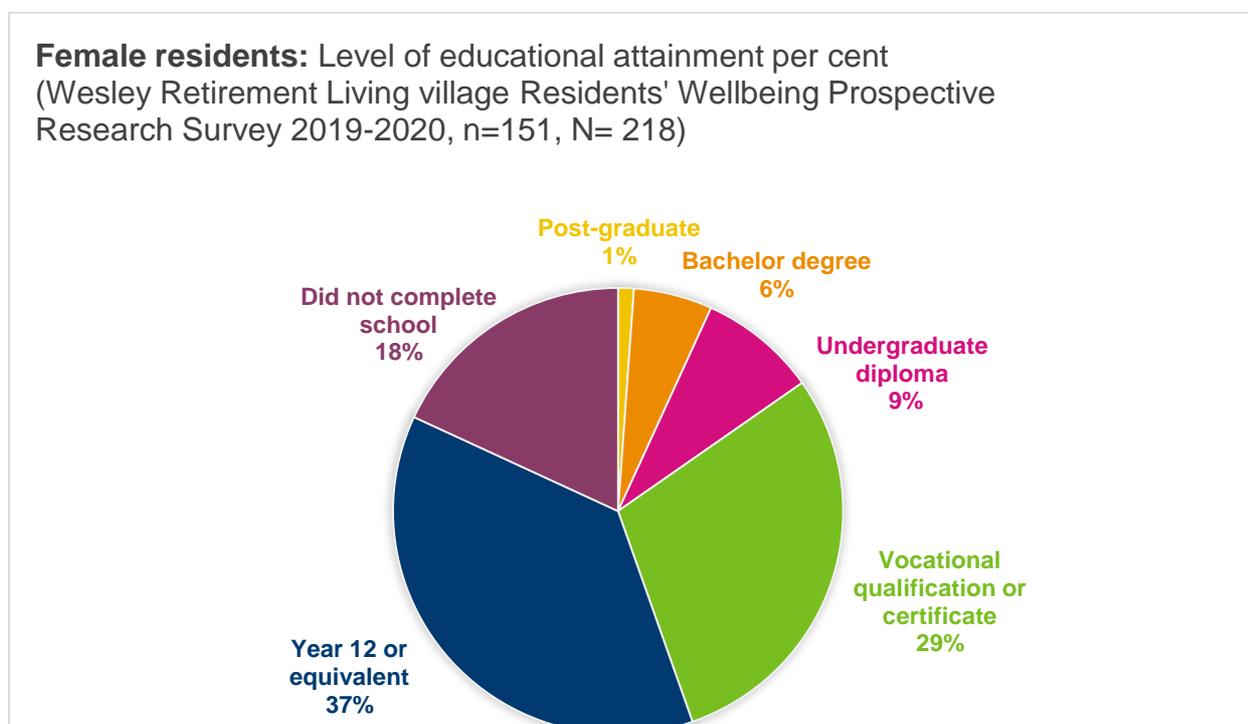
For males, on the 'suicidality scale' there were moderate negative relationships significant at p<.01:

- with Q15a, "I have made friends I share a good bond with" at - .377
- with Q15d, "I am satisfied with the opportunities in the village for social activities" at - .340
- with the sum of the score for Q15 at - .318.

Men were less likely to have suicidal thoughts if they had made friends, they shared a bond with or, were satisfied with the opportunities in the village for social activities. The sum of the sociability question scores was also negatively correlated with suicidal ideation.
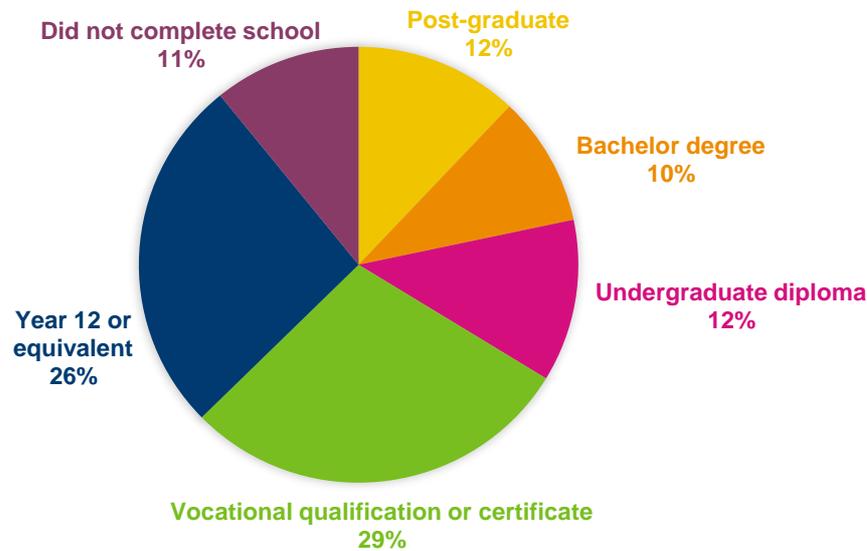
4.1.4 Educational attainment

Graphs 2 and 3: Levels of educational attainment – female and male

Female residents: Level of educational attainment per cent (Wesley Retirement Living village Residents' Wellbeing Prospective Research Survey 2019-2020, n=151, N= 218)

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[4] Question 15 in Appendix 8.6 plus the sum of the scores on the sociability questions. More detail is available in section 4.3 Sociability, activities and mental health wellbeing, pages 18 and 19.

Male residents: Level of educational attainment per cent (Wesley Retirement Living village Residents' Wellbeing Prospective Research Survey 2019-2020, n=65, N= 218)

Educational attainment has been including in the respondent profile to provide effective background information. It is not analysed any further in the paper as its information is unrelated to main purpose of the research and to the hypotheses.

However, the information collected here provides an opportunity when used with the whole dataset for more and insightful analyses. Such analyses could include a gender analysis and the data could also be applied to assessing the relationship between education and possible activities and to assess the opportunities for activities to expand life opportunities and mental health wellbeing.

4.1.5   Relationship status

The largest cohort of women was widowed. Over 55 per cent of women were 86 years of age or over compared to 23 per cent of males. Fifty-one per cent of men were married, compared with 23 per cent of women.

Similar proportions of males - 6.3 per cent, and females -7.3 per cent, described themselves as divorced and as single with males at 12.5 per cent and females at 13.1 per cent.

Not one resident nominated themselves as 'in a relationship', although the option was available.

4.1.6   Relationship status and mental health and wellbeing

Significantly, being married was negatively correlated:

- moderately with loneliness scores, at -.381 (p<.01)
- weakly with depression/anxiety scores, at -.182 (p<.01)
- weakly with suicidality scores at -.134.

That is, married people were less likely to be lonely, depressed, anxious or to have suicidal thoughts.

By the same token, the number of people living alone in a unit was associated:

- moderately with loneliness scores, at -.423 (p<.01)
- weakly with depression/anxiety scores, at -.172
- weakly with suicidality scores at - .131.

People sharing a unit were less likely than people living alone to be lonely, depressed, anxious or suicidal.
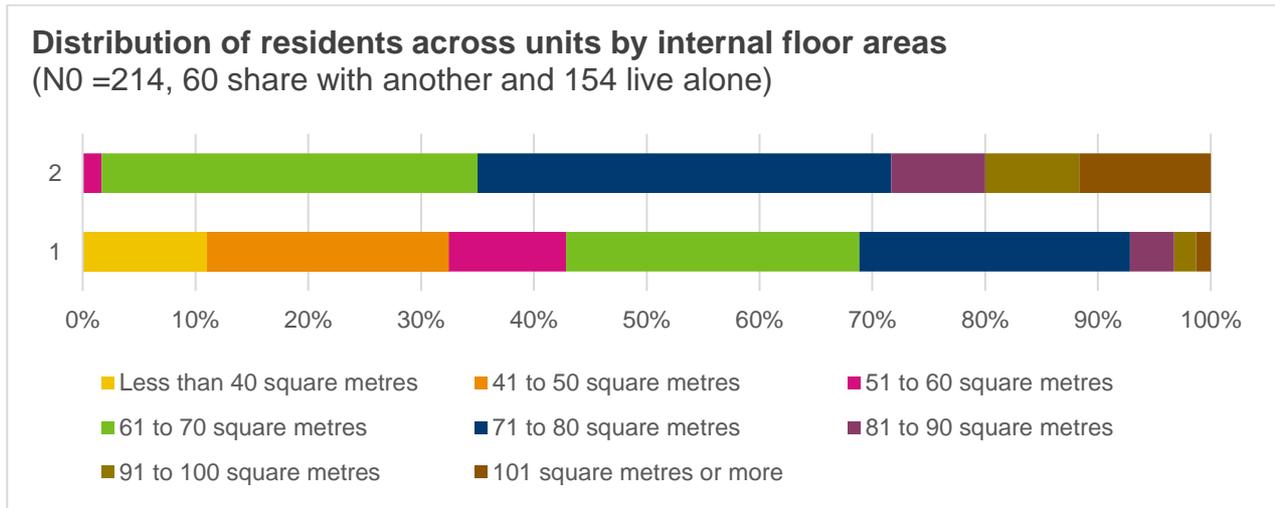
Being single was correlated:

- weakly with suicidality scores at +.159
- weakly with loneliness scores, at +.137.

Being divorced was weakly correlated with depression/anxiety scores at +.164.

Being widowed was weakly correlated with loneliness scores at +.192 (p<.01).

Graph 4: Residents living environment: actual floor space distribution

Distribution of residents across units by internal floor areas
(N0 =214, 60 share with another and 154 live alone)

Legend:
- Less than 40 square metres
- 41 to 50 square metres
- 51 to 60 square metres
- 61 to 70 square metres
- 71 to 80 square metres
- 81 to 90 square metres
- 91 to 100 square metres
- 101 square metres or more

[5]
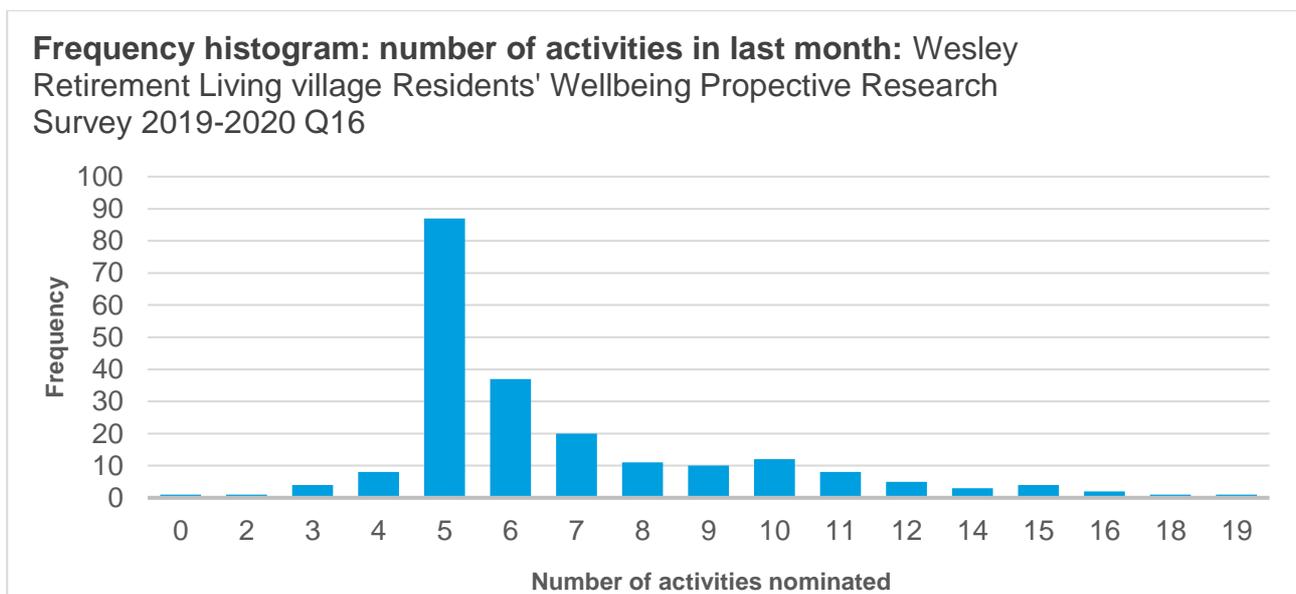
Forty-three per cent of people living on their own had less than 61 m2 in their units compared to just two per cent of people who shared.

4.1.7 Activities and mental health and wellbeing

The average number of activities nominated by the residents was 6.8 per resident.

Graph 5: Frequency histogram: number of activities in the last month

Frequency histogram: number of activities in last month: Wesley Retirement Living village Residents' Wellbeing Propective Research Survey 2019-2020 Q16

Number of activities nominated

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[5] Researchers were unable to identify the unit 4 respondents lived in from information received.

Eleven and a half per cent of all residents – 25 in number – who nominated between 11 and 19 activities were responsible for 23.5 per cent (330) of all the activities nominated for an average frequency of 13.2 activities nominated in the month.

At the other end of the scale, the 3.7 per cent of all residents – 15 in number – who nominated between zero and four activities in the last month were responsible for less than 3.4 per cent or 50 of the activities nominated for an average frequency of 6.2 activities nominates in the last month per month.

In the middle the scale, the 84.7 per cent of all residents – 178 in number – who nominated between five and 10 activities were responsible for 74.3 per cent or 1099 of all 1479 activities nominated for an average frequency of 3.3 activities nominate in the last month per month.

4.2 Correlations between scale scores for loneliness, suicidal ideation and depression/anxiety

4.2.1 Hypothesis 1 – residents who report more symptoms of depression report higher rates of suicidal ideation

Hypothesis 1 is supported: There is a moderate correlation between the depression/anxiety scale (Q24) and the suicidality scale (Q25) at +.361 (significant at p<.01).

Explanation and interpretation

Jo Anne Sirey[iii],et al, 2008 discovered, "Almost a third of older adults who endorsed suicide ideation did not report clinically significant depressive symptoms. Among men, suicidal thoughts were associated with chronic pain and greater depression severity, whereas pain was not a predictor of suicidal thoughts among women."

The purpose here is to underline the result and to provide preliminary information to lead into increasing levels of social explanation available from our data, as distinct from clinical explanation. The source of the differences between women and men among a population of homebound elders in this result are not explored other than in documenting the gender differences in response to chronic pain. Chronic pain and gender could be key elements in identifying likely signs that may presage any transition to the inhibition of an older person's independence.

By comparison, this paper produces new evidence to explore the social differences and relationships between the social factors, activity profile and environmental factors that can help explain the differences in mental health wellbeing. Three mental wellbeing scales are used to measure loneliness, depression and anxiety and suicidal thinking and to provide evidence and across the range of demographic, social and environmental factors and across the activity profile of older people in independent living.

4.2.2 Hypothesis 2 – Residents experiencing loneliness report more depression

There is a strong significant correlation between the depression/anxiety scale and loneliness scale .641 at p<.01.[6]

A moderate significant negative correlation exists between being married and loneliness -.323 (p<.01).

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[6] More exploration of other factors impacting this correlation is available in discussion on pages18-20 and 22.

Explanation and interpretation

Key differences uncovered previously[7] between women and men on trends by age and depression/anxiety and between loneliness and sociability provide some context to this result, already suggesting women who are more sociable or socially engaged are less likely to be lonely and less likely to be depressed.

On the other hand, men who were more sociable were less likely to have suicidal thoughts.

4.3 Sociability, activities and mental health wellbeing

4.3.1 Hypothesis 3 – lower levels of depression will be reported by residents perceiving themselves to have good social connections

For two sociability questions, there were significant negative relationships between sociability and depression/anxiety. As the result of the limited amount of correlation between social sociability questions, only two (below) of five questions and depression/anxiety scale scores, the evidence for hypothesis 3 is relatively and surprisingly weak.

As a result, the relationships between sociability on the one hand and suicidality and loneliness is explored in more detail. They both demonstrate more negative relationships with most of the parts of the sociability question.

Sociability and depression/anxiety scale scores

The depression/anxiety scale asked respondents to nominate over the last 30 days how often they felt the way described in each of ten statements over a five point range from "none of the time" to "all of the time".

The five-part sociability Question 15, asked for levels of agreement with each of five statements relating to sociability. There were weak negative correlations between the depression/anxiety scale and levels of agreement with the statements:"

- "Wesley Mission activities have engaged me socially" (Question 15e). at -.171
- "I participate in activities run by Wesley Mission" (Question 15d) at -145.

Sociability and suicide

There were significant moderate negative correlations between the suicidality scale (Question 25) and most of the questions about residents' 'experience of living in the village' relating to sociability (Questions 15a, b, c, d and e), including with sum of scores of all the sociability questions.

Negative correlations with the suicidality scale include:

- moderate negative correlations for levels of agreement with the statements (at $p<.01$)

  – "I have made friends I share a good bond with" at -.202 (Q15a)
  – "I participate in activities run by Wesley Mission" at -.201 (Q15d)

- weak negative correlations for agreement with the statements

  – "Wesley Mission activities have engaged me socially" at -.168 (Q15e)
  – "I am satisfied with the opportunities in the village for social activities at -.146 (Q15c)
  – "I interact socially with fellow residents" at -.142 (Q15b).

Men were more likely to agree at +.142 that they were "satisfied with the opportunities in the village for social activities", whereas women were more likely to disagree at -.140.

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[7] See pages 12 and 13.

The sum of the scores of the levels of agreement with each statement of the sociability question – Questions 15 a, b, c, d and e – had a moderate negative correlation at -.234 with the suicidality scale.

Sociability and loneliness

There were moderate negative correlations between most of the questions about residents' 'experience of living in the village' relating to sociability (Questions 15a, b, c, d and e), including the sum of scores of all questions, and the loneliness scale (Question 23).

There was a moderate negative correlation between the loneliness scale sum and the sum of the sociability questions at -.292 and "making good friends I share a bond with" Q15a) -.276 at p< .01.

The sociability questions were all negatively correlated with the loneliness scale. The correlations with the loneliness scale include:

- Moderate correlations[8] with levels of agreement for the statements:
    - "I have made friends I share a good bond with" at -.276 (Q15a)
    - "I interact socially with fellow residents" at -.214 (Q15b)
    - "I participate in activities run by Wesley Mission" at -.213 (Q15d)
    - "I am satisfied with the opportunities in the village for social activities" at -.204 (Q15c).
- A weak correlation with levels of agreement for the statement, "Wesley Mission activities have engaged me socially" at -.179 (Q15e).

4.3.2 Hypothesis 4 – lower levels of depression will be reported by residents engaging in meaningful activities

There were no relationships between depression/anxiety and most of the 18 sets of activities listed[9]. The research also shows no significant statistical relationship between respondents scores on the depression/anxiety scale on the one hand, and the sum counts of activities nominated by residents and the sum of frequencies of activities respondents nominated on the other.

However, relationships identified include:

- a significant negative correlation between the depression/anxiety scale and the nominated frequency of the activity 'visiting a friend or friends' at -.138[10]
- correlations with the depression/anxiety scale and the nominated frequency of the following activities:
    - 'Medical or professional appointments or therapies' weakly, at +.182
    - 'Work' weakly, at +.158.

Participation in 'medical or professional appointments or therapies' and its impact on sociability can be interpreted in ways all suggesting people in transition. Sociability could be inhibited as the activity would compete for time and focus with other more social activities thereby helping to promote loneliness and depression. An older person's increasing focus upon their illness or their partner's illness, which could be potentially life threatening and could also presage the loss of a partner.

This evidence appears to outline an experience of transition through unsought restrictions on social interaction heralding a new stage in one's life due to illness. From the perspective of a

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[8] All significant at p<.01.
[9] The activities are listed at Question 16 of the Questionnaire at Appendix 5.
[10] Spearman's rho.

present partner it may presage the loss of their sick partner with future challenges to mental health and wellbeing.

The correlations between loneliness and suicidal ideation scores and 'medical or professional appointments or therapies' and depression/anxiety could be interpreted in a number of ways.

Firstly, it could show that people have sought help in response to a mental health threat by participating in 'medical or professional appointments or therapies' and that the mental health issue may still be around as medical or professional appointments tend to address deeper or more intractable mental health including depression/anxiety.

Secondly, it could be that the medical condition and the associated appointments could be all encompassing, limiting the time the person (or their partner) may have for participating in other activities. With social activities losing out to 'medical or professional appointments or therapies', the older person could miss out on socially responsive activities. It is these activities which help to overcome loneliness, raise spirits and improve sociability as one prophylaxis against future mental health issues.[11]

Relationships between activities and wellbeing

There were few relationships between most activities and depression/anxiety, with one exception a weak negative correlation with 'visiting a friend or friends' at -.137.

Only one relationship was discovered between an activity and suicidality: a negative weak correlation with 'volunteering' at -.145. Volunteering was also correlated to four questions about sociability and with the sum of the sociability questions.

There were weak correlations discovered between loneliness and two activities counted, participation in 'general community activities' at +.120 and 'attend a self-help or support group' at + .130.

Suggestions from the literature review and from resident input to Advisory Focus Groups, that volunteering helps older people stay engaged with life are reinforced and confirmed by the research evidence that people volunteering are less likely to experience suicidal thoughts.

Attendance at a 'self-help or support group' could be interpreted as help seeking behaviour with lonely people seeking help via participation in a self-help or therapeutic group. At least some of this participation in a 'self-help or support group' could have occurred through the Wesley Mission Mental Health and Resilience Program.

The correlation between attending 'self-help or support group' and loneliness can be explained by self-help behaviour to participate and by the presence of the Mental Health and Resilience Program actively responding to loneliness or depression.

The result indicating no relationship with depression/anxiety as a significant part of the picture of resident mental health wellbeing is interesting and counter intuitive. Since depression is a key reason for attendance at a 'self-help or support group' provided proximately by the Wesley Mission Mental Health and Resilience Program, a relationship could be expected between group attendance and depression/anxiety.

One interpretation could be that given the two-year time span of the Program, it's had success with the impact reducing depression/anxiety experienced by residents.

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[11] Negative correlation established as evidence for the relationship identified between sociability and depression/anxiety, page 18 section 4.3 Sociability, activities and mental health wellbeing.

4.3.3   Hypothesis 5 – poor psychological states, poor social interaction and poor living environment are linked with feelings of unhappiness and loneliness

Respondents not happy with the size of their unit are more likely to experience a strong direct relationship between each of the three wellbeing measures, loneliness, anxiety /depression or suicidal thinking. If they experience one of the following: loneliness, anxiety /depression or, suicidal ideation, they are more likely to experience one or more of issues listed here.

If we measure social interaction through participation, the more activities a respondent does, the less likely a resident is to be suicidal, with a negative correlation (-.160) between the number of activities a person participates in and scores on the suicidality scale.

People who are less sociable (Question15 – sum of answers) are likely to be lonelier, more depressed and more suicidal (p<.01). The negative correlations with sociability are moderate for loneliness -.292, weak for depression/anxiety -.174 and moderate for suicidality at -.339.

The unit environment for residents venturing an estimate of their unit's floor area

Residents were also asked a range of questions (Q10) about their living environment and these answers were correlated with the actual floor area, estimated floor areas where available and with the scores on the three scales.

There were:

- moderate correlations between levels of agreement with the statement, "I feel confined within my apartment" (Question 10c) with scores - for loneliness +.290, - for depression/anxiety +.251, - for suicidality +.263 at (p<.01)
- moderate to weak negative correlations between levels of agreement with the statement, "I am satisfied where I live generally" (Question10d) and scores for loneliness -.205, for depression/anxiety -.177 and for scores for suicidality +.183 at p<.01.

For respondents living alone:

- levels of agreement with the statement, "I feel confined within my apartment" (Question10c) were moderately correlated with scores for loneliness +.374, for depression/anxiety +.331 and for suicidality +.346 at p<.01
- levels of agreement with the statement, "I am satisfied where I live generally" (Question 10d) were moderately negatively correlated with scores for loneliness -.227and for suicidality -.217.

In addition to the negative relationships reported between actual size of units and scores on the three wellbeing scales quoted previously, there were correlations between some elements of the living environment and the floor areas[12]. Correlations included:

- a moderate correlation between actual floor areas and levels of agreement with the statement, "I am satisfied where I live generally" (Q10d) at +.211 (P<.01)
- a weak correlation between actual floor areas and levels of agreement with the statement, "I like to spend time in my apartment" (Question10a) at +.155.

Examining the results of respondents venturing an estimate of the floor areas (n1=137) with the distinction in this sample between the reported sub-groups of respondents living on their own (n2=96) and respondents who share (n3=41), uncovered some interesting differences.

For those who share, moderately correlated with actual floor areas are levels of agreement with the statements, "I am satisfied with the natural lighting in my unit" (Question10b) at +.445 (p<.01) and "I feel confined in my apartment" (Question 10c) negatively at -.361. The latter was also

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[12] See pages 24 to 26 discussion of Hypothesis 6.

moderately correlated with the difference between the estimate and the actual floor area at +.484 (p<.01).

The interpretation is that the larger the difference of the estimate over the actual floor area for residents who lived together the less likely were residents to feel confined.

Also, for those who share a unit, the estimates of floor areas were also moderately correlated with (Q10b) levels of agreement with the statements, "I am satisfied with the natural lighting in my unit" at +.373.

While respondents living alone did not show any of the relationships discussed above, for respondents who shared, there were:

- positive correlations between actual floor areas and, Question10d), the levels of agreement with the statement, "I am satisfied about where I live generally" at +.250
- negative correlations between Q10a), the levels of agreement with the statements, "I like to spend time in my apartment" and "I feel confined within my apartment" (Question 10c) at -.281 (p<.01).

Explanation and interpretation

The strong correlations between loneliness, depression/anxiety and suicidal ideation scores suggest an increasing risk and vulnerability for the mental health and wellbeing. Individuals living on their own who were impacted by their living environment, suffered by having insufficient space, and additionally for those in the identified environment living on their own.

For a person living on their own feeling confined in their unit, such as those with limited natural light and with limited fresh air, if lonely the person is more likely to suffer depressive symptoms or anxiety, with these symptoms exacerbated by living in insufficient space. The data suggests the strength of these links across loneliness, depressive symptoms exacerbated by a poor living environment also link statistically increasingly more strongly with suicidal ideation.

Further analysis of that part of the dataset relating to floor space is required. This could generate more information regarding the negative impacts on mental health and wellbeing of confinement and unit liveability.

There is also an opportunity to conduct additional research about to explore residents' perceptions to elicit and assess what are the other factors that may impact residents' comfort, mood and sense of wellbeing for healthy independent unit living.

Other results: activities and mood[13]

Those resident respondents whose more frequent activities included 'medical or professional appointments or therapies' were more likely to be suicidal +.182 and lonely +.168 and less likely to agree with most of the statements that were positive about sociability.

In addition to providing some evidence of the need for intervention which could be supported by the application of an assessment tool, this and other evidence supports promotion or support for other activities.

Respondent nomination of their most frequent activities found, unsurprisingly, that 'visiting a friend or friends' was an activity less likely to be associated with depression/anxiety (-.137).

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[13] The statistic employed is Spearman's rho, more appropriate for relationships among rank order and scalar measures.

On the other hand, counting 'attend self-help or support group' or 'general community activities' among respondent activities was weakly correlated with loneliness scores (+.152 and +.140 respectively).

Activities and sociability

Activity counts that were correlated with sociability are listed below and include with any of the sociability Questions 15a, b, c, d, e or the sum score:

- 'volunteering' with:
  - "I have made friends I share a good bond with" (Q15a, +.185)
  - "I interact socially with fellow residents" (Q15b, +.146)
  - "I participate in activities run by Wesley Mission" (Q15d, moderate at +.202)
  - "Wesley Mission activities have engaged me socially" (Q15e +.148)
  - The sum of all parts of Question 15 (moderate at +.204)

- 'music performance' with:
  - 'I am satisfied with the opportunities in the village for social activities' (Q15c, +.145)
  - 'I participate in activities run by Wesley Mission' (Q15d, moderate at +.230)
  - 'Wesley Mission activities have engaged me socially' (Q15e, moderate at +.269)
  - The sum of all parts of Question 15 moderate at +.232

- 'visiting relatives with:
  - "I am satisfied with the opportunities in the village for social activities" (Q15c, +.140)
  - "I participate in activities run by Wesley Mission" (Q15d, moderate at +.153)
  - 'visiting a friend or friends' with "I have made friends I share a good bond with" (Q15a, +.178)
  - 'other exercise/walking/sport' (+.135) for the sum of all the sociability questions (Q15)
  - 'attend self-help or support group' (+.175) for the sum of all the sociability questions (Q15).

- There was a weak relationship between the respondent nominated frequency of the activity 'spectator sport' with "Wesley Mission activities have engaged me socially" (Q15e +.142).

A weak relationship existed between counts of activities and sociability questions for 'religious related activities' weakly associated with Question 15d, "I participate in activities run by Wesley Mission".[14] This suggests some people participating in 'activities run by Wesley Mission' were participating in 'religious related activities' also supported by Wesley Mission.

Some activities appear to detract from residents' sociability. Activity counts appearing negatively related to sociability are listed below and include those with any of the sociability Questions 15a, b, c, d, e or the sum score:

- 'medical or professional appointments or therapies' with
  - "I have made friends I share a good bond with" Q15a, moderately at -.238
  - "Wesley Mission activities have engaged me socially" (Q15e, at -.134)
  - The sum of all parts of Question 15 at -.153.

The sum of all activities respondents counted is correlated with moderate to weak levels of agreement with the following sociability statements and the sum.

- "I participate in activities run by Wesley Mission" (Q15d, moderately at +.249)
- the sum of all parts of Question 15 moderately at +.200
- "Wesley Mission activities have engaged me socially" (Q15e, at +.193)

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[14] On the edge of significance using Spearman's rho but were just significant using the Pearson's correlation (r). For "Religious related activities", r=+.135 and for "Spectator sport" r= +.147.

- "I interact socially with fellow residents" (Q15b, at +.153)
- "I am satisfied with the opportunities in the village for social activities" (Q15c, at +.144).

4.4   Environment: mental health wellbeing

4.4.1   Hypothesis 6 – residents living in larger apartments will experience fewer symptoms of depression

Residents living alone venturing an estimate for the internal floor area of their unit demonstrated the strongest relationships between scale scores for depression/anxiety and suicidality, depression/anxiety and loneliness and between loneliness and suicidality.

Analyses here relate to four sets of respondents:

- the full sample N0=218,
- a sample defined by the respondents who, ventured an estimate of the floor area of their apartments, n1=137, was split further between the sub-groups of:
  – respondents living on their own (n2=96) and
  – respondents who share (n3=41).

Please note, the design of Question 9, and its lower completion rate of 63 per cent indicates an intended and expected selection bias by design in favour of residents who had thought about the size of their apartment and its proxy measure floor area.

The bias is based upon the fact that for most respondents, the figure for their unit's internal floor area would not be easily to hand. This made the question self-selecting by attracting only those people for whom the topic – internal floor area – was relatively and sufficiently important to attract an answer. It excluded people who had either no idea of the floor area or who had little interest in it.

Results

There were moderate to weak negative correlations between the magnitude of actual internal floor areas of the units[15] and scores on the scales for loneliness at -.226 (p<.01), for anxiety/depression at -.146, and for suicidality at -.204 (at p<.01) for the full sample (N0=218).

This section refers to a smaller sample composed of respondents venturing an estimate of the floor areas answering Question 9 (n1=137) and split between the sub-group of respondents living on their own (n2=96) and respondents who share (n3=41).

For respondents living on their own who provided an estimate of the internal floor area of their unit, there was a moderate negative correlation between the actual internal floor areas of their units and scores in on the scales for loneliness at -.239, for anxiety/depression at -.233 and for suicidality at -.234, (N1=137, n=96). The smaller the actual unit floor area the more likely a person experienced loneliness or anxiety/depression or suicidal thoughts.

There was also a moderate negative correlation between residents' estimates of the internal floor areas of their units and scores in on the loneliness scale at -.254.

As a point of difference, for respondents who shared accommodation and who answered Question 9 asking for estimates of internal floor areas, none of the relationships between actual or estimated floor areas were significantly correlated with scores on either of the scales for loneliness, anxiety/depression or suicidality (N1=137, n3=41).

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[15] Information obtained from Village Managers

Explanation and interpretation

For residents living alone, the larger the unit, the less lonely, the less depressed or anxious and the less suicidal people were likely to be.

One explanation of the lack of statistical significance could have been as the result of the small number of respondents who were both living together and who provided an estimate of their unit floor area. Another explanation is that people who live together have less focus upon their physical living environment as distinct from their human companion who makes up a significant part of their life and their environment.

Living circumstances and relationships between elements of mental health and wellbeing:

For the group of resident respondents who answered Question 9 (N1=137), there were stronger correlations between the scales for loneliness, depression/anxiety and suicidality compared to the whole sample.

The correlation between depression/ anxiety scores and suicidality scores was well into the strong range at +.690 for the group offering an estimate of floor area compared to + .530 for the whole sample and even higher for those respondents living on their own +.721 (All at p<.01).

The correlation between loneliness scores and suicidality scores was well into the strong range at +.626 for the group offering an estimate of floor area compared to + .542 for the whole sample and even higher for those respondents in this grouping who were living on their own at +.654, (all at p<.01).

The correlation between loneliness scores and depression/ anxiety scores was well into the strong range +.679 for the group offering an estimate of floor area compared to + .511 for the whole sample and just higher for those respondents in this grouping who were living on their own +.686. (all at p<.01).

For the sub-group who ventured an estimate of the floor areas and who shared a unit, correlations were weaker, with correlations:

*   between depression/anxiety and loneliness just in the strong range at +.507
*   between depression/anxiety and suicide, moderate at +.377
*   between suicide and loneliness not significant at all.

Explanation and interpretation

A clear interpretation of these results about older people living apart or together and the size of units and whether respondents nominated the floor are of the unit, concludes:

*   that it appears that people who live together are more likely to score better on each of the loneliness scale, the depression anxiety scale and on the suicidality scale
*   that there is likely to be a less enmeshed and weaker relationship between these three elements if a relationship exists at all.

This could be interpreted as people living together having improved capacity to deal with challenges to their wellbeing. With the increased resilience of sharing accommodation, unit residents appear supported to generate effective responses to challenges of experiencing one of loneliness or depression/anxiety or suicidal thinking. This resilience appears to make them less likely to move from experiencing one of these mental health challenges to experiencing another additional mental health challenge than a person living on their own.

These results and others in relation to the respondent profile, which identify more loneliness among older people especially women as they age subject to the demographic dynamics of growing older alone, suggest living with another person could be part of the solution.

4.4.2 Hypothesis 7 – residents who perceive that their unit has adequate sunlight and air would report feeling less symptoms of depression

A Chi square test found people who "disagreed" or "strongly disagreed", they were "satisfied with the natural lighting" (10b) and were more likely to be more depressed or anxious than the group of those respondents who "neither agreed nor disagreed", "agreed" or "strongly disagreed agreed.[16]

"Liking to spend time in one's apartment" (Question10a) was weakly correlated with levels of agreement with, "I am satisfied with the natural lighting in my apartment" +.141.

For those who estimated floor areas and who share their unit, there is a moderate correlation between actual floor areas and levels of agreement with the statement, "I am satisfied with the natural lighting in my unit" (Question 10b) at +.445 (p<.01).

Explanation and interpretation

The hypothesis is supported, moderately relating the adequacy of sunlight and air to lower depression/anxiety scores.

The strength of the relationships around the adequacy of sunlight and air and the adequacy of floor areas has direct implications for the future design of independent living units and for living in retirement villages.

More analysis is needed to see if the data supports the identification of a tipping point. This point could identify where the key elements are that contribute to mood, such as solar access and air flow or the size of the apartment are sufficient. In doing so, the environment could begin to have a noticeable and measurable positive effect on resident mental health and wellbeing and suicidal thinking.

4.4.3 Hypothesis 8 – green spaces act as a resource to improve health and psychological wellbeing

Respondents agreeing with the statement, "There is accessible greenspace near where I live" (Question12a) are more likely to use and/or prioritise it.

There were weak correlations between agreeing, "There is accessible greenspace near where I live" (Question12a) with participating in 'exercise/ walking in green space' at +.174 at p<.01 and with the popularity of participating in the activity 'exercise/ walking in green space' as weighted[17] by respondents at +.140.

There was no statistically significant relationship between the nominated frequency of the activity 'exercise/ walking in green space' or the count of respondents' participation in it (Q16), and any mental wellbeing scale scores.

Explanation and interpretation

Residents who recognise the value of greenspace are more likely to use it, providing a behavioural recognition of it as a resource. Respondents are aware of the value and proximity of greenspace and were prepared to use it with some more likely to access green space more often than other activities.

There was also a weak to moderate negative correlation at -.185 between respondent nominated frequencies of 'exercise/walking in green space' (Q16) and agreement with the statement, "I miss

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[16] Chi Square test significant vs depression at p<05. For the test, answers were grouped in two categories, one including 'Strongly disagree' and 'Disagree' and the other including 'Strongly agree', 'Agree' and 'Neither agree nor disagree'.
[17] Respondents were asked to rank at least five of their most frequent activities over the past month to indicate their popularity.

having green space near where I live", suggesting a notional recognition of its value as a resource, including when it is missing.

4.4.4 Hypothesis 9 – accessible green spaces improve mood for people living in independent living units

There was no correlation between levels of agreement with the statements, "There is accessible greenspace near where I live." Question 12a and "I miss having greenspace near where I live", Question 12b and any of the scales for loneliness, depression/anxiety and suicide, with neither enough nor relevant information to support the hypothesis or the null hypothesis.

More research is needed to elicit data that properly addresses the role of green space as a resource for the health and psychological wellbeing of older people living independently in a retirement village, as sought in hypotheses 8 and 9.

4.5 Bereavement, belonging and sociability

4.5.1 Hypothesis 10 – residents who recently lost someone close experience more suicidal ideation

There was no relationship identified between suicidal ideation and recent bereavement.

However, there is evidence that respondents who experienced a bereavement more than 10 years ago were weakly correlated with scores on the depression/anxiety at +.150 (p<.01).

There is also a significant moderate negative correlation at -.240 (p<.01) between the number of bereavements experienced in the last 10 years and being married. This may reflect a larger social circle of couples compared with singles. On balance couples would know more relatives and friends than singles.

Some correlations existed between scores on the loneliness scale, p<.01) and Q19, with:

*   the total number of bereavements experienced in the previous ten years, moderate at +.215
*   the number of bereavements experienced over any period after ten years weak at +.166.

Explanation and interpretation

A significant impact upon the number of people who lose a partner to loneliness is because many people, especially women, do not re-partner as they age into their later years. The demographic imbalance towards women's survival creates many more women than men, with many becoming lonelier as they age. These statistics sit within this context.

As the information presented here is incomplete, there are opportunities to conduct further analyses of the dataset to explore and clarify the age and gender dimensions of bereavement and in relation to mental wellbeing and loneliness, and suicidality.

4.5.2 Hypothesis 11 – belongingness and its key antecedents, including but not limited to environmental antecedents, are likely protective factors against suicide.

The elements that are used to 'operationalise' the concept of belonging in the research analysis include:

*   activities that express commitment to community
*   satisfaction with habitation
*   satisfaction with the local environment
*   the extent of participation in activities and

- sociability and satisfaction with their social life.

Activities that express commitment to community: with one activity that expresses commitment to community as an element of belonging – volunteering – a direct negative relationship with suicidality exists at -.145.

Satisfaction with habitation: agreement with the statement, "I am satisfied about where I live generally" (Q10d) is moderately negatively correlated with suicidality - .206.

Although no correlation was uncovered between suicidality and Question 10a, "I like to spend time in my apartment", there were correlations between agreement about Question 10c, "I feel confined in my apartment" with suicidality scores + .174, with loneliness scores +259 and with depression/anxiety +.249.

Satisfaction with the broader environment: as there was no direct question asked about satisfaction with the broader environment generally, the research was unable to directly illuminate this specific element of belonging.

Although, belonging could have been indirectly related to the local environment through agreement with either of the two statements of Question 12 about awareness of green space or missing it, there were no relevant or significant relationships uncovered.

Extent of participation in activities: The data suggest no relationship between the sum count of all activities and suicidal ideation.

The count of each respondent's activities is correlated with stronger levels of agreement with the following sociability statements and their sum 'sociability' scores. This links with two elements of belonging – sociability and satisfaction.

- "I participate in activities run by Wesley Mission" (Q15d, moderately at +.249)
- "Wesley Mission activities have engaged me socially" (Q15e, at +.193)
- "I interact socially with fellow residents" (Q15b, at +.153)
- "I am satisfied with the opportunities in the village for social activities" (Q15c, at +.144)
- the sum of all parts of Question 15 moderately at +.200.

Sociability and satisfaction with their social life:

Sociability is measured as the sum of the five parts of Question 15 and as the score for each part of the question. The elements of sociability span moderate to weak negative relationships with suicidality scores. These results mean people who are more sociable with a satisfying social life are less likely to experience suicidal ideation.

Levels of agreement with the following statements and the sum were negatively correlated with suicidal scores including:

Moderate correlations with:

- the sum of all parts of Question 15 -.249
- "I have made friends I share a good bond with" -.202
- "I participate in activities run by Wesley Mission" -.201.

Weak correlations with:

- "Wesley Mission activities have engaged me socially -.168
- "I am satisfied with the opportunities in the village for social activities" -.146
- "I interact socially with fellow residents" -.142.

Explanation and interpretation:

The research asked no direct questions about belonging. However, although not precise, the operationalisation of the concept here appears to represent a good indirect approximation.[18]

The social dimension within the concept of belonging has revealed some key social strengths for residents. These social strengths appear to mediate suicidality, even though the findings suggest most activities appear to have no effect. Indeed, the key antecedents of belonging appear to be social, in the absence of direct information relating to the physical environment.

Taken all together, the results suggest effective social antecedents for belonging. The residents' answers about sociability suggest the potential for these social elements to countervail against suicidal ideation.

Indeed, the research results are interpreted to suggest that loneliness and belonging are opposites. A social activity – volunteering – committing a person to community and the contribution to the lives of others, appears to be one key for suicide prevention, along with a pro-social focus in retirement that supports belonging.

4.5.3 Hypothesis 12 – religious factors such as participation in religious activities and strength of faith:

- reduce suicidal ideation
- Influence attitudes to suicide
- Increase the likelihood of help-seeking behaviours.

There is no statistical relationship between the count of the activity participation in "religious related activities" and the respondent nominated frequency of this activity with scores on the 'suicidality scale'.

Strength of religious faith appears related to depression and anxiety. A positive correlation was discovered between the depression/anxiety scale scores and levels of agreement with the statement "Religious faith is important to me" at + .150.

Significant strong correlations were discovered in Question 16 between the levels of agreement with the statement, "Religious faith is important to me" (Q6) ($p > .01$) and the frequency of the activity nominated by respondents as "religious related activities" +.528 and with the count of this activity at +.548.

No relationship was found between attending "religious related activities" and scores on any of the mental health and wellbeing scales including attitudes to suicidal thinking.

Explanation and interpretation

These statistics should be broadly interpreted. The explanations and interpretations could range from interpretation of religious behaviour, as a form of 'help-seeking' – looking for comfort in faith for those who may already be experiencing some depression, to residents who turn to their religion or seek to renew their faith as the result of apprehension about approaching the end of life.

Another explanation for the positive relationship between strength of religious faith and depression or anxiety, could be that the contemplation by people of faith of key meanings of their life may raise issues about past conduct and their personal history.

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[18] Based upon the five elements listed on the previous page immediately under Hypothesis 11,

5   Research conclusions

As people move into older age there is evidence that transition points experienced along the way can and do threaten an individual's life or that of their partner, narrowing and reducing social connections and the activities in which they can participate. Example of transitions include transferring to independent living in a village, losing a life partner or experiencing an inhibiting or even terminal illness.

The research shows the limitations experienced by residents were due to the impact of medical attendance and associated illness(es). The research demonstrates a reduction in social capacity and inhibited participation in quality life-supporting activities, and details the risk of social disconnection, depression or loneliness which can result in the absence of social participation.

The findings of the paper include implications for older Australians living under COVID-19. Older people are more vulnerable and more likely to become isolated and segregated from others for longer periods of time.

Volunteering is associated with reduced suicidal thinking. Being able to support engagement in goal-oriented activities, which involve thinking and acting for others – volunteering –- provides an important key to the promotion of wellbeing for older people.

The implications of the research for the village residents are generally positive, reinforcing the value of the Mental Health and Resilience Program and the value of prosocial focus and activities.

In relation to the environment, the research promotes a focus upon air, sunlight and sufficient floorspace in the design of independent living units to support increased mental health wellbeing.

The following section identifies how the information gained in this research can be used to support the creation of new programs and services, and what these would look like. It also reviews how to reduce stigma around suicide and poor mental health for older persons and identifies some of the cultural barriers to more open discussion about these issues.[19]

This research has been constructed to lend itself to more intensive analyses, which should be able to yield new information to inform the field and to help guide future directions for new service development, policy and research.

A key emphasis of the research is promotion of revisitation of the data set as profitable, as recommended.

Prospective research recommendation

Recommendation 1

That the paper, and any further future papers, analyses or research derived from it or the dataset:

- be circulated and presented strategically to key areas of Wesley Mission, Western Sydney University and externally, as determined by either of the research partners
- be circulated, and the findings promoted in the broader community including for journal publication, to influence and raise awareness of, and support for, the mental health wellbeing of independent older people and to influence the issues that affect their lives
- be accompanied by strategic communication proposals to provide guidance for evidence-based change across the field of social and mental health and wellbeing and suicide prevention.

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[19] Such as: based on religious views, or on a 'natural' reluctance to confront the issue of suicide amongst particular groups and cohorts, or upon a cultural shibboleth that excludes mention of people who have died etc.

6 Implications for prospective project development

Findings from the research have implications for future projects addressing mental health and wellbeing and suicide prevention.

6.1 Transitions

A key implication of the research is to recognise the needs outlined by transitions confronting residents. The list below identifies some transitions identified, briefly noting some elements of the transitions in question, generally informed by findings from the research.

Transitions can include:

- moving into a retirement village which can involve:
  - unit selection and purchase
  - moving into a new unit and environment, including downsizing and shedding excess personal property, determining what to keep and grieving
  - change in finances, which may mean fewer or more resources or may include the need to continue or resume working
- the impact of illnesses personally or on a partner which may or may not be life threatening
- the loss of a partner
- consideration of re-partnering, sometimes with limited options
- seeking to participate in new local activities to support living in, and integration with, a new community including in the village and proximal community, shops and services
- challenges in maintaining linkages with family and friends not living in the village.

6.2 Loneliness and loss or lack of connections

The research suggests a key concern in ageing is loneliness and the absence of connectedness, which can come about at critical junctures in the life of older people or their partners. Whatever the source, loneliness can creep up on a person, resulting in them realising for the first time in a very long time that they are lonely and feeling intimidated by the challenges of overcoming the loneliness.

The research shows correlations between loneliness and anxiety/depression symptoms and suicidality and a negative correlation between loneliness and questions about sociability.

A participant in one of the focus groups gave the example of another person at her village, whose cheerful 'meet and greet' approach made her realise she felt inadequate in her own ability to socialise and was therefore not highly motivated to do so. Loneliness was mentioned during focus group meetings and in residents' answers to the survey, as was a need for more pro-social activities.

Although loneliness strikes both men and women as they age, more women are affected, in part due to the demographic imbalance in ageing. Some participants attending an advisory focus group, admitted to our researchers, that having had a partner and family meant that they had not had to seek external friendships until recently, and so had somehow lost the art of making friends. As part of the Mental Health and Resilience Program, some people are either attending self-help groups or seeing the provisional psychologist on a one-on-one basis to address depressive symptoms or anxiety which are likely to have their origins in loneliness.

Findings from the research may also have implications in residential environmental planning, service provision infrastructure and management of retirement villages, along with the structure and design of future projects to meet the mental health and suicide prevention challenges faced by older people living independently in the community.

The research identifies the value of the pro-social aspect of some activities for reducing suicidality, loneliness and/or depression/anxiety and other activities for increasing mental health and wellbeing. Section six seeks to identify and suggest prospective strategies and/or services indicated from the results.

6.3   Opportunities for more analyses and research

Beyond the production of quality evidence to directly support the development of new services within the proposed model of care in the following section, another key purpose of the paper is to guide others to more analyses of the extensive dataset and to further research.

Recommendation 2

That the paper, Suicide prevention – Collaborating with older people in independent living units be used to promote more analyses and research associated in the first instance with Wesley Mission and its research partners from Western Sydney University:

- to address the needs of older people living independently in the community including, but not limited to, mental health and social wellbeing issues
- to introduce the reader to a range of data and quantitative answers
- to encourage and enable further analyses to take place for related purposes
- to support additional analysis of the collected data
- to support additional research, including but not limited to the development of literature reviews, in conjunction with findings from the Independent Living and Wellbeing Research and/or further analyses of the collected data.

There are a range of opportunities for more analyses or for complimentary research, with suggested areas referred to elsewhere in the paper.

7 Proposed model of care

Sociability is the overarching rationale for most of these proposed models of care. The more sociable a person is demonstrated to be in the research, the less likely they are to experience loneliness, suicidality or depression/anxiety. Proposed models of care that may increase sociability are promoted in addition to those activities or factors that enhance positive elements of mental health and wellbeing.

Indeed, it could be argued the very success of the research in achieving access to an exceptional sample of village residents occurred as the result of a highly inclusive social process. The process sought to communicate with and achieve access to a very large proportion of the sample. As many people, as possible were encouraged to have their say and to provide essential private data about their mental health and wellbeing and about those factors that may have influenced it.

7.1 Project Proposal: linked assessment tools

Unit solar and air flow assessment tool:

Recommendation 3

That Wesley Mission be funded to support the assessment of independent living units and retirement villages across Australia to evaluate the redesign and renovation of units and villages and the design of new villages to improve air flow, solar access and overall liveability.

This could include local access to sociable spaces outside a person's unit but proximate to it.

Recommendation 4

That resources be allocated for the development and implementation of an air and solar access assessment tool that could also be used to inform and complement the design of unit renovation and renewal and for better design of new units and new villages.

Wellbeing assessment tool:

Recommendation 5

That voluntary assessment tools be created for retirement villages to proactively support residents' mental health and wellbeing by identifying if a person is at risk as they deal with a life transition, in the first instance, into living within the village and for other transitions as they may arise.

The relationships noted between the three measures of mental health and wellbeing themselves, with key demographic questions and with questions about sociability, suggest there is an opportunity for the development of a simple method to enable identification of some signs that may indicate a risk to individual mental health and wellbeing at the time of entry to the village.

The tool would include factors such as age, gender, relationship and work status, as well as recent bereavements or ongoing chronic illnesses. This could alert carers about emerging needs and mental health issues which may develop due to a transition and enable support for better pathways for a new resident's social integration.

Use of the tool would be voluntary and confidential. It could be introduced when purchasing a unit, when moving into the village or in conjunction with other transitions such as the loss of a partner.
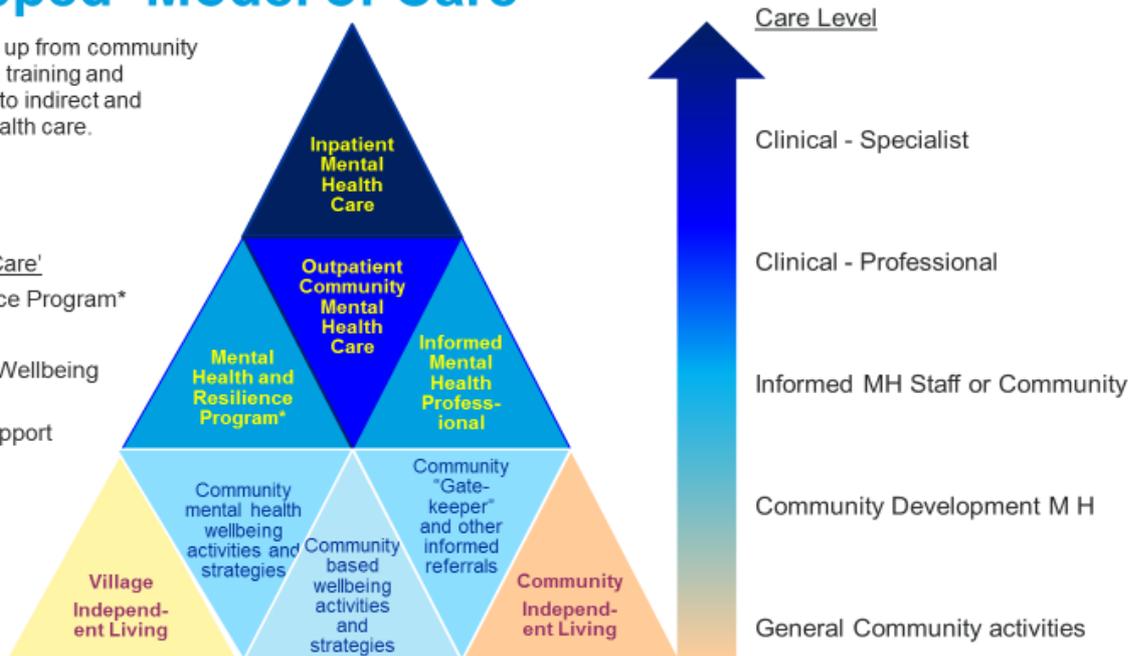
Diagram 2: A stepped model of care

A Stepped 'Model of Care'

N.B. Care steps up from community based activities, training and referral through to indirect and direct mental health care.

Care Level

WM 'Model of Care'
- MH Resilience Program*
- Screening
- Community Wellbeing Networks
- Activities Support

Inpatient Mental Health Care

Outpatient Community Mental Health Care

Mental Health and Resilience Program*

Informed Mental Health Profess-ional

Village Independ-ent Living

Community mental health wellbeing activities and strategies

Community based wellbeing activities and strategies

Community "Gate-keeper" and other informed referrals

Community Independ-ent Living

Clinical - Specialist

Clinical - Professional

Informed MH Staff or Community

Community Development M H

General Community activities

* The Mental Health and Resilience Program currently provided by Wesley Mission will require ongoing funding in future.

7.2   Linkages to stepped levels of mental health care:

In the research attendance at 'self-help or support groups' and 'medical or professional appointments or therapies' is associated respectively with loneliness and depression/anxiety. The screening tools and the process of screening itself provides opportunities to support a stepped model of care for older people at risk by linking them with groups or professional therapies.

Recommendation 6

That additional ongoing resource allocation be provided by the Australian Department of Health to continue to provide trained psychological and other counselling resources through the Older Peoples' Mental Health and Resilience Program and to enable the expansion and management of these resources by Wesley Mission for people living in other retirement villages nationally.

Referral via assessment tools or directly to a local Mental Health and Resilience Program, would support referral to higher levels of care in the community, for mental health outpatients or to in-patient mental health care as required. Allocation of ongoing resources could ensure seamless levels of care into specialised older persons mental health support or community, outpatient or inpatient care within Wesley Hospital facilities at Kogarah and Ashfield.

7.3   Activities support

Although significant relationships between depression/anxiety and activities were limited, there were some as well as between activities and loneliness and suicidality.

These relationships suggest participation in selected activities may be able to help people experiencing transitions, reducing the risk of loneliness, mental health issues or suicidal thinking that can arise during these critical times.

Simple activities can have a huge pro-social benefit. For example, organising social activities provides a pro-social role with effective opportunities to communicate and meet people in the village.

The experience of being onsite and running focus groups with residents in the villages alerted researchers to the wide variety of activities providing residents with the chance for social interaction. In addition to participation in any of the nineteen or more different activities listed in Question 16 which respondents could nominate, there were also opportunities for informal or formal social interaction not listed in the question.

For example, the architecture in a village could provide areas that promote social interaction both by happenstance and in formal meeting spaces. Residents could meet and have a conversation with whoever decided to experience the light and morning sun in a comfortable 'lounge' area adjacent to a corridor. As some residents' units faced on to a green central area with a small recreation room located in it, people knew at certain times of day they could go there for an informal game of cards or a conversation or just to read in the sun. Alternatively, a person could attend a monthly get together in a formal meeting room/kitchen where people could meet to welcome new residents or just to see other residents.

The layered and informal nature of these social activities, taken with the quantitative results about the impact of participation in activities, suggests a more professional approach is needed.

Recommendation 7

That a healthcare professional (a diversional therapist or an occupational therapist) be employed to support more activities across retirement villages that are likely to counteract the development of loneliness, depression/anxiety and suicidal ideation, including the type of activities that have been identified as such by the research.

The relationships between activities and loneliness, depression and anxiety and suicidal ideation are quite complex, and residents would benefit from additional expertise to support the development of a stronger understanding of the relationships between sociability and activities for promoting mental health and wellbeing among older people.

7.4   Project proposal: Community Wellbeing Networks

Recommendation 8

That Community Wellbeing Networks be developed in retirement villages across Australia, beginning with a pilot Community Wellbeing Network at a Wesley Retirement Living village. Existing villages' support infrastructure could be utilised and expanded upon to support a new service with similar elements to a community suicide prevention network to promote and support residents' mental health and meet mental health and suicide prevention needs in situ and by outreach and expansion into the surrounding community.

The objectives of the Community Wellbeing Networks would be:

- to promote and support connection among residents and community members living independently in older age
- to utilise and expand on existing villages' support infrastructure
- to support a new service with elements similar to a Wesley LifeForce Community Suicide Prevention Network – a Community Wellbeing Network that supports and develops ways for residents of villages and surrounding communities to participate by volunteering and contributing
- to provide a range of activities and strategies to promote sociability and connection in older age and to address and improve mental health and wellbeing and prevent suicide.

The Community Wellbeing Network seeks to occupy the community, preventative and early intervention end of the spectrum of the proposed model of care for older people living independently in the community.

The Community Wellbeing Networks proposal is a natural progression from Wesley Mission's extensive experience with the development of suicide prevention networks in communities across Australia. It sits beside experience and expertise in running independent living units in Wesley Retirement Living villages and the Mental Health and Resilience Program for residents begun two years ago. The Independent Living and Wellbeing Prospective Project Research was initiated by Wesley LifeForce to provide evidence to support improving the model of care to address the mental health and wellbeing of older people living independently in retirement villages and in the community.

Evidence from research

The findings support key elements of this proposal, with statistically significant correlations:

- between volunteering and the number of activities participated in
- negative correlations between volunteering and suicidality scores
- negative correlations between 'visiting a friend or friends' and depression and anxiety scores.

By promoting volunteering opportunities, the Community Wellbeing Networks would promote more social life and provide opportunities to contribute to the development of community and support mental health and wellbeing. By enabling older people to contribute in a variety of ways to the development of community, the service would promote belonging in the community and among individuals and help lift mood through both volunteering and participation. The service would achieve an impact on the community by supporting the development of a variety of projects and activities from within the village and support and promote mental health and wellbeing and help prevent suicide.

The Community Wellbeing Networks are intended to encourage residents and community members to help themselves and others to participate in activities that help lift the spirits and the mood of their communities. Their volunteering and participation in the community will effectively support the development of a range of activities to help overcome loneliness and help people to belong and, according to the research, should improve their own mental health and reduce their suicidal thinking.

An evaluation of the Wesley LifeForce Community Suicide Prevention Networks by the University of Melbourne has highlighted some of the benefits formalised networks could also realise in aged care communities, particularly as they relate to support for increased social and potentially instrumental connections.

Other research evidence: Wesley LifeForce Suicide Prevention Networks Evaluation

The independent evaluation conducted by the University of Melbourne found networks had positive impacts including[iv]:

A sense of personal satisfaction and connection to the community due to their involvement, which also provided meaning and purpose.

A sense of connection… the most significant outcome of the network for the community.

Firstly, and most strongly, connection was expressed in a community development sense of the network, connecting people to each other and building the community. Secondly, as the conduit for connecting people to services. Thirdly, facilitating networking between service providers. Building of close interpersonal relationships and beneficial professional connection.

Many participants described increased help-seeking behaviour amongst the community, which was attributed to peoples' increased comfort and willingness to talk about suicide or approach network members with a strong sense that network activities were contributing to reducing stigma.

Opportunities for learning and capacity-building which created confidence, for healing and sense-making among people with lived experience, and in the ability to make a difference in the community as change agents, experienced as being intrinsically rewarding.

The ability to share one's lived experience and have a voice was reported as being empowering.

Wesley LifeForce Networks were seen to provide a source of personal support, an avenue for capacity building, and opportunities to support other.

Overcoming stigma to promote mental health and wellbeing

Focus groups of residents were set up prior to the survey to provide advice on gathering information on the mental health and wellbeing within the communities. Many residents were reluctant and uncomfortable to discuss the areas of depression/anxiety and suicide prevention, particularly the rationale for participation in the groups. The advisory focus groups found the topic of suicide was a barrier for people who were otherwise interested in participating in the focus group or survey research.

To engage people in more activities and join a Community Wellbeing Network, promoting sociability and community connection, needs to be the overarching broad and non-threatening purpose. This would effectively encourage participation of people on their own initiative and recognise them as individuals living independently in the community.

Recommendation 9

That Community Wellbeing Networks would firstly focus on the promotion of a broader role in support of activities that raise spirits and increase sociability. And, once each network has demonstrated it is fully operational and sufficiently prepared, move to strategies and activities which may more directly support mental health and wellbeing and suicide prevention.

The rationale of the initial focus is to enable the support of less threatening opportunities to improve and promote community wellbeing and mental health generally. This strategy would make these activities and strategies more accessible to older people who would not be comfortable with the direct discussion of mental health issues and suicide.

The second step along the spectrum of a model of care should focus upon relieving depression and anxiety and suicide prevention. Having this option would give people a choice about what they might do through their participation. Indeed, after a positive experience with participation in 'ordinary' social activities and having developed relationships with other community members, volunteers may develop some confidence and be empowered to decide to develop more directed preventative community activities and strategies.

In addition, participation in the more directed activities or strategies, would help raise awareness and provide guidance about what to do along the next step of the model of care to escalate responses to a person they know who may need help, or may be experiencing depression, anxiety or suicidal thoughts.

Overarching rationale: sociability

The Independent Living and Wellbeing Research found sociability is negatively correlated with loneliness, suicidality and depression/anxiety. The more sociable a person, the less likely they are to experience loneliness, suicidality or depression/anxiety.

Another purpose of the rationale of sociability is to enable participants to stay empowered in their choices and activities, to promote an active and independent place for older people in the community and to enable them to contribute from an extensive life experience to improving their community.

The 'advisory focus group' research suggested residents of our villages are a group for whom the maintenance of their independence is a primary concern. It is expected that other older people living in the community would place no less a premium on their independence.

Mental health wellbeing or suicide prevention activities

Focused voluntary participation in mental health and wellbeing or suicide prevention activities, would be only one of a variety of activities or projects network members could choose to support. They could also decide their level of involvement with volunteering to support the development and/or to running of a Community Wellbeing Network, activities or projects of the network or participating in activities or projects in the general community.

A Community Wellbeing Network could also assist people to identify the support they may need to help them through key transitions that challenge their social, emotional and mental health wellbeing. The Community Wellbeing Network aims to generate the capacity for the creation of a community that provides social and psychological support for residents and support and outreach into the wider aged community.

Network members would also have the freedom to engage with activities, which do not directly support mental health wellbeing or suicide prevention, but are supported by the network in accordance with the overarching sociability purpose.

8 Appendices

8.1 Appendix: list of recommendations

Recommendation 1

That the Suicide prevention – Collaborating with older people in independent living units paper, and any further future papers, analyses or research derived from it or the dataset:

- be circulated and presented strategically to key areas of Wesley Mission, Western Sydney University and externally as determined by either of the research partners
- be circulated and promoted in the broader community including for journal publication to influence and raise awareness of, and support for, the social and mental health and wellbeing of older people and to influence the issues that affect their lives
- be accompanied by strategic communication proposals to provide guidance for evidence-based change across the field of social and mental health and wellbeing and suicide prevention.

Recommendation 2

That the paper be used to promote more analyses and research associated in the first instance with Wesley Mission and its research partners from Western Sydney University:

- to address the needs of older people living independently in the community including, but not limited to, mental health and social wellbeing issues
- to introduce the reader to a range of data and quantitative answers
- to encourage and enable further analyses to take place for related purposes
- to support additional analysis of the collected data
- to support additional research, including but not limited to the development of literature reviews, in conjunction with findings from the Independent Living Unit Prospective Project Research and/or further analyses of the collected data.

Recommendation 3

That Wesley Mission be funded to support the assessment of independent living units and retirement villages across Australia to evaluate the redesign and renovation of units and villages and the design of new villages to improve air flow, solar access and overall liveability.

This could include local access to sociable spaces outside a person's unit but proximate to it.

Recommendation 4

That resources be allocated for the development and implementation of an air and solar access assessment tool that could also be used to inform and complement the design of unit renovation and renewal and for better design of new units and new villages.

Recommendation 5

That voluntary assessment tools be created for retirement villages to proactively support residents' mental health and wellbeing by identifying if a person is at risk as they deal with a life transition, in the first instance into living within the village and for other transitions as they may arise.

Recommendation 6

That additional ongoing resource allocation be provided by the Australian Department of Health to continue to provide trained psychological and other counselling resources through the Older

Peoples' Mental Health and Resilience Program and to enable the expansion and management of these resources by Wesley Mission for people living in other retirement villages nationally.

Recommendation 7

That a healthcare professional (a diversional therapist or an occupational therapist) be employed to support more activities across retirement villages that are likely to counteract the development of loneliness, depression/anxiety and suicidal ideation, including the type of activities that have been identified as such by the research.

Recommendation 8

That Community Wellbeing Networks be developed in retirement villages across Australia, beginning with a pilot Community Wellbeing Network in a Wesley Village. Existing villages' support infrastructure could be utilised and expanded upon to support a new service with similar elements, to a community suicide prevention network to promote and support residents' mental health and meet mental health and suicide prevention needs in situ and by outreach and expansion into the surrounding community.

The objectives of the Community Wellbeing Networks would be:

- to promote and support connection among residents and community members living independently in older age
- to utilise and expand on existing villages' support infrastructure
- to support a new service with elements similar to a Wesley LifeForce Community Suicide Prevention Network – a Community Wellbeing Network that supports and develops ways for residents of villages and surrounding communities to participate by volunteering and contributing
- to provide a range of activities and strategies to promote sociability and connection in older age to address and improve mental health and wellbeing and prevent suicide.

Recommendation 9

That Community Wellbeing Networks would firstly focus on the promotion of a broader role in support of activities that raise spirits and increase sociability. And, once each network has demonstrated it is fully operational and sufficiently prepared, move to strategies and activities which may more directly support mental health and wellbeing and suicide prevention.

8.2   Appendix: Community Wellbeing Network development

The process of developing a Community Wellbeing Network would begin with the establishment of key criteria, which optimise the successful outcome of the project. These could include researching general or local information suggesting the need for a service and communicating with village residents and staff about the perceived need for a local network.

The Community Wellbeing Network would be initiated through a visit from a Wesley Mission staff member to the village residents and management to explain, publicise and ground the concept in the life experiences of local older people. This would be reinforced by high quality data collected through the Wesley Retirement Living villages Residents' Wellbeing Prospective Research and any available local demographic information. It could include village focus groups, older people living in the general community or older people's leadership or policy groups.

Initial communication strategies would include outlining the key elements of the network including the voluntary nature of the activities, the development and coordination of community activities and possible outreach to build bridges into the broader community.

It will be important to determine the capacity of the village and village management to practically support a Community Wellbeing Network in the village or near to it. This will include being open to negotiating a memorandum of understanding with the relevant auspice body. This would delineate the responsibilities for selection and contracting of staff and joint support to run the network. This could eventually lead to consideration and support for development into the broader local community.

Once these initial steps have been successfully completed, development of a sophisticated communication strategy is required to inform and engage residents. This would focus on the central concept that the project represents an opportunity to develop a network which supports the creation of an effective community with the capacity for living well, independently and healthily.

The involvement of the residents committee, village management and other stakeholders such as staff or local residents, in developing the strategy will enhance the effectiveness of communication through their awareness of local issues, which may be of relevance to the project.

The final step in launching a network is the appointment/election of a steering committee to determine a model for oversight and support of the network and guide the role and responsibilities of each party in developing its activities and projects. This will include developing a formal agreement between the auspice organisation, village management and the resident representative body.

The primary role of the steering committee is:

- to relieve the volunteers of the responsibility of the administrative workload in running the network
- to free up volunteers' time to enable their efforts and time to be devoted to the development and co-ordination of activities;
- with the assistance of the auspice organisation, to apply for additional resources as required to run activities or to support wellbeing strategies in the community;
- to help focus the network's effort on achieving the goals of sociability and improving the mental wellbeing of older people in the community;
- to liaise with staff employed to coordinate the Mental Health and Resilience Program
- to maintain the continuity of administration of the network and enable succession planning as required as changes occur with volunteers and contracted staff.

8.3   Appendix: acknowledgements

Wesley Mission staff acknowledged include:

- Andrew Moore, Group Executive Manager Wesley Health Conferences and Education who commissioned the research
- Group Manager Wesley LifeForce, James Bell and Manager Mental Health and Resilience Program, Jasmin Cox who oversighted the research project
- Senior Community Development Coordinator Suicide Prevention Networks Program, Tony Wyld who supported consultations and provided advice and support from the networks program perspective
- Manager Suicide Prevention Networks Program Linda Fielding, Suicide Policy Advisor Stan Piperoglou, Hospital Operations Manager Wesley Clinical Care/Mental Health, Adam Goss and Strategic Projects Coordinator Wesley Life Force, Azmeh Khan for their input to the paper and their suggestions about the final draft.
- Wesley LifeForce Researcher, Tim Sussman, who designed, conducted, analysed and wrote up the research and who initiated and managed consultation or negotiation with residents,

village managers and Western Sydney University project partners including students and academics

- Village Managers Adam Murray, Sharon Brooks and Tony Cassidy who helped negotiate access to residents and who supported our work within the villages.

Western Sydney University staff, students and other resources acknowledged include:

- for the preparation of literature reviews and draft questionnaires, social work students (Masters Qualifying) Nicolletta Kokkalaris, Ardashah Dhungel, Sulaxana Rumba and Rajani Sharma
- research assistance and support for the submission and carriage of the Western Sydney University (WSU) Human Research Ethics applications and approvals by Ph.D student Sam Lane, employed by WSU
- a social work student, Justine Boutros who supported the design, administration and monitoring of Advisory Focus Groups, supporting communication with the villages and who assisted with the completion of the questionnaire design
- two final year social work students Valerie Sedin and Joshua Jones, who managed the delivery and administration of the questionnaire with extensive doorknocking
- one social work student (Masters Qualifying), Anna Maria Hanna, who assisted with the analysis and helped elicit feedback about the research and proposals, including their feasibility from residents
- Dr Neil Hall, Assistant Director, Men's Health Information and Resource Centre and Senior Lecturer and Director Academic Programs (Social Work), Social Work and Community Welfare, Western Sydney University, who provided advice and support, and enabled the provision of resources, including his research placement students and their supervision and elicited the resources to enable the research to attract human research ethics approval.

In prospect, there is the expectation that more students and academics will be needed to conduct and support further analysis to fill gaps in knowledge in the area of mental health and wellbeing for older people living independently in the community.

By the same token, we expect more students, social work academics and social and community welfare operatives will seek to take up the opportunities created by the research to participate in the design, promotion of projects and in the conduct and facilitation of social processes that create, pilot and administer new services to 'do all the good we can" in response to the evidence created.

8.4 Appendix: Wesley Mission's strengths for community mental health strategies

Wesley LifeForce has more than ten years' experience as the lead agency in setting up local communities for independent suicide prevention through Wesley LifeForce Suicide Prevention Networks.

Wesley Mission has three New South Wales villages with independent living units for older people, with associated infrastructure and services, social activities and meeting infrastructure

Wesley Retirement Living villages Mental Health and Resilience program has been running for two years.

Wesley Lifeforce's training program has included provision of nationwide training specifically addressing suicide prevention for 'community gatekeepers' and other mental health resilience training

About 50 years ago, Wesley Mission was the initiator of the first Lifeline telephone and counselling service.

The Independent Living and Wellbeing Research was conducted to elicit information from village residents to underpin and address mental health wellbeing needs and to inform suicide prevention needs, with all the findings informing our understanding of the experience and mental health wellbeing of residents of villages and their perceptions of the living conditions, activities and of the living environment.

8.5   Appendix: glossary

Term	Explanation
Confidence	Social Sciences usually presents significant results at the p(probability) <.05 which means there is a five in one hundred probability or one in twenty chance (5/100=1/20) that the result occurred merely by chance as the result of sample population variance. Where the result is p < .01 it is a one in one hundred chance that that the result occurred merely by chance as the result of sample population variance.
Correlation	Correlation is a mutual relationship or connection between two or more things. Correlation is used to relate interval, ordinal and other numeric measures. A perfect correlation is one to one or 1.0 whereas no correlation at all is 0.
Correlation strength	A weak correlation is between .1 and .2 or between -.1 and -.2 A moderate correlation is between .2 and .5 or between -.2 and -.5 A strong correlation is greater than .5 or less than -.5.
Mixed Method Action Research (MMAR)	A generic term for a social research model that provides the stakeholders and participants of the research with information and knowledge that can support and help drive a change. In this case, it was to develop new services for improving community and individual mental health and reducing suicide, while at the same time supporting and generating increased motivation among stakeholders for the changes and to help delineate the directions and details of what is required. See Kemmis S. and Mc Taggart R. 2005[v].
Random sample	Respondents were selected by applying a random number generator to a list of residents' units in each village.
Replacement	Respondents in the sample unable to communicate due to impairment were excluded and replaced by random reselection from the remaining unselected population.
Representativeness	A sample is representative of the whole population if it is collected randomly and if any biases in the sample are limited or can be effectively reduced through collection techniques or as result of the completeness of the sample.
Sample Completeness	While 82 per cent of the sample (218 in number) were successfully polled, 18 per cent (49) were not surveyed. This included 5.5 per cent or 15 refusals and 12.5 per cent who were simply not contactable, including about 7 per cent who were away or in higher levels of care or who had since moved out and another 5 per cent about whom we knew nothing.
Statistically significant	This means that there is a strong chance according to probability that a result is not arrived at by chance and reflects the whole population.

8.6   Appendix: questionnaire

Wesley Mission is conducting this survey in conjunction with Western Sydney University to collect evidence to understand and improve the wellbeing of residents of Wesley Villages.

The questions are about various aspects of your environment and your wellbeing as a resident of a retirement village. Evidence is being collected to help develop a new service to promote mental health wellbeing and suicide prevention for retirees.

If you are experiencing a personal crisis, help is available! Please call Lifeline on 13 11 14.

Alternatively, contact the Wesley Villages Provisional Psychologist.

Your Village and time living in it

Q1.   Which Village do you live in? Please tick the box that applies. (It's optional to write down the number of people living in your unit and to confirm your address).

☐ Frank Vickery Village   ☐ Alan Walker Village   ☐ Wesley Taylor Village

Number of people living in your unit: _____ Address: _____

Q2.   How long have you lived in this village? (Please tick the box which applies)

☐ Less than 6 months	☐ 4 years	☐ 9 years
☐ 6 months to less than 1 year	☐ 5 years	☐ 10 years
☐ 1 year	☐ 6 years	☐ 11 to 15 years
☐ 2 years	☐ 7 years	☐ 16 to 20 years
☐ 3 years	☐ 8 years	☐ 20 years or more

Demography: This section contains questions about age, gender, relationship status, religious faith, educational attainment and employment and retirement status.

Q3.   Age: Please, write down your age in years in the box provided.

☐

Q4.   Gender (Tick the box that applies to how you identify on gender).

☐ Male   ☐ Female   ☐ Other

Q5.   What is your current relationship status (Please tick the box that applies)

☐ Single   ☐ Married   ☐ Separated   ☐ Divorced   ☐ In a relationship   ☐ Widowed

Q6.   Please tick a box to indicate the level of agreement/disagreement with the statement.

	Strongly agree	Agree	Disagree	Strongly disagree
Religious faith is important to me	☐	☐	☐	☐

Q7.   Educational attainment? (Please tick all the boxes that apply)

☐ Did not complete school	☐ Undergraduate diploma
☐ Year 12 or equivalent	☐ Bachelor degree
☐ Vocational qualification (certificate)	☐ Post-graduate degree

Q8. Work status (Please tick all the boxes which apply)

☐ Employed Full-time
(more than 20 hours per week)

☐ Employed Part-time or casual
(20 hours per week or less)

☐ Underemployed

☐ Unemployed

☐ Retired

☐ Volunteer

☐ Student

Environment: A few questions about your living environment and how you live in it.

Q9. Please tick the box below which represents your best guess for the floor area of your unit (the one you live in).

☐ Less than 40 square metres

☐ 41 to 50 square metres

☐ 51 to 60 square metres

☐ 61 to 70 square metres

☐ 71 to 80 square metres

☐ 91 to 100 square metres

☐ 101 square metres or more

Q10. Please tick the box which indicates the strength of your agreement or disagreement with each of the statements below

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
a) I like to spend time in my apartment .	☐	☐	☐	☐	☐
b) I am satisfied with the natural lighting in my unit.	☐	☐	☐	☐	☐
c) I feel confined within my apartment.	☐	☐	☐	☐	☐
d) I am satisfied about where I live generally.	☐	☐	☐	☐	☐

Q11. Please tick the box that best describes how often you left your unit in the last week.

- I go out of the unit on average more than three times a day ☐
- I go out of the unit on average between once and three times a day ☐
- I go out of my unit between 4 and 5 times a week ☐
- I go out of my unit between 2 and 3 times a week ☐
- I go out of my unit once a week or less ☐

Q12. Tick the boxes below that apply best to the statements below about 'green space'.

(Green spaces have land cover including grass, bush, trees, possibly water, an open recreation area, as well as social and environmental qualities and amenities such as. seating, footpaths tables etc)	Strongly agree	Agree	Disagree	Strongly disagree
There is accessible green space near where I live	☐	☐	☐	☐
I miss having green space near where I live	☐	☐	☐	☐

Sociability: Some questions about social life in the village and how you feel about it.

Q13.   Are you aware of School for Seniors?   ☐ Yes   ☐ No

If No, above please skip to Q15.

Q14.

a) Have you participated in any courses: ☐ Yes   ☐ No

    If Yes above, go to b) immediately below. Otherwise skip to Q15 below.

b) Please list any courses you may have attended below.

_____

_____

c) Have the course(s) attended increased your social engagement? ☐ Yes   ☐ No

    If Yes, describe how the doing the course(s) increased your engagement socially?

    If No, skip to Q15.

_____

_____

Q15.   Please tick the boxes below that apply best to your experience living in the village

	Strongly agree	Agree	Disagree	Strongly disagree
a) I have made friends I share a good bond with	☐	☐	☐	☐
b) I interact socially with fellow residents	☐	☐	☐	☐
c) I am satisfied with the opportunities in the Village for social activities	☐	☐	☐	☐
d) I participate in activities run by Wesley Mission.	☐	☐	☐	☐
e) Wesley Mission activities have engaged me socially	☐	☐	☐	☐

Q16.   If you went out of your unit over the last month where did you go most often?

NB: This question asks you to do two things: 1) On the left, **rank your most frequent activity** and 2) On the right, **specify where each activity you ranked** mostly occurred.

A) **Rank at least 5 of your most frequent activities below** by placing 1 in the box next to the most frequent activity, 2 in the box for your second most frequent activity, and so on through the numbers (until at least 5).
B) Where did your ranked activities mostly occur? →

B) Please tick the box below which best describes **where the activities you ranked occurred most.**

		Mostly in the Village	Equally in and outside the Village	Mostly outside the Village
☐	Work	☐	☐	☐
☐	Visiting a friend or friends	☐	☐	☐
☐	Coffee/a meal etc	☐	☐	☐
☐	Hobbies and/or pastimes	☐	☐	☐
☐	Exercise/walking in green space	☐	☐	☐
☐	Exercise/walking/sport. Describe	☐	☐	☐
☐	Medical or professional appointments or therapies	☐	☐	☐
☐	Attend self-help or support group	☐	☐	☐

☐	Visiting relatives	☐ ☐ ☐
☐	Shopping	☐ ☐ ☐
☐	Holidays	☐ ☐ ☐
☐	Religion related activities	☐ ☐ ☐
☐	Spectator sport	☐ ☐ ☐
☐	Drama or cinema	☐ ☐ ☐
☐	Music performance	☐ ☐ ☐
☐	Social, community, environmental or political activism	☐ ☐ ☐
☐	General community activities	☐ ☐ ☐
☐	Other: Please describe on the line below	☐ ☐ ☐

_____

Q17.   Do you think there are adequate opportunities to socialise?   ☐ Yes   ☐ No

Q18.   Would you like there to be more village support of:

a) Opportunities for group learning   ☐ Yes   ☐ No
   If Yes please describe here_____
b) Social activities inside the village   ☐ Yes   ☐ No
   If Yes please describe here_____
c) Social activities outside the village   ☐ Yes   ☐ No
   If Yes please describe here_____

Bereavement: If you lost someone… Who or what helped you in the village?

Q19.   Have you lost someone close to you over the past ten years? ☐ Yes   ☐ No

If you ticked No, please go directly to Question 23 (in the Wellbeing section)

If you answered Yes, How long ago did you lose someone?

☐ 0 - 6 months	☐ 5 - 6 years
☐ 6 - 12 months	☐ 7 - 8 years
☐ 1 - 2 years	☐ 9 - 10 years
☐ 3 - 4 years	☐ More than 10 years

Q20.   From whom did you receive support while you were grieving?

☐ Family	☐ Pastoral Carer
☐ Friend(s)	☐ Medical practitioner
☐ Partner	☐ Other (Please specify)
☐ Psychologist /counsellor	……………………………………………

If you did not experience bereavement in the village please skip directly to Q23.

Q21.   What about the Village may have helped you to cope during bereavement?

_____

_____

Q22.   What about the Village did not help you to cope during bereavement?

_____

_____

Please describe the help you sought and any help you may have received above.

_____

_____

_____

_____

Wellbeing: How are you faring? Our research seeks to find out about people's wellbeing in your Village. Wesley Mission will use this information to discover how to promote mental health better, how to develop avert suicide risk and support prevention strategies.

Q23: Over the past two weeks or so, how frequently have you felt the way listed in each statement?

Please tick all the boxes that apply.	I often feel this way	I sometimes feel this way	I rarely feel this way	I never feel this way
a) I am unhappy doing so many things alone	☐	☐	☐	☐
b) I cannot tolerate being so alone	☐	☐	☐	☐
c) I lack companionship	☐	☐	☐	☐
d) I feel as if nobody really understands me	☐	☐	☐	☐
e) I am unable to reach out and communicate with those around me	☐	☐	☐	☐
f) No one really knows me well	☐	☐	☐	☐
g) I feel isolated from others	☐	☐	☐	☐
h) I am unhappy being so withdrawn	☐	☐	☐	☐
i) It is difficult for me to make friends	☐	☐	☐	☐
j) I feel shut out and excluded by others	☐	☐	☐	☐
k) People are around me but not with me	☐	☐	☐	☐

Q24.   During the last 30 days…

Please tick the box that applies to each question below!	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a) About how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
b) About how often did you feel nervous?	☐	☐	☐	☐	☐
c) About how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
d) About how often did you feel hopeless?	☐	☐	☐	☐	☐
e) About how often did you feel so restless or fidgety you could not sit still?	☐	☐	☐	☐	☐
f) About how often did you feel depressed?	☐	☐	☐	☐	☐
g) About how often did you feel that everything as an effort?	☐	☐	☐	☐	☐

h) About how often did you feel so sad that nothing could cheer you up? ☐ ☐ ☐ ☐ ☐

i) About how often did you feel worthless? ☐ ☐ ☐ ☐ ☐

Q25. Please tick the boxes applying to your wellbeing over the past two weeks or so.

a) Are you basically satisfied with your life? ☐ Yes ☐ No.
b) Do you feel that your life is empty? ☐ Yes ☐ No.

If you answered Yes to b), can you please explain how in the space below?

_____

c) Do you often get bored? ☐ Yes ☐ No
d) Are you in good spirits most of the time? ☐ Yes ☐ No
e) Have you dropped any activities and interests? ☐ Yes ☐ No
f) Do you feel happy most of the time? ☐ Yes ☐ No
g) Do you prefer to stay home, rather than going out and doing things? ☐ Yes ☐ No
h) Do you think its wonderful to be alive now? ☐ Yes ☐ No
i) Have you had thoughts of ending your own life in the last 12 months? ☐ Yes ☐ No
If Yes to i) above, have you sought any help? ☐ Yes ☐ No

Please describe the result of any help you sought and what you received below.

_____
_____

Q26. As a village resident, are there any other impacts upon your wellbeing which are related to living in the village you would like to describe?

_____
_____
_____

Thanks very much for completing the questionnaire.

Please accept the appreciation of Wesley Mission and Western Sydney University for completing the Wesley Village Residents' Wellbeing Questionnaire.

We thank you for your contribution to our understanding of the wellbeing of your village and the issues experienced in it.

If you are having a personal crisis, help is available! Please call Lifeline on 13 11 14.

Alternatively, contact the Wesley Villages Provisional Psychologist.

8.7   Appendix: consultation feedback sheet responses

In place of workshops, feedback sessions that did not occur due to respect for resident safety during the COVID-19 pandemic, Wesley Mission opted for a feedback via letter box drop.

The feedback was requested via a posting to each resident present through their letter box.

It included:

- A cover letter from Wesley LifeForce researcher and Wesley Retirement Village manager, informing the reader about the next steps in developing new services from the survey research and seeking their feedback about the research, the service proposals and any ideas for new services and any general feedback. The letter also included a link to a 'Survey Monkey feedback sheet for people who preferred to respond electronically.
- A brief summary of the research findings, conclusions and descriptions of the model of care and its elements – assessment tool, activities support and community wellbeing networks.
- A feedback sheet asking for:
  – contact information
  – permission to contact the respondent again to be involved with new services or with more research
  – feedback about the research results provided
  – feedback about the Screening (Assessment) proposal
  – feedback about the Activities Support proposal
  – feedback about the Community Wellbeing Networks proposal
  – any ideas for new services in the village
  – any other comments about any other elements of the research or consultation.

Feedback/comments about research results

Respondents across three Wesley Retirement Living villages were asked for feedback about the summary of research results provided with the consultation feedback sheets. Overall, residents reported a general sense of agreement with the findings presented to them.

Residents also expressed their preferences for how we present the research results, project proposals and other information of this nature. The comments provided in response to this question included suggestions of information to be presented in plain English, including illustrations, elimination of 'jargonistic' or technical terminology and either short, spaced-out lines of text or dot-point form.

The residents also utilised the consultation methodology to note some housekeeping requirements and issues that were important to them. Examples of these issues were meal payment methods, adding more gardens to the premises. Another common response from residents was that they want the outcomes and points they raised in previous surveys and residential meetings to be considered when implementing the proposals outlined.

Screening (Assessment)

Participants were asked to provide their comments and feedback about the Assessment proposal, as well as any suggestions for how to make this more appropriate for their village. The most common response to this question was that the voluntary nature of the screening proposed meant it may not be completed by those it would serve the most.

Some respondents said they believed isolation within units could often lead to depression in some residents, while other residents were merely 'self-sufficient', so screening would need to differentiate between these groups of people.

Residents overall suggested that appropriately communicating the importance, reasons and benefits of screening would increase participation and effectiveness. The consensus among responses to this question was that assessment should not only occur once, but regular follow-up assessments would also enhance its effectiveness. Some of the responses specified preference for the assessment to be conducted by a trained or qualified professional and more specifically, someone who understood the warning signs and referred on as appropriate. Further from this, residents also suggested general screening of residents' needs and pre-existing medical/mental health concerns to occur prior to moving into the unit.

Given that the people who replied to the feedback consultation are a potentially more active cohort, the resident body as a whole and village management, would need to agree with any move to change the resident expectation for completion of assessment tools away from being voluntary.

Depending on the village and residents support, it may be possible to put processes in place to support the completion of relevant assessment tools as part of living in a unit in the retirement village. It would be a matter for residents participating in supporting the model of care, to push for determining how it could be done and whether it should be functionally a requirement, rather than completely reliant on voluntary completion.

Activities support

Some residents provided the feedback that volunteers involved in activities would need to be external as existing pressures on residents for volunteering were already high due to age, varying levels of ability and health. The employment of a diversional or occupational therapist was also strongly suggested by most residents to ensure responsibility for maintaining programs did not fall solely on them. The same respondents stated that an external role specifically employed for this purpose also provides a sense of coordination and guidance. Residents from one of the villages (Frank Vickery Village) noted they already have an Activities Officer present and suggested utilising this current resource to integrate a greater number of different activities into the current program. Some respondents also provided comments requesting "staff support" to provide encouragement to participate in activities, skill development and the access to resources in order to sustain activities.

Wesley School for Seniors, choir and group sports were the most frequently noted activities in response to the question about the Activities Support Proposal. There were also many suggestions from respondents to introduce opportunities for residents to congregate and meet in groups, e.g. group dinners, exercise classes, talks, Open Mic nights or 'Happy Hour'. These respondents are indicative of a yearning for social contact and integration within villages. The responses also indicate that some residents prefer activities that are more dynamic in nature, allow them to develop or learn new skills and are conducted collectively.

Community Wellbeing Networks

Residents provided many and various activity suggestions in response to the proposal for Community Well Being Networks within the independent living units. Wesley School for Seniors, choir and group sports were the most frequently noted activities in response to these questions. The overall theme of the feedback provided was working to generate a sense of community in each of the villages. Participants expressed that fostering community was most effective through a focus on groups and team building as opposed to individualised activities

Further to the feedback on the proposal for Community Wellbeing Networks, residents noted that access to support and resources was essential to navigating major life transitions. One participant responded to the consultation suggesting professional advice for residents transitioning from independent living units to aged care and provided examples of agencies such as My Aged Care

and Centrelink that were commonly accessed by this age group. Overall, the consensus was that providing tangible support to assist with these transitions would make them seem less overwhelming. Another common response to this question was the suggestion from residents about the flexibility of regulations around alcohol consumption.

Ideas for new activities/projects

List of activities that were supported in the feedback, included:

- social gatherings (with distance) to build a sense of community, e.g. group dinners or 'Happy Hour'
- opportunities to meet others
- talks
- Wesley School for Seniors
- group exercise classes, e.g. yoga, aqua aerobics, Tai Chi
- coffee shop setting
- group facilitated board/card games
- music program/choir
- outings/excursions
- debating team
- petting zoo hire or therapy dogs
- book club
- language classes
- open mic/poetry
- swimming pool.

Other comments

One of the residents noted that COVID-19 restrictions currently limited the "feasibility for any existing activities" or sociability initiatives to take place. Another resident wrote that the "depression and anxiety" felt by residents "was exacerbated by the halt of activities and the continuing COVID-19".

A common response in the residents' feedback noted a sense of caution about ensuring their autonomy was maintained while implementing the proposed services. The residents overall stated that their sense of independence and opportunities for leadership were extremely important to them, if they were able to participate at a level that they felt comfortable with and their abilities were considered. One of the responses provided stated, "scope needs to be provided for the village folk to be encouraged and supported in taking a leadership role...it is good to let people, whatever age, feel effective". Overall, the over-arching themes of the participants' responses emphasised listening to their concerns, promoting relationships as well as creative collaborative solutions between the staff and residents with actual outcomes.

8.8   Appendix: guide to dataset analyses and future research

The following section outlines some areas for further analysis of the data set or future research. This appendix seeks to guide you to analysis providing greater insight about the sample population and addressing any limitations or gaps within the current research.

Residents who frequently attend medical appointments

Further analysis could compare the levels of participation in other activities and opportunities for sociability (Q15) of residents who frequently attended medical appointments.

The dataset could also be analysed to compare the prevalence of medical appointments between males and females and to explore a range of other relationships. (Q16b)

Medical conditions

Patient activities (Q16b) and resident health could be investigated in future research, particularly in relation to chronic mental health issues, chronic medical conditions or disabilities.

Research into sociability, depression and anxiety in residents with health concerns could help delineate the needs of older people in transition.

Employment

Comparison of attendance at work (Q16b) between males and females may provide further insight into the significant correlation found in the current research between attending work, depression and loneliness.

Additionally, information about the type of work and number of hours worked by residents or retirees could also be collected.

Further research needs be conducted to determine whether work is a necessity for retirees or if they are working for personal fulfilment/engagement purposes.

Demographics – cultural and linguistic diversity

Further research could be conducted about the cultural and linguistic diversity of older people and in support of more appropriate service provision.

Demographics – Indigenous Australians

More research is needed about the relationships between suicide and factors such as sociability, loneliness, anxiety and depression in the general Indigenous population.

Gender

The research could analyse whether there are differences in the activities that attract and are offered to male and female residents. Research can also be conducted on the input male and female residents had in the activities on offer.

Living environment

Data on living environment needs further analysis to determine whether feeling confined in their unit space (Q10c) was a single determinant of loneliness and depressive symptoms. This information may be able to be used to design living spaces that are optimal for mental health and wellbeing.

Activities

Deeper analysis of the specific activities (Q16a) that are highly rated by residents is needed to understand the context (Q16b) of such activities, e.g. whether they occur indoors, outdoors, within the retirement village or outside of the retirement village.

Comparison of activities residents were prompted to rank (Q16a) to those respondents listed themselves in the 'other' category (Q16a) can indicate what residents feel was not adequately reflected in the list provided. This has implications for survey and questionnaire design in future research.

Sociability

Research and dataset analysis could be conducted to measure the residents' perception of opportunities to socialise in comparison to the ways in which they currently socialise at Mission's independent living Units. (Q. 13-17)

School for Seniors & Adult Learning

Analysis of residents' highest level of education and preferences towards educational/academic learning to show relationships between education, loneliness and sociability. Comparing this data to the types of village support residents noted (Q 18) will highlight programs in demand while informing potential educational opportunities.

Intergenerational visits

Further data about the resident's attitudes to intergenerational visits can be collected to inform potential activities offered in Wesley Independent Living Units.

Research could also investigate the effects of intergenerational visits on older people and the relationships this may have with sociability and wellbeing.

Storytelling

Researching the stories of older people as well as their attitudes about and responses to them can help identify the relationships storytelling has with factors such as sociability, depression/anxiety, loneliness and suicidality. This data could also contribute to activities and programs within Wesley Independent Living Units.

Social media/technology and sociability

Research into older people's social media use and investigating the relationships this has with their mental health and wellbeing factors can assist in creating strategies to increase sociability during COVID-19 social-distancing restrictions.

8.9 Appendix: references

[i] Wesley Missions' full vision statement is:
'Do all the good you can by all the means you can, in all the ways you can, in all the places you can, at all the times you can, to all the people you can, as long as ever you can.'

[ii] Australian Bureau of Statistics. (2019). Intentional self-harm key characteristics. Retrieved 1 October 2019 from https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2018~Main%20Features~Intentional%20self-harm,%20key%20characteristics~3

[iii] Jo Anne Sirey, Martha L. Bruce, Mae Carpenter, Diane Booker, M. Carrington Reid, Kerry-Ann Newell, and George S. Alexopoulos 2008, Depressive Symptoms and Suicidal Ideation among Older Adults Receiving Home Delivered Meals, Int J Geriatr Psychiatry. 2008 Dec; 23(12): 1306–1311, Cornell, United States of America.

[iv] 2020, Lennart Reifels, Michelle Williamson, Marisa Schlichthorst, Tiffany Too, Amy Morgan, Rebecca Roberts, Patrick Mercer, Kinjia Munkara-Murray, Helen Jordan, Wesley LifeForce Suicide Prevention Networks Evaluation, the University of Melbourne, 2020. An Independent Evaluation Commissioned by Wesley Mission of Wesley LifeForce Suicide Prevention Networks Program, pages 90 to 92.

[v] Kemmis, S & McTaggart R, 2005, Participatory action research: Communicative action and the public sphere, 3rd edn, Sage, California.

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