ABSTRACT

This small scale, Welsh qualitative study explores how a new "*moving on*" service empowered older people to move voluntarily from their home to an extra-care facility. 18 older people were interviewed about their experiences of the service which offered in-person, bespoke information, advice, financial, practical, brokerage and emotional support about moving. Findings indicate three service use patterns; *continuous*, *partial; discontinued*. It was instrumental in empowering clients to exercise *decisional*, *executional*, *delegated* and/or *consumer* autonomies. Recommendations for future developments of a proto-type "moving on" service include a multi-partner approach and case worker case management training modelled on social work practice.

Keywords: voluntary relocation transition; housing; autonomy; service developments; moving; Wales

INTRODUCTION

Facilitating aging in place by enabling older people to remain living at home in the community generally assumes a desire for residential *im*-mobility and there is considerable evidence from UK, European and North American settings to support this premise: for example, high levels of residential satisfaction with the home (Chapman & Lombard 2006; Dekker, de Vos, Musterd & van Kempen, 2011), feelings of attachment to familiar local area or community environments (Gilleard, Hyde & Higgs, 2007), concern over the stress or risks of negative health outcomes associated with relocation (Ferraro, 1983) , or difficulties with integrating into a new environment such as an independent living community[1] (Rossen & Knafl, 2007). Consequently, "moving on"[2] services that facilitate voluntary residential relocation for older people by offering choices about the "if", "when" and "how" of moving from one home setting to another - what we call a *home-to-home* move - have only recently begun to emerge (e.g. Masciocchi Messikomer & Cabrey Cirka, 2010; McCarthy & Stone, UK *Smooth Move* services; *Movadom*, France; *National Association of Senior Move Managers*, USA; Novack, 2004).

Conceptually speaking, we frame the notion of "home" to mean a private or rented residential dwelling in the community setting. This may include individual dwellings or purpose-built, multi-unit dwellings for older people, offering self-contained, private living quarters, with communal facilities and access to varying levels of support. In the UK, the latter could include sheltered housing[3] complexes or extra-care facilities (a term limited to the UK

[1] Defined by Rossen & Knafl to mean "residential settings of multiunit independent living apartments adapted to meet the special needs of elderly persons".

[2] A generic term referring to a service designed to assist with voluntary moves and which, in the context of this research, stems from the title of the Welsh pilot service, but is not a proprietary brand or product.

[3] Sheltered: independent units generally reserved for older people, provided as social housing with 24 hour alarm support and/or a warden available to respond in emergencies; Extra-care: independent units reserved for older age groups; 24 hour access to a range of non-medical, low-level care and support services in situ or commissioned by residents.

which can be equated with the more generic term of assisted living in the US context (for discussion see xxxx 2014). Other "home" settings could include independent senior living communities, retirement communities and senior co-housing schemes which in the UK, broadly encompass purpose built complexes offering independent accommodation, service charges for maintenance of communal areas and entry based on age, normally 50+.

On this basis, "moving home" can be contrasted to a transition or move to an "institutional care setting", including a hospital or nursing care environment characterised by communal and shared living arrangements (e.g. shared bedroom), and 24 hour provision of specialised care to meet a range of medical, physical and cognitive needs. Moves to this type of setting may not be voluntary and are generally in response to increasing need for medicalised interventions due to changing health needs.

The gap in services designed to facilitate *home-to-home* moves outlined previously sidesteps evidence that staying put can be problematic for both service providers and older people when, for example, home adaptation service provisions are fragmentary, under-funded or poorly organised (Zhou, Oyegoke and Sun, 2017); when housing becomes unaffordable (Golant, 2015); access to community health and social care services are problematic (xxxxxx. 2013); technological solutions are beyond reach (LeCrone Fields & Dabelko-Schoeny, 2015); and when adaptability of housing stock is limited, say by issues of space (Lansley et al, 2004). In such situation, aging in place at home can translate into complex realities for service provision (Farber & Shinkle, 2011). For older people themselves, housing adaptations may not suffice to facilitate aging in place if they do not keep pace with changing needs (Thordardottir, Fange, Chiatti & Ekstam, 2018); staying put may incur excessive costs, including heating, with implications for poor health outcomes (Chard & Walker, 2016); and for those with complex cognitive needs such as dementia (Kaplan et al, 2015) or in more vulnerable socio-economic circumstances (Golant, 2008; Means, 2007), trying to age in place at home can be challenging.

Supporting older people to move to a different home could therefore potentially improve well-being, help meet the housing requirements of those with evolving and complex needs, as well as freeing up space in housing stock by supporting residential transitions to smaller dwellings.

Furthermore, some UK survey evidence (Wood, 2013; xxxxxxx 2013) suggests that significant proportions of older people wish to or are thinking about moving or downsizing but do not, because of the lack of alternative housing opportunities or financial incentives and support (CLGC, 2018). If anything, this makes empowering older people who want to move increasingly important, but it is only very recently that UK policy makers have started to recognise that there is an unmet need for services which facilitate choice about moving home or staying put in later life (Welsh Government, 2017; CLGC, 2018).

Institutional care and *home-to-home* moves: identifying knowledge gaps

Research examining transitional care provisions for older people where relocation involves moving to, between (inter-) or within (intra-) different institutional care settings characterised by the provision of specialist health or medical treatment or support (e.g. home to nursing care, hospital to long term care, within the same nursing care facility) has been extensive. In social work, studies have focused on understanding the role social workers play in facilitating these transitions (Berkman, Gardner, Zodikoff & Harootyan, 2006; Phillips & Waterson, 2002; Simons, Shepherd & Munn, 2008). In nursing practice, studies on moves to or between institutional care setting have examined the role played by clinical staff in these transitions (Morgan, Reed & Palmer, 1997), or ways to reduce stress and negative health outcomes for older people (see Castle 2001 for a review; Ferrah, Ibrahim, Kipsaina & Bugeja, 2017; Hsueh-Fen, Travis & Acton, 2004; Mallick & Whipple, 2000; Sullivan & Williams, 2017), particularly when transitions are precipitated, and result in dissatisfaction and disempowerment (Mikhail, 1992; Reinardy, 1995; see Luppa et al., 2010 for a review).

Other studies have focused on identifying the most effective interventions designed to facilitate transitions from institutional care to home settings for more vulnerable, high risk groups (see reviews by Allen, Ottmann & Roberts, 2013 focusing on inpatient or emergency department care to home; Chenoweth, Kable, & Pond, 2015); including people living with dementia and their carers (see review by Hirschman & Hodgson, 2018 on transitions between the hospital and home or residential settings, and delaying moves to residential settings).

Notwithstanding this volume of research, the nature of relocation studied has generally involved individuals who are under the radar of health care professionals, and has been in response to health changes which compromise aging in place at home in the short or longer term, and require interventions provided in specialised health care settings.

Much less is known however, about the potential intervention or service requirements of older people who voluntarily undertake a *home-to-home* move. A few studies have focused on facilitating transitions involving a move to assisted living (Koenig, Lee, Fields & Macmillan, 2011; LeCrone Fields, Koenig & Dabelko-Schoeny, 2012), but have not looked at the potential role of a service to support the moving process (Tracy & DeYoung, 2004), despite the recent growth in the demand for this type of housing facility (Kane, Wilson & Spector, 2007).

Furthermore, a literature review undertaken by the authors covering the last 20 years showed that no research[4] has been undertaken to assess the role that the few existing "moving

[4] A literature search was completed for 1998-2018 in the databases ASSIA, Business Source Complete, IBSS, ProQuest Dissertations and Theses Global, Scopus and Web of Science for the period 1999 onwards. Key words (with truncations) included: "relocation", "downsize", "move", "transition", "transfer", "industry", "management", "aging", "senior", "elderly", "intervention", "older person", "pensioner", "later life", "silver economy", "silver market", "service", "program", "geriatric". Limiting the search with these parameters produced 2 results.

on" services (op. cit) which do exist may have in supporting the residential transition process for older people relocate from a *home-to-home* setting.

We therefore lack understanding of the potential for such services in empowering older people to make informed decisions about "if", "when" and "how" to move, when aging in place no longer provides a satisfactory solution, but relocation to a short- or long-term institutional care setting is not required.

The purpose of this study is to address this knowledge gap by exploring the influence that a new "moving on" service has in empowering older people to make a *home-to-home* transition by moving from their current private home to an extra-care facility, and to identify any broad parameters which could inform future developments of a proto-type "moving on" service model.

The Welsh context

The Welsh "moving on" service was developed over 12 months (mid 2014 to mid-2015) amongst older people registered with a housing association and who were transitioning from privately owned or rented accommodation, to a new, local extra-care facility. These facilities are akin to assisted living as they offer individual, independent accommodation in a communal setting with 24 hour staff presence, but no nursing or medical infrastructure. In the context of this study, residential transition refers to voluntary and permanent relocation to a setting other than short- or long-term health care facilities such as a hospital or nursing home. We explore the questions: how have older people used the service and has it empowered them through the relocation journey?

As one of the UK's four devolved nations, the Welsh context presents particular challenges for addressing the housing needs of its aging population (xxxxxxx, 2017). The rural nature of many communities and their inadequate infrastructures creates problems of

loneliness, isolation and service access for these populations, of whom a third are aged 60 or more and are ageing more rapidly than their urban-dwelling counterparts (xxxxxxxx, 2015). Although the likelihood of moving decreases with age, this pattern does change around the pre-retirement phase (xxxxxxxx, 2009), suggesting that some are proactively thinking about future housing and care requirements. The quality of Welsh housing stock is poor compared to other parts of the UK, and with about 8 out of 10 of older people aged 65 or more as home owners (the remainder are either private or social tenants), the onus lies with them in ensuring maintenance of their properties. Research on motives for residential relocation amongst a representative sample of people aged 65 or more living in Wales indicates that about one fifth said their first reason for moving was because they wanted smaller properties, about 14% a better neighbourhood and 16% gave reasons relating to personal mobility issues or home maintenance (xxxxxx, 2009 op cit). There is no trend data to indicate the demand for different types of accommodation in Wales, but based on limited national level figures for 2011 on the social rented stock, there were about 194,000 units meeting general needs housing, another 33,000 supported or sheltered housing, and 2,300 extra-care units (xxxxx, 2015 op cit.). A survey on extra-care involving all Welsh local authorities, housing associations and service developers indicated current and projected demand outstrips supply (xxxx W & G, 2017). Together, this evidence suggests an increased likelihood for voluntary residential relocation amongst older people in Wales.

DESIGN AND METHODS

Data about the "moving on" service were collected during a research project commissioned by a Welsh housing adaptations agency (the service provider) responsible for designing and piloting the service. The aim was to provide descriptive, qualitative insights into service users' perceptions and use of the service as the basis for service expansion. A naturalistic inquiry approach and qualitative study design were adopted (Patton, 2015); these are appropriate when

the aim is to provide descriptions and practical insights into a given phenomenon (Sandelowski, 2000).

FIGURE 1 HERE

Conceptual framework

The conceptual framework (Figure 1) developed in this study serves as the heuristic tool to guide coding and interpretation of findings. It reflects residential transitions as dynamic, multi-stage processes evolving over time (Coulter & van Ham, 2013; Granbom et al., 2014; xxxxxx, 2017; Koss & Ekerdt, 2016) across three phases: *pre-move* (motives for considering relocation), *decision/action* (deciding whether to move and taking appropriate actions) and *post-decision* (moved or stayed put). The service was introduced to all participants in the second phase.

The notion of service user "empowerment" is applied using the concept of "autonomy" previously developed as an interpretive tool to understand older people's perceptions of autonomy and independence in different care settings. Four sub-concepts identified in the literature are used:

- *decisional autonomy*: being able and free to make decisions without being coerced or restrained by others (Collopy, 1988: 1);
- *executional autonomy*: having the freedom and ability to carry out and implement personal decisions or choices (Collopy, op. cit. 11);
- *delegated autonomy*: someone freely accepts activities from others, authorising them to make decisions and carry out activities on their behalf (Collopy, op. cit. 12);
- *consumer autonomy*: the provision of financial resources creates opportunities for an individual to engage in negotiations and decisions which enhance their ability to exercise agency in a given situation (xxxxxxxx, 2014: 428).

Sampling and recruitment

A utilization-focused, purposeful sampling strategy was adopted; this is appropriate when findings are used to inform changes in practice, programs or policies (Patton, 2015: 270, 295), and because the decision to include service users was made explicit by the research funders to ensure that findings were relevant to their goals of scaling up the service. The housing association responsible for registering older people eligible to move to the extra-care facility gave access to their client register; 40 clients were identified as eligible for the study as they had been recorded as "moving on" service users, having received at least one in-person visit or telephone contact from the service's caseworker. Of these, 18 agreed to participate in the study and were recruited with assistance from the service provider, using phone calls and postal information packs, including consent forms. Recruitment proved difficult as some individuals were in the process of relocating or had only recently moved and felt they needed time to settle in before talking about their experiences. Prior to recruitment, xxxxxxxx ethics approval was secured, including procedures for participant consent, confidentiality and safe storage of data.

Data collection

Eighteen in-depth, face-to-face interviews were completed with participants by the fieldwork researcher from January to April 2015. By the time of interview, 3 had not moved, and the remainder had been *in situ* between 2 and 4 months. Interviews were held in participants' home environment, averaged 90 minutes (ranging from 60 to 120 minutes) and were recorded and transcribed by the research team. Two interview schedules were developed for those who had relocated and who were about to, including core questions (demographic characteristics; previous residential history; motives for wishing to move; sources of information about the service). Depending on their relocation status, other questions included: use of the different service components; reasons for service use or discontinuation; appraisal of service benefits and disadvantages.

Qualitative content analysis

After reading transcripts, a four stage inductive approach for qualitative content analysis was used (Bengtsson, 2016): (i) thematic coding of participants' perceptions and experiences of the residential transition and the service (e.g. motives for relocating; service awareness, use, benefits and disadvantages); (ii) identifying uncoded segments; (iii) creating group codes corresponding to the three phases of the residential transition process represented in the conceptual model and aligning these with relocation motives and service use. Participants fell into three groups: *discontinued users* (no service use beyond first contact with caseworker); *partial users* (used service beyond first contact with caseworker during the *decision/action* phase); and *continuous users* (used the service for both the *decision-action* and *post-decision* phases); (iv) higher order coding was applied using the concepts of autonomies to explore whether access to the service was empowering for participants. Coding confirmed the relevance of the four concepts of *decisional*, *executional*, *delegated* and *consumer* autonomies.

The service package and service use

One caseworker was allocated to the new service. As a workforce, caseworkers within the housing adaptations sector in Wales are not qualified as health or social worker practitioners, but have a background in charity, housing association, local government or private business sectors, with vocational and/or school level qualifications. Their role encompasses working with clients on a one-to-one basis to assess service needs, complete financial assessments and facilitate links with other service providers to ensure installation of housing adaptations. The "moving on" service caseworker introduced clients to the service concept and its elements by giving *information and advice* (e.g. general information, specific contacts for recommended removal, solicitor and estate agents) which helped them decide which components, if any, they would use. These included *practical support* (e.g. furniture disposal; garden and pet arrangements; assistance with benefit applications; packing; service transfers and change of

address for energy or phone suppliers and postal services); and *financial assistance* in the form of a non-means tested allocation of £500 (U$700) as a contribution towards various relocation costs.

The total number of contacts with the caseworker was the measure of service use as defined and recorded by the service providers, and was independent of the number of service components participants recalled having used; for example, there could be only 1 contact, but use of multiple components of the service. A vignette was developed as an aide-memoire in case clients had difficulty recalling the service components.

Data collection tools were piloted with two clients from the housing association register. To ensure trustworthiness of the coding procedure, results from each of the four coding stages were discussed during peer debriefing meetings with the lead and fieldwork researchers and one other researcher using the data for other purposes (Lincoln & Guba, 1985). To maximize interpretive convergence (Saldana, 2009), they coded 4 transcripts at each stage and then compared for internal consistency with the remaining 14, and coding adjustments made.

RESULTS

Table 1 shows equal numbers of males and females were interviewed. Participants averaged 76.5 years; 5 were living with a partner and all but one reported a disability. Eight had previously lived in social or private rental accommodation and the majority (n=15) had moved by the time they were interviewed. Regardless of relocation status, on average, clients had used the service 3.6 times (number of contacts with case worker). Intensity of service use is defined as high or low in relation to the average number of contacts clients had with the case worker (as reported by the service provider). All had used the service at least once, half intensively (>3.6 contacts, range 4-9); and half much less so (<3.6 contacts, range 1-2).

Table 1 here

Service use

All participants recollected receiving at least 1 contact from the caseworker about *general information and advice*; reading from left to right across Table 2, 11 used at least one of the *practical support services* (including 6 receiving help with service transfers, decluttering & moving, and removal services, 1 using a solicitor and 1 an estate agent firm). Six had drawn on the *financial assistance* which evolved more as transactions on behalf of the client (e.g. facilitating payment arrangements for removal or clearance services; purchase white goods).

Table 2 here

The inductive coding process identified 2 other additional service elements; we have called these *brokerage* and *emotional support* service components. The caseworker had liaised on behalf of 4 clients with third party service providers, the extra-care facility manager, energy companies, other family members or the housing association. She also responded to the more stressful aspects of the relocation process by providing 7 participants with emotional support in the form of reassurance, encouragement, confidence building and explanations of the moving process.

Three distinct patterns of service use were identified; half of the participants (n=9) were *partial users*, a third (n=6) *discontinued*, and 3 were *continuous users*. Three participants had decided not to move, including 2 *discontinued* and 1 *partial* user.

Evidence of empowerment

Transcript analysis showed that the service empowered 12 of the participants during their relocation journey (see Table 2), through a combination of facilitating decisions, translating these into actions with or without further support from the service, or by relieving some of the

financial burden of relocation. One participant's narrative suggests service use was disempowering. Extracts of narratives from 6 participants illustrate the ways in which contact with the service has empowered them by facilitating one or more experiences of autonomy. These individual cases have been selected because they represent different and distinct approaches to patterns of service use (discontinued, partial, continuous), intensity of use (high/low) and relocation decision outcome (stayed put/moved).

1. Mrs. R-S (TGC9): *moved, continuous and high intensity service use (6 contacts)*

The couple in their nineties had engaged with the caseworker 6 times as *continuous users* whilst moving from their own home in an isolated mountainous location to the extra-care facility, due to increasing frailty and declining visual capacity.

> Participant (P): Even to post a letter we had to drive. He (husband) has not been able to drive because of his eyes … I was looking into how we would cope in the future when both of our medical situations were getting worse (*pre-move* phase).

Pro-active planning, combined with the flat becoming available crystallised their decision to relocate: "Opportunity .. we were offered a flat". During the *decision/action* phase they had used the service extensively for the practical elements, and accepted help with brokerage.

> P: We had that lists of estate agents, solicitors and removal people to help us decide. We used the estate agent that was recommended, and the removal people, and the solicitor …She (caseworker) notified a whole lot of people for us.

The caseworker's brokerage and practical support continued during the *post-decision* phase.

> She was wonderful. She is still wonderful …. our mobiles don't work … when we have it (phone connection), it will be because of the caseworker badgering them. When she was here the other day, she spotted the fact that we still had boxes …. We weren't able

to get hold of that removal chap to come and take them, so she puts them in her car and takes them.

The couple recognised the pivotal role played by the caseworker in facilitating their move.

Interviewer (I): How would you say the "moving on" service has helped you the most?

P: She made it possible as far as I am concerned. We couldn't have done it without her.

Contact with the service had empowered this couple to exercise decisional autonomy by receiving appropriate information, to delegate responsibility and to entrust the execution of the practical tasks to a third party; this support had "made it possible" for them to undertake the relocation.

2. Mrs. J. (TGC12) *: non-mover, partial and high intensity service use (6 contacts)*

Mrs J., 93 was widowed and had moved from Japan many years ago to marry; she lived alone in a large and very remote house in a rural location. She was initially motivated to consider relocating during the *pre-move* phase through a feeling of increasing isolation, and eventually became a *partial service user*, with 6 caseworker contacts in total.

I: Why did you decide to move there?

P: Because of the age… all my friends are gone … I have a grand-nephew in Kent but they live so far away. I see them once or twice a year.

She had initially been pro-active during changing circumstances, having put her house up for sale, and had drawn extensively on the service. The caseworker had helped with general information, and decluttering in preparation for a move.

P: She helped me with lots of things … which things to throw and which things to keep.

I: Did she help you pack as well?

P: Yes, she did.

Finally, she opted not to relocate, but recognised the emotional support provided through the caseworker's intervention as a positive influence in her decision.

P: She asked for my opinion … about all sorts ... She said, "If you want to stay, tell me. If you don't, tell me". So it's my free choice… if it's a free choice, then "ok, I decide to stay here". Maybe someday…I will stay a couple more years here, I can do my cleaning and my cooking and maybe a couple more years and then go to a home.

In Mrs. J's case, contact and extensive use of the service finally empowered her to reverse the initial decision to relocate by exercising *executional* and *decisional* autonomy.

3. Mr. T. (TGC26): *moved, partial and low intensity service use (2 contacts)*

Previously a home owner and living with siblings, Mr. T. aged 75, had sought alternative accommodation during the *pre-move* phase, motivated by changing family circumstances, a large property and personal health problems.

P: The reason I moved is my brother passed away, then my sister in law went to live with her daughter and I put the house up the sale. It was a 3 bedroom house so too big.

After 2 caseworker contacts, he used the service extensively during the *decision-action* phase.

P: My nephew kept in touch with her, he could phone her. It (service) saved me the bother … the furniture people she recommended packed plates … she helped me with that and the recycle people.

Mr. T. was a *partial user* and when asked what advice he would offer to people considering the service, he replied:

> P: Well, *do it*. You don't have the trouble to find someone to do it for you. It saved me the worries of looking at things, giving calls and worrying whether they were reliable …. organising the removal and all that. That was a big help….To be quite honest, I wouldn't have had the money. I wouldn't have been in a financial situation to pay for it. It's simple as that.

The service therefore enhanced his *executional autonomy* by assisting with the removal, and empowered him to exercise *delegated autonomy* by taking away "trouble" and "worries" and authorising both the caseworker and his nephew to work on his behalf. His reliance on the financial element of the service empowered him to exercise both *consumer* and *executional autonomy* to carry through on an intention to move.

4. Mr. P. (TGC48) : *moved, discontinued and low intensity service use (1 contact)*

During the *pre-move* phase, Mr. P and his wife's motives for planning a move included house maintenance difficulties, and family members' previous experience with conditions of dementia.

> P: We have been thinking of downsizing about two or three years … I was passing this building by chance while the construction was on and I saw something about a show flat. So I spoke to (manager) and he explained a bit … My mother had dementia and we had to put her into a home … it was a hell of a decision … if we go to that state in a few years' time …

As *discontinued users* they had made minimal use of the service and after one information meeting with the caseworker, decided they no longer needed help.

> P: (CW) came to see us and she offered any help with moving.
>
> I: Did she make your aware of the services?

P: Yes. She was *very* thorough and we thought about it and about using the service. To be honest I was very impressed with her, but … my son-in-law has a big van … and I am quite used to doing this sort of thing….so I decided we could do everything in the end, we realised we could manage.

In this instance, the one off contact with the caseworker contributed to empowering the couple in exercising *decisional* and *executional* autonomy; it affirmed their confidence to use their own informal support networks for the move.

5. Mrs. K. (TGC52) *: moved, partial and high intensity service use (7 contacts)*

Mrs. K's decision to move was part of a long process, precipitated in the *pre-move* phase by hospitalisation, in combination with a hearing impairment which meant she needed extra support. Despite being unable to adapt her home, she did not want respite care.

P: When I was first ill, I had to go the hospital and they wanted me to go to respite care and I refused… I just asked some friends to collapse my dining table and put a single bed in its place, so I slept in the lounge for a while (no option of stair lift because) I had four steps, seven steps and four.

A *partial user,* and benefitting from 7 caseworker contacts, she drew on the service extensively.

P: She's (CW) a nice, bubbly person so I was quite happy to let her arrange the removal.

I: What sort of information did you receive?

P: They said you could get things packed and as I use a walking stick and with my balance, I knew that I can't carry things.

I: Did she help you with changing address?

P: Yes. She did a lot of paperwork for me.

When asked if she would have contemplated the move without support from the service, she replied:

> P: Well, it made it very easy. I'm a good haggler … but without any hearing I just felt I couldn't bargain. She (CW) was somebody I could ring up throughout if I needed any information. And I did... Confidence boosting. She gave me the feeling "*Yes*, I can do it".

The practical elements of the service and contact with the caseworker empowered Mrs. K. to exercise *decisional* and *executional* autonomy. She subsequently agreed to *delegate* authority to the service provider to carry out work on her behalf, all the time gaining confidence that she would be able to move.

6. Mr. G. (TGC58) : *moved, continuous and high intensity service use* (6 contacts)

This participant suffered from long term mental health problems, including obsessive compulsive behaviours; his narrative suggests he was not fully engaged in the decision to relocate, and was seemingly unhappy with his new environment.

> I: Why did you decide to move to *X*?
>
> P: For health reasons, I suffer with depression. It's a sore point. I didn't decide to come here…. I was talked into coming here by the council … it was put to me that there were luxury apartments being built …right next to door to the hospital. They told me that because of where I lived in *M*, it was out of the way and there was not much help out for me there. …. I hate living here. I feel that they conspired to get my bungalow off me.

As a *continuous user*, Mr. G. had received 6 contacts from the caseworker and was unhappy about the support received.

I: So (CW) probably called you about helping you to move and came to visit you?

P: That's right.

I: Did (CW) give you a list of people who could help you, like removal companies?

P: No. She told me *she* was going to help me.

I: Did she tell you, "these people are going to come, pack your stuff and move them here"?

P: Yes.

I: Did she help you sort out your furniture and bring them over here?

P: No, the removal men did it …. the council paid for my removal.

I: Did (CW) read the gas meter for you?

P: That's right.

I: Did you spend money on a carpet?

P: Yes.

I: Did (CW) help you with that?

P: Yes, *that is the point*. She wrote to someone for me I believe to ask. So *someone else* was supposed to pay for the carpets. Well, I believe that's why she applied to them on my behalf.

Mr. G. was also disgruntled about the service during the *post-move* phase.

P: They were supposed to send cleaners but they have still not come…My cooker is there on the floor because I cannot fit it myself. The washing machine is in the middle of the kitchen and needs to be plumbed… There's no one here to help me and then the removal people, where they put the things down I cannot move them around to where they need to be. If you look around, all my boxes are there. I haven't unpacked because I am not comfortable here.

In this instance it appears the service had a disempowering effect, as its role in facilitating *decisional*, *delegated* and *executional* autonomies were perceived by the participant to have had a negative impact on the relocation process and its outcomes.

DISCUSSION

Although this is a small scale and localised study, findings can provide broad parameters to help inform the development of a proto-type "moving on" service in other contexts.

A targeted and phased service

First, three well recognised factors acted as triggers for the residential transition decision-making process (Erickson, Krout, Ewen & Robison, 2006) and subsequent service use amongst the study population: individuals experiencing the onset of health or disability problems; changes to family or household circumstances such as widowhood; a progressive or precipitated "misfit" between the older person's physical needs and the suitability of their living environment. These processes and events can provide useful evaluative markers to target those who would be likely to benefit most from such a service, in relation to their relative position in the decision-making process (see Conceptual Framework).

The three patterns of service use identified amongst participants – *discontinued, partial and continuous* - suggest that clients will have a variety of short or longer-term needs for the service. A proto-type "moving on" service could therefore be structured to provide bespoke support at one or more of the *pre-move, decision-action and post-decision* phases of the process. For example, the idea of moving could be introduced during a *pre-move* phase, as individuals begin to experience health problems, changes to family structure (e.g. widowhood) or retirement, and come under the radar of health, financial, welfare or social care providers. An initial assessment of service needs during this phase could help identify whether clients have the social (e.g. family networks), material (e.g. having time to pack), physiological (e.g.

the necessary physical capacities) or psychological (e.g. feeling confident to "do it themselves") resources upon which to draw during relocation. This pre-move assessment is similar to what LeCrone Fields and colleagues (2012) suggest social workers could undertake for pre-admission assessments for assisted living to ensure clients' "physical and psychological compatibility" with providers and facilities. Rossen and Knafel (op. cit.) recommend that older women with depression and low self-esteem would benefit from interventions to ease the transition process and improve their integration into an independent living community.

Empowerment: case workers as central to the service

Second, findings suggest that such a service can effectively empower older people to make decisions and take action during their residential transition from home to a non-institutional setting such as extra-care. Empowerment came from both material components (i.e. provision of information, advice, practical support, financial assistance) and contact with staff.

Contact with the service helped older people to *execute* an initial decision to relocate, as they considered the information and advice provided, organised their resources, chose which service elements to use, or carried on without further support. A financial component to the service also empowered some such as Mr. T. to exercise *consumer autonomy*, by providing an element of choice about how they could embrace and manage the relocation process. Only one participant's narrative suggests that the service had hindered, rather than empowered a successful transition.

The staffing element to the service – direct contact and interaction with the caseworker – enabled some to exercise *delegated autonomy* (e.g. Mr. T and Mrs. R.S in her couple) by allowing others to assume part of the decision-making process. The case worker also proved pivotal in helping to preserve participants' self-determination; in particular, the emotional and brokerage support stimulated a sense of confidence and independence, provided a source of

support and reassurance when dealing with challenging tasks and helped participants confront the traumatic nature of deciding to relocate by alleviating stress and anxiety. A study by LeCrone Fields and colleagues (2012) examining which conditions Medicaid Assisted Living Waiver providers considered important for successful resident transitions included clients' awareness of what to expect from the transition; feeling the choice to move was their own; having confidence in their ability to adapt to new circumstances and express their needs. Our study shows examples where the caseworker role was instrumental in facilitating these conditions. The confidence some participants bestowed on them corresponds to findings from Rossen and Knafel's study (2007) which showed that amongst a small group of older women who had moved to independent living communities, their chances of experiencing a positive, less stressful or anxious relocation transition were enhanced if they had reported having a confidant – a person they could confide in - both pre-and post-move. Other studies on the role of social workers in the assisted living setting show similarities with the caseworker role as coordinators of the decision-making and transition processes, advocating on behalf of residents, providing counselling support, and facilitating care planning (Koenig et al., 2011); and mitigating poor residential transition outcomes resulting from lack of awareness about costs and care planning (LeCrone Fields et al., 2012).

As Golant (2017) notes, if achieving residential normalcy for older people (having positive feelings both about mastering their environment and feeling that their residential settings are comfortable and enjoyable), means moving to a different place to live rather than aging in place, this will in part be shaped by how they perceive their abilities to cope with such a change, and the opportunities available to help them. The role of the case worker in providing information and advice from a recognised and trusted service has been shown in this research as a decisive influence in older people's awareness of coping opportunities and their abilities to exercise both decisional and executional autonomy. As Golant notes:

> "How aware older people are of their coping opportunities will initially frame their ageing in place or moving actions. Obtaining complete and accurate information about "what solutions are out there" is often one of the most demanding coping tasks …. Whether they act on their acquired information will further depend on their perceptions of the credibility and trustworthiness of their communicators. Once aware of potential solutions, they will judge some alternatives as more efficacious, that is, enabling them to manage or eliminate their incongruent residential arrangements …. Once judging their coping strategies as efficacious, they must also assess if they are viable, that is, doable or implementable… they must also appraise the act of moving itself viable or doable" (Golant, 2017, ppp).

Our research points to the case worker as key to triggering this process of recognising coping opportunities and their viability, and hence to older people's attempts to achieve residential normalcy, in this instance, by moving.

A multi-partner approach to service delivery

Finally, our study also provides examples which show the importance of a multi-team intervention for enhancing client empowerment. For Mrs. J, a three-way conversation between herself, caseworker and nephew may have helped crystallise her decision to relocate. For Mr. G, suffering from longer term mental health issues, liaison between the service provider and health teams may have been beneficial during the *pre-move* stage. Studies evaluating successful interventions for transitions in care for frail older groups, including those with dementia, have also identified the importance of inter-professional collaboration (see Hirschman & Hodgson, 2018 for a review). Similarly, Hsueh-Fen Kao and colleagues (2004) identified the importance of care coordination across different care teams to reduce stress and enhance coping capacity for those in transition, regardless of whether they are being admitted from their own home or an institutional setting.

In sum, based on these findings, development of a proto-type "moving on" service for piloting in other geographic contexts and client groups will require: (a) development of an assessment tool designed to reflect residential decision-making as a potentially multi-phased transition process, with needs assessments during pre-, decision- and post-move phases to ensure a bespoke service; (b) a business model which ensures the service is affordable for clients, and may therefore require development on a means-tested basis so that those with limited financial resources are not precluded from using it; a commitment to cross-partnership working across housing, health and social care sectors, a resource-effective form of service delivery but often hard to achieve in a climate of competition for limited public funds; and service sustainability in the social enterprise environment such as that in which the agency initiating the pilot service was operating, and where initial developments were based on a publicly funded seed grant, with an expectation that the service would become self-funding in the medium to long term; adequate resourcing for case worker staff to ensure effective needs assessment as well as bespoke delivery of the service if it is to achieve a goal of user empowerment; case worker training which reflects elements of case management competencies similar to those provided to social workers.

Limitations to the study and conclusion

Although findings from this study cannot be generalised, they can provide some initial pointers to inform further developments to a hitherto neglected area of service provision – how to facilitate later life residential decision-making and actions. Given the absence of research on services that facilitate *home-to-home* transitions, these insights are invaluable. Developing further research along the lines of our own study would also mean recognising the challenges of recruiting participants who may be at various stages of the relocation process – deciding, moving or settling post-move. All three phases have well documented effects on willingness to participate in studies, quality of recall, and difficulties in measuring the longer term effects

of relocation and service benefits. Further research spanning a more longitudinal time frame would help address some of these challenges. The role of the service provider in facilitating the fieldwork may have led to some selection bias in terms of those clients who were finally interviewed.

Recognising these limitations, our study nonetheless suggests that a "moving on" service, if designed with client and business considerations in mind, has the potential not only to empower, but also to enhance choice and reduce anxieties associated with moving home in later life.

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