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UNDERSTANDING THE MENTAL WELL-BEING OF OLDER ADULTS IN CARE HOMES

Submitted to Swansea University in fulfilment of the requirements for the Degree of
Doctor of Philosophy

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MSc

Suggested Layout of Declaration/Statements page

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This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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SUMMARY

Older adults' mental well-being is often overlooked, even though many stressors and triggers of mental health issues are experienced in later life. These may include the loss of family and friends through bereavement and the loss of ability and independence (Forbes-Thompson & Gessert, 2006). One of the main findings from the Older People's Commissioner for Wales' report 'A Place to Call Home?' (2014) was that there was a risk that older adults in care homes become institutionalised. Being in this kind of environment would have a significant impact on an individual's mental well-being. To date there has been limited research into the experiences of older adults in care homes and what contributes to their mental well-being (Denning & Milne, 2011).

The purpose of this PhD research was to better understand the mental well-being of older adults in care homes and look at ways to maintain and promote it. A mixed methods research design was developed to address these questions. The first quantitative stage used the Mental Health Continuum Short Form (MHC) to measure the mental well-being of 141 older adults from 23 care homes in South Wales. One of the findings from the first stage were that younger residents were more likely to have lower levels of mental well-being. The findings were then used to inform and develop the interview questions for the second qualitative stage of the research. The second stage comprised of twenty interviews with residents from six care homes. The interviews aimed to explore what was important to residents' mental well-being. Reflexive thematic analysis (RTA) was used to analyse the interviews and generate themes important to residents' mental well-being.

Analysis indicated that residents experienced many losses in later life and since moving to a care home which impacted their mental well-being. The themes generated from the Reflexive Thematic Analysis (RTA) of residents' experiences of what contributed to their mental well-being were 'challenges to liberty', 'changes in identity', and 'importance of relatedness'. By considering these three themes, it is possible to better understand and offer recommendation on how to help maintain and promote the mental well-being of older adults in care homes.

CONTENTS

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1 CHAPTER 1: INTRODUCTION

This thesis explores the mental well-being and experiences of older adults living in care homes and offers recommendations on how their mental well-being can be maintained. This introductory chapter provides a background and brief contemporary overview of the policy context for the research and an overview of the research's rationale, the research objectives, including background on defining mental well-being and the models that underpin these definitions. I also include context on the recent and current situation regarding COVID-19 and how this has impacted the research and research findings. The chapter ends with a synopsis of each of the thesis' chapters.

1.1 Background to the research

The planning and data collection for this PhD research was conducted before the COVID-19 pandemic. COVID has had an enormous impact on the older population, especially those living in care homes. Some of the information presented in the thesis may not be accurate now, and care home residents' mental well-being is likely to be different, possibly worse, now after the experience of the pandemic and experiencing strict restrictions for 18 months.

1.1.1 Demographic, policy, social, and cultural context

Figures published in 2020 indicated that the UK population of older adults was increasing faster than any other age group in the UK. For example, compared to 2009, the population of adults over 65 in 2020 had increased by 22.9%, the number of adults over 70 had increased by 24.7%, and the number of adults aged 85 and over had increased by 23% (Office for National Statistics, 2020). It was estimated that the number of centenarians in the UK will rise from the current 9000 to 58000 by 2032 (Anderson et al., 2009). In Wales, it was estimated that 27% of the population was over 60 years old (Welsh Government, 2019a), and it has been projected to increase to 33% of the population by 2030 (Office for National Statistics, 2019).

A proportion of older adults in the UK do not live in the community, instead they live in care homes, where they receive care and support from care staff, which also includes nursing care for a number of care home residents. In Wales, it is estimated that 15,371 of the older adult population live in care homes, which accounts for 2.4% of the adults over 65 in Wales (Welsh Government, 2019b). With an increasing number of people living longer and the care needs of older adults estimated to increase by 87% between 2002 and 2051 (Moullin, 2008), there will be a larger proportion of the population living in care homes which will compound the strain on the health and social care system and increase demand for care home places. Developing a better understanding of what contributes to the mental well-being of older adults who live in care homes and how their mental well-being can be promoted and maintained is an important aspect to looking after the mental well-being of an increasing number of older adults who are living in care homes.

1.1.1.1 Well-being policy

The UK has seen an increase in legislation and policies promoting mental health and protecting service users, including older adults. These policies mark a shift in focus towards a more holistic approach to maintaining and promoting the health and well-being of the population, including older adults. However, research has found the mental well-being and mental health support for care home residents is often below the standard expected and below what others would receive (Tucker et al., 2007).

Mental health is responsible for reduction in life span, quality of life, increase in costs for individuals and wider society, and a reduction in engagement and contribution of individuals associated with stigma and reduced esteem (WHO, 2019). This makes mental health everyone's business, care homes, local authorities, employers, government, and also each member of society. This can be seen in the legislation mentioned above and in mental health policy such as the Welsh Government's Together for Mental Health (Welsh Government, 2012) which is an age inclusive cross government strategy for mental health and well-being.

In recent years there has been a focus on population, and older adult well-being in international policy, in addition to UK policy. For example, the United Nations Principles for Older Persons (1991) encourages governments to improve older adult well-being by making them a priority in policymaking. Stating that older people should have access to health care that allows them to maintain and regain physical, mental, and emotional well-being, and to help them prevent or delay illness (United

Nations, 1991). The National Institute for Health Care and Excellence (NICE) have also published six quality statements specifically on the mental well-being of older people in care homes. The six quality statements include that older people have opportunities to participate in meaningful activities that promote their mental well-being; that older adults are enabled to maintain and develop their personal identity, that symptoms of mental health conditions, and physical problems are recognised and recorded, that any need from sensory impairments are recognised and recorded, and that care home residents have access to healthcare services when needed (NICE, 2013).

In Wales, there have been several Acts and policies implemented with the stated intention of improving the nation's well-being and particularly the well-being of older adults living in Wales. The Welsh Government's Older People's Wellbeing Monitor for Wales was introduced in 2009. The monitor aims to provide a holistic picture of older adults' well-being living in Wales by using well-being indicators, which include well-being indicators from the United Nations Principles of Older Persons (1991). The well-being indictors give Welsh Government and its partners an overview of older people's well-being and raises awareness of issues that affect older adult well-being and highlights areas that need to be addressed.

Interest in the concept of well-being has continued to grow in Wales in recent years with the introduction of the Social Services and Well-being (Wales) Act 2014 [SSWWA] and the Well-being of Future Generations (Wales) Act 2015 [WFGWA] by Welsh Government, which both work towards understanding and promoting well-being, including the well-being of older adults. The SSWWA 2014 refers to well-being as 'physical, mental health, and emotional well-being' (SSWWA 2014 s.2) and aims to improve social services in Wales and the well-being of people who need care and support by providing the framework for how Local Authorities must provide support services for people who need care and support, including their carers. This includes older adults who live in care homes and those who receive care and support at home. The Act advocates that older adults and their carers are involved in the decisions about the care they receive and the services they use. The Act sets out four key principles:

- **Voice and control** – ensuring that the individual is at the centre of their care and any decisions made about their care, and ensuring they have a voice in their care decisions.
- **Prevention and early intervention** – ensuring that preventative measures and early interventions are put in place to reduce disruption and risk to service users, and they are not negatively affected.
- **Well-being** – Ensuring that service users are supported to achieve their well-being and that the efficacy of care and support is measured and reviewed.
- **Co-Production** – Ensuring that service users and their carers are involved in service delivery and design.

These four key principles aim to provide a framework to ensure people who need care and support, and their carers are involved in decisions that are made about their care and are placed at the centre of their care and have their voices heard.

The Welsh Government's Health and Social Services Outcome Framework for people who need care and support, and their carers was developed to fulfil the requirements of the SSWWA 2014 and outlines how services should be promoting and improving well-being outcomes (Welsh Government, 2019c). In addition to the SSWWA 2014, Welsh Government introduced The WFGWA 2015, which also impacts older adults' well-being by promoting and maintaining well-being and ensuring that the current and future generations have improved mental well-being and a better quality of life. The WFGWA 2015 refers to a 'healthier Wales in which people's physical and mental well-being is maximised' (WFGWA 2015 s.4). The Act aims to achieve this through improving social, economic, environmental, and cultural well-being through requiring public bodies in Wales to work better with people and communities to prevent issues such as poverty, health inequalities and climate change. In line with the Act, care homes have been involved with projects such as Amgueddfa Cymru – Objects of Comfort project, cARTrefu Programme with AGE Cymru, and the National Library of Wales – Living Memory project, in order to improve the quality of life and well-being of care home residents (Future Generations Commissioner for Wales, 2020). These aims will have an impact on the current older population of older people in addition to the future generations of older people in Wales.

Together with these Acts, the Welsh Government is currently in its third phase of the 'Strategy for Older People in Wales 2013-2023' (Welsh Government, 2013), aiming to provide older adults in Wales with better social, environmental, and financial resources and support to enable them to age well and recognises that good mental health is important to well-being. The strategy sets out key elements for building a good quality of life in later life. The key elements include maintaining good relationships and social support, having a sense of purpose, and include financial resources in order for older people to afford a good quality of life and environmental factors that allow older people to feel comfortable living in a community that caters for their needs. All these elements contribute to an individual's mental well-being. The broader concept of well-being for all older people is outlined in the strategy complements the legal definition found in the SSWWA 2014 and also the NHS Together for Mental Health strategy which refer to older people, people at risk, and those who need support. Together for Mental Health (Welsh Government, 2012) is the Welsh Government's mental health and well-being strategy for all ages, which includes children, working age adults and older people. For example, £1.5 million has been made available for Young Onset Dementia Services across Wales and to expand Welsh Older People Community Mental Health services (Welsh Government, 2013).

These policies reflect a more general focus on Welsh public policy for involvement and engagement of people in their health and well-being. This focus is positioned as a positive development, but it can also be interpreted as a subtle realignment of responsibility from the system and onto the individual.

1.1.1.2 Care homes

There are two types of care home provision available in the UK, residential care homes that provide personal care for residents and nursing care homes with registered nursing staff available to provide nursing care for residents. There are also dual registered care homes that provide residential and nursing care with a specified number of beds available for nursing care. In this thesis I will use the term 'care home' to refer to both residential and nursing homes, including care homes that provide both residential and nursing care. Care homes are either local authority run (public sector) or independent sector. Independent sector care homes are run by either the private sector or third sector, which include housing associations, or religious or charitable organisations and groups. The majority, 95%, of care home beds provided by the independent sector (privately run) (Competition & Markets Authority, 2017). Table 1.1 below shows the distribution of care homes in the public and independent sector in Wales.

Table 1.1 Table of distribution of care homes in Wales by provider type. Numbers obtained from Public Policy Institute for Wales and CIW 2015

	Number of homes
Public sector	84
Independent sector	589

Care home residents are either local authority funded, where the local authority pays their care home fees or privately funded, where the resident pays their care home fees. According to CIW, in 2018, there were 22,466 beds in 643 care homes across Wales (Care Inspectorate Wales, 2018), which were home to 15,371 people over sixty-five in Wales (Welsh Government, 2019b).

As the general population ages, the care home population age also increases. As people live longer, they are more likely to become ill, frail, and need extra care and support which is usually received in care homes which can provide nursing care, personal care or both types of care (Barker, Hanratty, Kingston, Ramsay & Matthews, 2021). Due to an ageing population and an emphasis on care in the community in recent years, the majority of older adults live in the community for longer. This has subsequently led to the care home population changing, many of the care home population will have multiple morbidities, and care homes have needed to adapt to provide more dementia and mental health care for residents (Barker et al., 2021). Care home residents with more complex needs, such as dementia, are also more likely to have lower mental well-being levels than other care home residents (Brooker, 2008). Barker et al. (2021) conducted a cross-sectional analysis over a 24-year period of 1,745 care home residents in England and Wales. Their analysis found the prevalence of severe disability (difficulty in tasks such as washing, and using the toilet), experienced by care home residents increased from 63% to 87%, and the prevalence of multimorbidity (cardiovascular, cerebrovascular, musculoskeletal, endocrine, respiratory or cognition) conditions increased from 33% to 54% of the care home population included in the research. This indicates that the majority of care home residents are now older and have more complex needs requiring higher specialised care levels and consequently higher levels of support to maintain their mental well-being (Barker et al., 2021).

1.2 DEFINING MENTAL WELL-BEING

Well-being, and mental well-being in particular, is challenging to define. Before beginning the research, I intended to search for a clear definition and model of mental well-being that fit within the context of this research study and was applicable to research with older adults in care homes. From the initial literature search it was clear that there were many definitions and synonyms for mental well-being, and many of the studies in the literature used terms interchangeably. A number of the terms used in this research area were mental well-being, well-being, mental health, quality of life, satisfaction with life, and positive mental health and these were often used interchangeably. Therefore, I searched the literature for an appropriate definition and model of mental well-being that fit within the context of older adults in care homes. In this section I will give an overview of the well-being models I considered and how they relate to mental well-being before setting out the model and definition that best fit the context of this research study.

1.2.1 Well-being models

Well-being is considered a multidimensional concept made up of different components and there are several well-being models to consider when defining mental well-being. These well-being models are often based on the needs-based satisfaction model Maslow's (1943) hierarchy of needs and Rogers' (1951) humanistic self-actualisation approach that individuals have needs that must be satisfied in order to achieve growth, well-being or self-actualisation. Similarly, to Maslow and Rogers, later models such as Jahoda (1958) proposed that positive functioning consisted of six components: attitudes to self, self-actualisation, integration, autonomy, perception of reality and environmental mastery. In addition to Maslow, Rogers, and

Jahoda, Allardt’s (1976) theory of well-being proposed that there are three main categories that influence well-being which were having (material things), relating (loving, supportive relationships), and self-actualisation.

Jahoda (1958) and Gurin et al. (1960) studies led to the development of subjective (or emotional) well-being proposed by Diener (1984) and psychological well-being developed by Ryff (1989). More recent models such as Ryff's (1989) model of psychological well-being also contain six similar components to earlier models, these were autonomy, environmental mastery, personal growth, positive relationships, purpose in life, and self-acceptance. In comparison, Ryan and Deci (2001) incorporated self-determination theory into their theoretical framework consisting of autonomy, competence, and relatedness, which suggests that individuals become self-determined when these needs are met.

Later models similarly proposed six component models of well-being or quality of life models. For example, Bowers et al. (2009) proposed personal identity and self-esteem, meaningful relationships, home and personal surroundings, meaningful daily and community life, personalised care and support, personal control, and autonomy as the six components contributing to quality of life. While Nolan's (2006) 'Senses Framework', put forward a sense of security, continuity, belonging, purpose, achievement, and significance as the six components essential to psychological well-being. Diener et al. (2010) proposed that positive well-being included purpose in life, their model included positive relationships, engagement, competence, self-esteem, optimism, and contribution towards the well-being of others. With many models including similar and overlapping components of well-being it is challenging to clearly define and incorporate one model into the research project.

When choosing a model and definition of well-being there are also the hedonic and eudaimonic perspectives to consider. Current research on well-being has been divided into hedonic and eudaimonic perspectives. The hedonic perspective focuses on an individual's feelings of well-being, while the eudaimonic perspective focuses on an individual's ability to function well in their life and community. Eudaimonic well-being consists of two dimensions, the psychological and social dimensions, which focus on the skills and abilities an individual needs for optimal functioning.

While hedonic well-being is concerned with the emotional component of well-being and how an individual is feeling. Many of the theories of quality of life focus on an individual's functional ability (eudaimonic) rather than incorporating both hedonic and eudaimonic elements of well-being (Taillefer et al., 2003). Whereas the hedonic perspective has been the main focus in measuring and assessing well-being, with research focusing on how an individual feels and their subjective thoughts and feelings (Flugerl, 1925; Bradburn, 1969). In comparison, Steptoe (2015) discusses the three aspects of psychological well-being and proposes that well-being consists of evaluative well-being (life satisfaction), hedonic well-being (feelings), and eudaimonic well-being (a sense of purpose and meaning in life). While Seligman’s (2011) PERMA model of happiness and well-being incorporated the five elements of pleasure, engagement, meaning, accomplishments and relationships which includes both hedonic and eudaimonic dimension of well-being. Keyes' (1998) model of psychological well-being (eudaimonic) incorporates developmental, humanistic, and clinical psychology and is based on the work of sociologists Durkheim and Marx and incorporates the hedonic perspective, Ryff's six eudaimonic dimensions, with social well-being to give a comprehensive model of individual well-being consisting of six components which are autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. In addition, Keyes (1998) proposed that mental well-being combines components from the hedonic and eudaimonic perspectives of well-being with social well-being in order to develop a complete model of mental well-being. In addition to incorporating the hedonic and eudaimonic aspects of well-being, he also considered the two-continua model of mental health, that positive mental health and not only the absence of a mental health condition in the conceptualisation of mental well-being. This holistic model and consideration for the two-continua model of mental health would be an appropriate model to use in this research study.

Various approaches suggest that only the emotional component of well-being is needed to assess mental well-being, which can be achieved using only a hedonic measurement of well-being and there has been criticism of the distinction between the hedonic and eudaimonic aspects of well-being (Kashdan, Biswas-Diener, & King, 2008). Kashdan et al. (2008) argued that the hedonic and edaimonic dimensions are not distinct enough from each other, and there is only a need to focus on the hedonic component of well-being to assess an individual's level of well-being. However, Joshanloo (2016) found that both hedonic and eudaimonic components would need to be assessed to achieve a more accurate measurement of well-being. The inconsistencies in the findings could be due to the different methods used to assess instruments' factor structure. Using Confirmatory factor analysis (CFA) to assess the factor structure has been found to produce large factor correlations that suggest that hedonic and eudaimonic components of well-being are not distinct from each other (Kashdan et al., 2008). However, research using Exploratory Structural Equation Modelling (ESEM) has not found the same issue (Joshanloo, 2016a; Joshanloo, 2016b; Joshanloo, Jose, Kielpikowski, 2016c; Joshanloo & Lamers, 2016d; Joshanloo, Capone, Petrillo, Caso, 2017). Suggesting that hedonic and eudaimonic components of well-being are distinct from each other and need to be considered when measuring well-being or mental well-being.

The majority of well-being theory, model development, and research is from a Western perspective, the concept of mental well-being and what contributes to an individual may possibly be different in different cultures as attitudes vary between cultures (Gopalkrishnan, 2018). For example, individuals from a more collectivist culture may have a different belief towards what contributes to mental well-being and concepts such as autonomy may have different levels of importance or meaning in different cultures such as in collectivist countries in Asia and Africa (Diener et al., 1997; Markus et al., 1996). It is possible to say that older adults living in care homes are from a different culture and may view things differently from the general population. Older adults may have different attitudes towards mental health and perhaps have different priorities to younger generations (Robb, Haley, Becker, Polivka & Chwa, 2003). Therefore, the culture older adults are a part of needs to be a consideration when discussing mental health and well-being models with older adults in care homes.

Symptoms of mental health disorders such as depression and anxiety are often used when defining well-being. The World Health Organization (WHO) (World Health

Organization, 2018) considers mental well-being to be a synonym for positive mental health and an integral part in their definition of health, and that health is '*not merely the absence of disease or infirmity*' (WHO, 2001, p.1). The WHO's definition also supports the suggestion that mental ill health and mental well-being are distinct from each other, and that work needs to be done on promoting and maintaining mental well-being. These statements by WHO are also in line with Keyes' hedonic and eudaimonic perspectives and the two-continua model of mental health and well-being which support a more holistic and comprehensive approach to defining mental well-being.

After considering different well-being models and definitions it is possible to say that the literature proposes that mental well-being combines components from the hedonic and eudaimonic perspectives of well-being with social well-being and the two-continua model of mental health which suggests that mental health is not only the absence of mental illness but also the presence of positive well-being (Keyes, 1998; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011). By including components from the hedonic and eudaimonic perspectives and focusing not only on the absence of mental illness but also the presence of positive mental well-being it is possible to develop a comprehensive understanding of what contributes to the maintenance and promotion of mental well-being. These are the models and definitions that have been used as a guiding framework for this PhD research.

1.2.1.1 The Two-continua model of mental health

The Two-continua model of mental well-being describes mental illness and positive mental health and well-being as being related but distinct from each other and includes different components of well-being (Westerhof & Keyes, 2010). For example, an individual may have poor mental well-being but not have a diagnosable mental health disorder. Alternatively, an individual may have a mental health disorder but have high levels of mental well-being. Therefore, having a mental health disorder does not necessarily mean that individuals are not able to lead fulfilling lives. Below in Figure 1.1 is a diagram of the two continua model of mental well-being depicting how it is possible for individuals to live with a mental health disorder but are still able to function well in their daily lives and therefore have high levels of mental well-being. On the other hand, it is possible that an individual who does not have a mental health disorder, but they are not 'feeling good' and functioning well and therefore have low levels of mental well-being. A mental illness does not necessarily mean low levels of mental well-being and no mental illness is therefore not synonymous with high levels of mental well-being. Therefore, it is important not to only focus on diagnosing mental ill health if we are to understand and improve mental well-being. Additionally, the two-continua model of mental health is congruent with the World Health Organisation's definition of positive mental well-being which focuses on positive mental health (WHO, 2001) and combines the two hedonic and eudaimonic well-being perspectives, providing a holistic model to understanding mental health and mental well-being. The holistic approach to understanding mental health and mental well-being, and its congruence with the WHO definition of positive mental well-being, and consideration of the hedonic and eudaimonic perspectives of well-being are the reasons why the two-continua model has been used as a guiding framework for this research study.

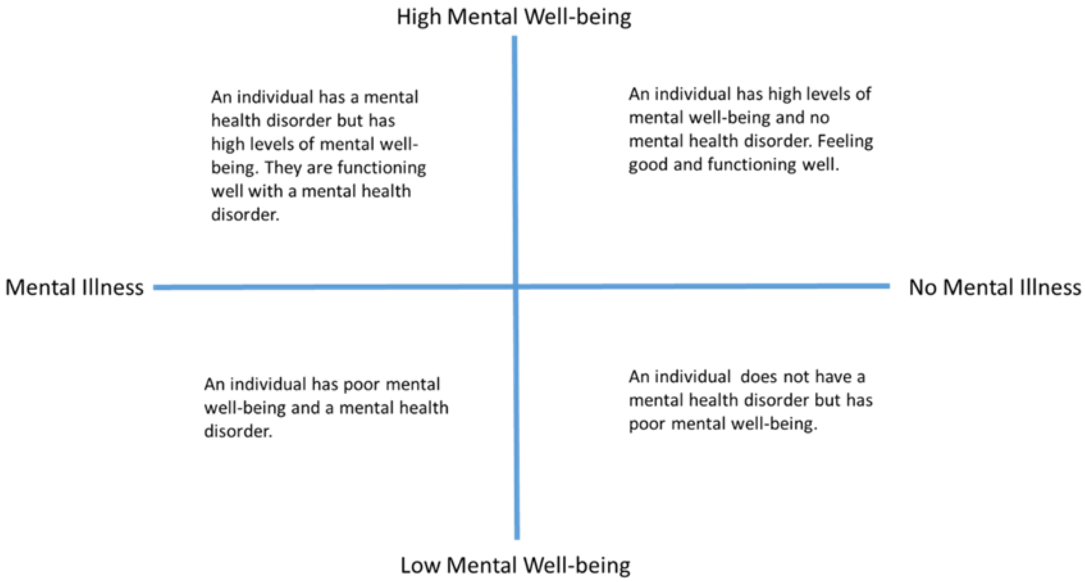

Figure 1.1 Two Continua model of mental health and well-being: adapted from the theoretical work of Keyes et al. (Keyes et al., 2002)

Mental well-being and mental illness have been found to be good predictors of psychosocial functioning (Keyes, Shmotkin & Ryff, 2002; Keyes, 2005 & 2007). The two combined have been found to be better indicators than on their own, which supports the two-continua model of mental well-being. Further support for the two-continua model of mental well-being was found in Davidson et al.’s (2009) study, which suggested that individuals may have positive mental well-being without being completely free of any psychopathology. Therefore, it is crucial to not only focus on mental illness when developing ways to improve mental health and well-being (Keyes, 2007). The two-continua model has also been validated in studies using Confirmatory Factor Analysis (CFA), and Exploratory Structural Equation Modelling (ESEM) (Greenspoon & Saklofske, 2001; Keyes et al., 2008; Lamers et al., 2011; Suldo & Shafer, 2008; Kendler, Myers, Maes, & Keyes, 2011)

Mental health research has mainly focused on ways to treat psychopathology (Greenspoon & Saklofske, 2001) rather than on promoting and maintaining positive mental health and well-being, which could help prevent mental ill-health. A clear definition and terminology of mental well-being were challenging to find. The two-continua model fitted well with the WHO definition, and both eudaimonic and hedonic perspectives, as well as the context of this PhD research study. Furthermore, as there is evidence to suggest that it is not only the absence of mental illness that is important to mental well-being then this needs to be an important part of the model and definition underpinning this research study. It is important to utilise a model and definition that supports a dual perspective to mental health when researching mental well-being in older adults and how it can be better understood, promoted, and maintained. A strength of utilising the two-continua model of mental health is that the research would not only be from the perspective of the presence or absence of mental illness but also from the perspective of whether residents are feeling good and functioning well within the care home setting. Therefore, a model and definition of mental well-being that not only considers that absence of mental illness but also positive feelings and functioning as being integral to mental well-being is embedded in this research study.

1.3 MENTAL HEALTH AND WELL-BEING IN LATER LIFE

Mental illness in later life is often seen as an inevitable part of ageing, this is untrue which is why it is important to find ways to better understand mental well-being in later life and to find ways to promote and maintain it (Milne, 2009). In the UK, many older adults suffer from mental health issues. It has been reported that 40% of older people attending their GP suffer from mental health issues, while 50% in hospitals and 60% in care homes are reported to have mental health issues (Healthcare Commission, 2009). Older adults have not benefitted from developments in health and well-being in the same way as younger adults (The National Directors for Mental Health and Older People, 2004) and The Royal College of Psychiatrists (RCP) report stated that since 2004 little has improved for older adults in promoting and maintaining their health and well-being (Anderson et al., 2009). Research has found that only 6% of older people are referred to mental health services for depression compared to 50% of younger adults (Tadros et al., 2013) while Burns and Warner (2015) suggest that 85% of older adults with depression will receive no treatment from the NHS. Therefore, these figures suggest that many older people and those living in care homes do not have the same access to services as younger people living in the community. The RCP (2018) suggest that making these services available will not only help improve and maintain older adults' mental health and well-being but also be cost-effective and improve older people's quality of care. These issues are important to older adult mental well-being, however, there is a much broader issue of maintaining and promoting mental well-being in the older adult population. Many different external factors also affect an individual's mental health and well-being. For example, socioeconomic factors, political factors, cultural values, and policy effect and predictors of mental illness are often social, for example, poverty or lack of social support (Karlin, Duffy & Gleaves, 2008). These services are often trying to address issues that are due to social problems, therefore it is also important to also address these social issues to help maintain and promote positive mental health and mental well-being.

Older adults consider depression and loneliness to be an inherent part of old age (Barg et al., 2006). However, it is important to change this belief, and ensure that older adults are able to live fulfilling lives with social support and positive mental well-being as they grow older. Furthermore, when measuring and understanding well-being it is important to not only study the absence of depressive symptoms because an absence of symptoms does not necessarily guarantee experiences of well-being (Björk, Lindkvist, Wimo, Juthberg, Bergland & Edvardsson, 2017).

Older adults themselves have recognised that good mental health or mental well-being is important to 'ageing well' (Bowling & Dieppe, 2005). Many factors contribute to an individual's level of mental well-being. Feeling useful and contributing to society has been found to affect an individual's level of mental well-being positively, whilst activities, relationships, and experiences that improve an individual's self-esteem and self-worth have a positive effect on their mental well-being (Joshanloo, 2016; Bowbowick et al. 2015). Research by Ward (2012) has found similar findings, their research found that good relationships and social interactions were important factors that contributed to older adult well-being. Their research also found that being listened to and having easy access to services helped their well-being. Factors that negatively affected older adults' well-being were having to deal with deteriorating health and a decline in their ability to engage with activities and people (Ward, 2012). Older adults found poor relationships with healthcare professionals and poor access to healthcare services and GP surgeries disempowering and that feeling useful, being respected, and treated fairly were also important to maintaining their well-being (Ward, 2012).

There have been mixed findings in the literature looking at the mental health and well-being of older adults. Studies have found that older adults are happier than younger adults (Jopp & Rott 2006; Yang, 2008), while other studies have argued that as people grow older, their levels of well-being and life satisfaction decreases (Baird, Lucas & Donnellon 2010; Gerstof, Ram, Esatbrook, Schupp, & Wagner, 2008; Gerstof, Ram, Myraz, Hidajat, Lindenberger, Wagner et al., 2010). Furthermore, decreasing levels of well-being and life satisfaction may be due to different factors influencing levels of life satisfaction and well-being as we age, and as our priorities change as we get older, these are discussed in more detail below. Westerhof and Keyes (2010) found that older adults had fewer mental illnesses than younger adults. However, they did not have better positive mental health than the younger age group in the study. An earlier study looking at depression in older adults found that older adults had clinically significant depressive symptoms, but the symptoms did not meet the diagnostic criteria for diagnosing depression. This suggests that older adults may have subsyndromal depression (Koeing & Blazer 1996), which may indicate that older adults present differently to younger adults and have low levels of mental well-being. It is important to consider that even if symptoms did not meet diagnostic criteria, these symptoms would still have a negative impact on an individual's mental well-being.

Good social relationships, social roles and activities, health, psychological outlook and well-being, home and neighbourhood, finances, and independence have been found to be important to older adults QoL who live at home in the UK (Bowling, Gabriel, Dykes, Dowding, Evans, Fleissig, Banister & Sutton, 2003). However, care home residents have been found to spend a high proportion of their time being socially inactive (McKee, Harrison & Lee, 1999). Older adults living in the community have been found to value independence, managing self-care independently, having control of their daily lives, mobility, and vision more than younger adults (Ratcliffe et al., 2017). These aspects of QoL need to be considered when developing ways to assess, maintain and promote older adult mental well-being in the community and care homes.

The importance of social inclusion and social capital has been identified as being important to care home residents' well-being (Forsman et al., 2011). Social capital can affect older adult mental well-being and residents must be given the opportunity to remain engaged with the community and their social life or even to re-engage with them in order to maintain their well-being as social well-being is vital to an individual's overall mental well-being (Forsman et al., 2011). As a lack of social support, such as access to neighbours, has been found to have a significant association with depression (Forsman et al., 2011). The research shows that social capital is an important factor to consider when developing interventions to promote and maintain mental well-being. Forsman et al.'s (2011) study did not find high levels of depression or psychological distress in the older adult community-based population, however, not having trusting relationships with others and having feelings of mistrust were also associated with psychological distress. It would be interesting to find whether similar findings would be found in a care home setting.

1.3.1.1 Older adult mental health and well-being in care homes

Older adults' mental well-being in care homes is often overlooked, even though many stressors and triggers of mental health issues are experienced in later life, for example, the loss of family and friends through bereavement and the loss of ability, self-esteem, and independence (Forbes-Thompson & Gessert, 2006). Unfortunately, there has been limited research into older adults' experiences and perspectives in care homes (Dening & Milne, 2011). Depression is a common mental illness in adults over the age of 65 (Anderson, 2001). However, older adults are less likely to have their depression recognised and treated than younger adults (Birrer & Vemuri, 2004). Additionally, older adults diagnosed with co-morbid anxiety and depression have shown to have worse outcomes than those with a single diagnosis. A co-morbid diagnosis of anxiety and depression is associated with an increased risk of cognitive decline and Dementia (DeLuca et al., 2005).

1.3.1.2 Mental well-being and Dementia of care home residents

It is estimated that 70% of care home residents are living with dementia (Matthews et al., 2013) which is a significant proportion of the care home population. Therefore, it is important to consider people with dementia's experiences of mental health and well-being in care homes. Behavioural and psychological symptoms of dementia (BPSD) affect 90% of people with dementia, and over half continue to feel distressed and agitated (Mitchell et al., 2009). By maintaining mental well-being and addressing psychological distress, it is possible to reduce BPSD and improve their quality of life and mental well-being (Katz & Parmelee, 1994). A further reason for maintaining and promoting mental well-being in residents with dementia is that research has found that residents with dementia and symptoms of depression have higher mortality rates, BPSD, poorer nutrition, and require more staff time than residents who do not have any depressive symptoms (Katz & Parmelee, 1994). This indicates that care home residents with dementia would also benefit from research into understanding and promoting mental well-being in care homes.

In this research project care home residents with dementia were neither excluded nor purposely included. Care home managers and owners acted as gatekeepers as recommended by Luff, Ferreira, and Meyer (2011) to facilitate research in care homes and were asked to approach all residents that would be able to participate and consent to participate in the research. As it is estimated that 70% of care home residents are living with dementia (Matthews et al., 2013), whether diagnosed or undiagnosed it is likely there were residents who participated in the research that were living with dementia.

1.4 STUDY OBJECTIVES AND DESIGN

With new legislation and recent campaigns, there has been a significant push towards improving the well-being and mental well-being of the population, including older adults living in care homes. However, little research has been conducted into what contributes to older adult mental well-being and how it can be maintained and promoted in care homes. Policy and research to date have mainly focused on assessing and measuring mental health and well-being outcomes and it is beneficial to include the views and experiences of older adults in research, in addition to empowering older care home residents (Bowling, 2009).

The aims of the research are:

- To develop a better understanding of mental well-being in older adults who live in care homes.
- To explore ways to promote and maintain older adults living in care homes' mental well-being.
- Offer recommendations for best practice with regards to promoting and maintaining and promoting mental well-being of older adults in care homes.

The research reported in this thesis used a mixed-methods design underpinned by a pragmatic world view to developing a better understanding and more detailed view of older adults' mental well-being in care homes in Wales. The study used a sequential design (Plano Clark & Ivankova, 2016) and used quantitative methods for the first stage and qualitative semi-structured interviews for the second stage of data collection. The rationale for this methodology is discussed fully in Chapter three. The study consisted of two distinct phases. The first stage of data collection used the Mental Health Continuum Short Form (MHC-SF) (Keyes, 2009) to assess older adults' mental well-being in care homes. The findings were then used to develop a semi-structured qualitative interview schedule for the second qualitative data collection stage. The aim of interviewing older adults was to better understand what contributes to their mental well-being. The study also aimed to generate analysis to explore ways to promote and maintain residents' mental well-being and quality of life.

1.5 THE RESEARCHER

My interest in mental health and well-being is long standing. I have worked as a Mental Health Mentor for seven years supporting university students with a mental health diagnosis through their degrees. I have always worked in supporting roles, and prior to working as a Mental Health Mentor I worked in primary and secondary schools supporting pupils with additional needs. I was drawn to this PhD studentship for a number of reasons, although I was working as a Mental Health Mentor with mainly younger adults, my personal experience due to the mental ill-health of a family member meant that I had continued to develop my interest in the mental health of older adults. My grandmother has had severe depression and anxiety for many years and since my grandfather's death I have become more acutely aware of the challenges she faces in terms of maintaining a good quality of life. Prior to making a permanent move to a care home I had visited her at several care homes during respite breaks and because of my academic and professional background have viewed much of what I see in a more objective way: observing the way older adults are treated and the limited opportunities different settings offer for fulfilling activity appears to impact on their mental well-being and behaviours. I became more acutely aware of the challenges my grandmother faces in terms of maintaining her mental well-being.

I have always had a keen interest in researching and promoting mental health support for everyone. I believe that everyone has the same rights to access mental health support, but above all I believe that a greater focus on promoting a good quality of life using a holistic, person-centred approach applies to all older people. This would ensure that well-being is maintained, and the human rights of older people respected.

I hope in the longer term to establish a career that involves promoting a more effective interface between research, practice, and policy development. I hope that during my career my knowledge of theoretical and practical aspects of delivering care and support will contribute to improve the outcomes and quality of life for older people in Wales.

1.6 ORGANISATION OF CHAPTERS

The thesis comprises of six chapters. In chapter one, this chapter, I discuss the demographic, policy, social, and cultural context of the research. I also discuss the complex task of defining mental well-being by summarising well-being and quality of life models, with the overall aim of selecting a definition and model of mental well-being for the research study. To close the first chapter, I then discuss the background context of mental health and well-being in later life and include a brief background of the mental health and well-being of older adults in care homes and care home residents with dementia. The chapter finishes with a description of the study objectives and the research design implemented in this research study.

Chapter two provides a review of the literature and studies that have informed the research questions and the research methodology. Two substantial literature reviews were undertaken as follows; a literature review on mental well-being of older adults in care homes to provide background to this research study, and a second review examining existing well-being measures to support my decision to deploy a relevant measure for the survey part of the study. The chapter ends with a description and background to the Mental Health Continuum Short Form (MHC-SF) which was selected for use in this study.

In chapter three I describe the methodology and methods implemented in this research study. I begin the chapter by discussing the epistemology of pragmatism for mixed methods research and the importance of integration in mixed methods research. The chapter also included the research approach and design of this research study and I discuss the ethical considerations of conducting research in care homes.

The chapter concluded with a detailed description of the research design, materials, sampling strategy, and procedure for both the quantitative and qualitative stages of data collection.

Chapter four presents the analysis and findings of the MHC-SF and the development of the qualitative interview schedule for the second stage of data collection.

In chapter five I present the analysis of the qualitative interviews conducted with care home residents. Firstly, I present a thematic map and overview of the themes generated from the Braun and Clarke's Reflexive Thematic Analysis (RTA), the remainder of the chapter is divided between the three themes generated from the analysis. Each theme is discussed with extracts from the interviews to support the analysis.

The sixth and final chapter discusses the main findings from the research study and how they fit in with the current research landscape. I also discuss the mixed methods integration of the two types of data collected during the study and where the two data sets converge, diverge, and are complimentary. In the chapter I also discuss the strengths and limitations of the study, the practical issues of care home research, my reflections on the research and the current COVID-19 context. The chapter concludes with recommendations for policy and practice and suggestions for further research.

2 CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews the academic literature, 'grey' literature, and social theories that have informed my PhD research design, methodology, and data collection. I conducted two separate reviews, first to summarise the current research landscape around mental well-being in care homes, and a second review to select an appropriate scale to use in the study. To begin I discuss the literature review methods used to search for literature relevant to the PhD research, focusing on understanding the mental well-being of older adults in care homes. I then present the findings of the literature review and the rationale for conducting the research. Next, the process of reviewing prospective well-being measures for the study and the process of selecting an appropriate measure for the first stage of data collection are explained. An overview of the Mental Health Continuum Short Form (MHC-SF), the scale that was selected for use is also provided. The chapter concludes by outlining the research questions informed by the review, and the methods I have used to answer these questions.

2.2 APPROACH TO REVIEWING THE LITERATURE

The research proposal was developed by Professor Charles Musselwhite and Professor Michael Coffey in order to secure funding for the research project, this meant that the research topic was predetermined as well as the research design of mixed methods. The specific research methods and measures were yet to be determined and I developed the research protocol by choosing an appropriate measure of mental well-being for use with older adults in care homes and building on these findings through developing a qualitative interview schedule for the second stage of data collection. Two literature searches and reviews were undertaken, firstly, the literature review concentrated on developing an understanding of the current research background into older adults' mental well-being in care homes. A second literature search and review was then carried out on measuring older adults' mental well-being. This included reviewing available well-being scales to select the most appropriate measure to use within this research study.

A traditional-narrative review was chosen to provide a comprehensive background to the current literature on older adult mental well-being in care homes. Through integrating different research approaches to identify possible areas for future research, a traditional-narrative review examines theories, studies, and the methods used in the existing literature to inform the research methodology and theoretical background (Jesson, Matheson, & Lacey, 2011). A strength of narrative reviews is that they draw from various disciplines and include a diverse range of research approaches, which offers a comprehensive understanding of the research area (Efron & Ravid, 2018). Therefore, a narrative review is useful when researching areas where people's lived experience is of interest, and qualitative data is collected. While a systematic review involves a thorough search of scientific databases using a strict search strategy with inclusion and exclusion criteria to answer a specific research question, the aim of a narrative review is to provide interpretation and critique and most importantly a deepening understanding of the research topic (Greenhalgh, Thorne, Malterud, 2018). Furthermore, a narrative review approach is also appropriate with different research approaches such as mixed methods because it produces broad enough research questions.

2.3 MAPPING THE PROCESS

This narrative review provides an overview of the research landscape around older adults' mental well-being in care homes. The literature searches focused on academic peer-reviewed literature found through systematic searches of online databases. A search was conducted which focused on identifying existing literature that looked at older adults' living in a care homes’ mental well-being. A further literature search was also used to look for well-being measures and the use of well-being measures with older adults. Details of the search strategies can be found in the section below. More details of the well-being measures searches are in section 2.6 below.

Although the searches were carried out in a systematic way; however, no quality assessment framework was used to determine which papers to include or exclude in the review or to appraise the papers included (Grant & Booth, 2009). The aim of the literature review was to provide an overview of the current knowledge and theories.

Therefore, the current traditional narrative reviews used in this research study differed from a systematic review.

2.3.1 Search Strategy

Searches were limited to peer-reviewed English language materials and no time span was specified in order to gain a comprehensive view of the mental well-being of older adults in care homes, measures of mental well-being, and how the well-being of older adults in care homes had previously been measured. For the search on mental well-being in care homes, I used a limiter for studies including older adults. Synonyms for mental well-being were also used as search terms (these can be found in Appendix 1) for the literature search on older adults' mental well-being in care homes and the well-being measures search. The online databases used in the literature searches were PsychINFO, Web of Science, ProQuest, and IBSS. Literature recommended by supervisors, academics, and fellow PhD candidates was also reviewed. Existing systematic reviews on the quality of life or mental well-being of older adults in care homes were also drawn upon.

2.4 MENTAL HEALTH AND WELL-BEING IN OLDER ADULTS AND CARE HOMES

In recent years there has been an increased interest in improving the well-being of the UK population, this includes the well-being of older adults and those living in care homes. In addition to the legislative shift towards protecting and promoting well-being which is discussed in section 1.1.1, there has been encouragement for care homes to move towards a more holistic or person-centred model of care. Historically, care has centred on more of a medical model of care provision with a focus on meeting the physical needs of care home residents (Caspar, O'Rourke, & Gutman, 2009). Rather than a holistic approach of caring for the individual as a whole, which incorporates meeting the residents' emotional, psychological, social needs in addition to their physical care needs. This change is slow, which for example, is often reflected in the language used around care homes, such as 'admission', or 'toileting', which are not congruent with the care home being an actual home for the resident to live in and a more resident centred approach. These words are more in keeping with the paternalistic medical model of patients being admitted, managed, and treated. In recent years there have been attempts to move away from the medical model of care and towards either a social model, person-centred, relationship centred or biopsychosocial models of care (Nolan et al., 2006; Caspar et al., 2009; Social Care Institute for Excellence, 2017). These approaches to care argue for a move away from a traditional reactive approach and encourage a more proactive approach. A proactive approach focuses on attempting to take a more holistic, humanistic, individualised approach to care and consider the impact of biological, social, psychological factors on an individual and how these are important aspects in their care and well-being.

Within the research on older adults' experiences in care homes, it is often difficult to draw a distinction between the concepts of mental well-being, mental health, quality of life (QoL) and life satisfaction due to these terms being used interchangeably and having overlapping and intersecting concepts and domains. A common issue is the variation in factors that are included in different studies, not all components are always included, and terms used interchangeably make it difficult to clearly define each concept. For example, an issue found in Wilkinson, Kiata, Peri, Robinson, and Kerse (2012) study was that happiness may not mean the same as QoL when residents were asked about their happiness when assessing their QoL. Much of the research on quality of life (QoL), well-being, mental well-being measure and identify similar and overlapping components and domains of older adults' experiences of living in care homes (van Maldren et al., 2013; Murphy et al, 2014). These overlapping components and domains are discussed earlier in Chapter 1 section 1.2.1. The studies have also used different, models, theories, and measures to understand and assess the experiences of older adults in care homes, and to uncover what is important to their experience of living in a care home. Many of these studies include measures of depressive symptoms in their measurement of QoL or well-being (van Maldren et al., 2013) which do not fully capture the whole concept of QoL. With this in mind, and due to the limited research on mental well-being in care homes, and the complex nature of defining mental well-being and drawing a clear distinction between mental illness and mental well-being in the literature. I include studies on the prevalence of depression and mental illness found in older adults within the care home population, in addition to research on quality of life and well-being in care homes in my review of the literature.

2.4.1 Mental ill health and mental health services for care homes

Often older adults are a forgotten population, even more so for those living in care homes. They are frequently excluded from research (Bayer & Tadd, 2000) and services such as rehabilitation, psychotherapy, and addictions are developed for working-age adults, resulting in those over 65 being excluded from accessing these services (Anderson, 2009). In England, less than three quarters of Community Mental Health Teams (CMHTs) who responded to a survey said they provided support to care homes (Tucker, Wilberforce, Brand, Abenstern & Challis, 2014), and care home residents often have difficulty accessing primary healthcare services and specialist services (British Geriatric Society, 2011). Additionally, Steves et al. (2009) and Fahey et al. (2003) found that geriatricians have become disengaged from care homes. It has been estimated that between 50% and 70% of care home residents with depression do not receive any treatment for it (George et al., 2007; Rovner et al., 1991). These issues make assessing the prevalence and addressing depression and mental health issues in the care home population difficult. Indicating that the experiences of care home residents and understanding their mental well-being has not been a priority.

There is conflicting evidence on the experiences of older adults of mental ill health and depression. Research has suggested that older adults experience less mental ill health except for the oldest of the older adult population (Snowden, Dhingra, Keyes, & Anderson, 2010; West, 2010). The conflicting findings may be due to numerous reasons such as the possibility of older adults presenting differently to younger adults with mental health disorders and not meeting diagnostic criteria (Koeing & Blazer 1996; Westerhof & Keyes, 2010). One of the reasons it has been difficult to establish an accurate prevalence rate of depression in the care home population is that depression is often not detected amongst those living in care homes (Davidson et al., 2006). Depression has been found to be difficult to detect because of an issue with the different assessment tools relating to depression, and many are not designed for use with older adults or older adults in care homes. An additional issue to assessing depression in the care home population is staff not recognising symptoms. Bagley et al. (2000) found that care home staff could not recognise depression in their residents. The study which used a staff survey to assess recognition of depression by staff in 30 nursing and residential homes found that fewer than 2% of staff had received specific in-service training on depression in older people. Training on recognising symptoms of depression and poor mental well-being in older adults could be one possible way of maintaining and promoting mental well-being.

The prevalence of depression in residential care can be challenging to measure accurately for various reasons. Teresi, Abrams, Holmes, Ramirez, and Eimicke (2001) found that 77.4% of their participants had clinically significant symptoms of depression, and 11% had subsyndromal symptoms of depression. While Hyer et al. (2001) found 44% of care home residents to meet diagnostic criteria for major or minor depression. While a study on prevalence of depression in England and Wales was found to be 27% in care homes and 9.3% for those older adults living at home (McDougall, Matthews, Kvaal, Dewey, & Brayne, 2007). However, it is likely that this is underestimated as there were issues such as missing data from the older participants and the research was not designed for institutional settings. In McDougall et al. (2007) participants were divided into three groups; those without symptoms, sub-clinical symptoms, and those with case level depression. Care home residents were more likely to report depressed mood, crying, wishing to be dead, the future looking bleak, and staying away from others than those living in the community. Care home residents also reported different symptoms to those living in the community (McDougall et al., 2007). These findings indicate a need to look at different depression indicators for care home residents and the need to better understand the mental health experiences of care home residents.

2.4.1.1 Comparisons between care home residents and older adults living in the community

Compared to older adults living in the community nursing home residents have been found to suffer more from hopelessness, helplessness, and depression (Ron, 2004). Older adults living in a nursing home in Japan were found to have higher levels of depression than community-dwelling older adults (Nagatomo, Nomaguchi & Matsumoto, 1993). Similarly, compared to older adults living in the community in a study in Pakistan, older adults in care homes had higher levels of depression (Shyam & Yadev, 2006). Additionally, older adults living in nursing homes have also been found to score higher on the Geriatric Depression Scale-15 (GDS-15) and had more impairments in well-being than older adults living in the community (Cessetti, Vescovelli & Ruini, 2017). These findings suggest that those living in care homes experience depression and mental health issues differently to older adults living in the community.

Continuing with the theme of there being a marked difference between the mental health of older people living in care homes, compared to those living in the community, various research findings support this finding (see above, Nagatomo, Nomaguchi & Matsumoto, 1993; Ron, 2004; Shyam & Yadev, 2006), with older adults living in care homes having worse mental health than those living in the community. However, other scholars have found the opposite (Dobrzyn-Matusiak, Marcisz, Bak & Marcisz, 2014). For example, community-dwelling older adults in Spain have been found to have lower levels of well-being than institutionalised older adults (Rodriguez-Blazquez et al., 2012). The study found that age impacted community-dwelling older adults' well-being more than it did for older adults living in an institution. One issue the authors highlighted is that the institutionalised older adults were interviewed by the care staff where they lived, therefore they were less likely to answer honestly and more likely to give socially desirable answers about their well-being. The participants may have also had a healthy relationship with the care home staff, therefore expressing more positive answers. In order to address this issue and combat the potential of bias built into using pre-established care home staff, future studies could use independent researchers to carry out data collection.

In a 2005 study, Boyle compared the QoL, autonomy, and mental health of older adults living in care homes with those of older adults living at home and receiving domiciliary care in Greater Belfast. Conversely to other research (Nagatomo et al., 1993; Ron, 2004; Shyam & Yadev, 2006; Cessetti et al., 2017), Boyle (2005) also found that those living at home were more physically impaired and had greater levels of mental ill health than care home residents. The findings suggested that the lower levels of mental health were associated more with the restrictions on the participant's decisional autonomy than their physical impairment. While long term care environments that constrain an individual's autonomy were found to contribute to the development of depression and high levels of autonomy were found to be associated with good mental health (Boyle, 2005). However, the sample size of those living in a care home was considerably smaller than the sample of participants living at home which makes an accurate comparison difficult. It was also difficult to differentiate between residents who became depressed after moving to the care home and those who were already depressed when they moved to the care home. Following the study, Boyle (2005) argued that priority needs to be given to preventing depression in care homes and promoting and maintaining positive mental health and mental well-being, and therefore, not only treating mental ill-health in a reactive manner. These conflicting findings suggest that measuring depression and mental health issues in the care home population is a complex task with many variables to consider.

2.4.1.2 Risk and protective factors

Additionally, to care home residents having dissimilar levels of depression and QoL compared to older adults living in the community, older adults living in care homes have been found to have different predictors of depression than older adults living in the community. Compared to community-dwelling older adults, personal meaning, optimism, social resources, and physical health predicted depression in older adults living in an institution, whilst choice, social resources, and physical health were predictors for depression in community-dwelling older adults (Reker, 1997). Reker's (1997) study highlighted the importance of personal meaning, choice, and optimism in combating depression in older adults. Having purpose, sense of order, a reason for existence and an optimistic outlook were also found to predict lower instances of depression. Reker (1997) also drew attention to the overlapping and multifaceted nature of constructs such as depression, QoL, and well-being which is a significant methodological issue when measuring and researching these constructs.

Research with the older adult population has identified several risk factors for depression in later life. Loss of independence and autonomy combined with deteriorating physical or mental health has been found in general to contribute negatively to older adult QoL, rather than physical illness on its own (Bond & Corner, 2004). While research specifically in care homes has found functional impairment, loneliness, resident higher education levels, a family history of depression and neuroticism were associated with depression in a study of 479 care home residents in the Netherlands (Eisses, Kluiter, Jongenelis, Pot, Beekman & Ormel, 2004). Female gender, a history of cerebrovascular diseases, previous mental health issues, and long-term institutional care have also been found to increase the risk of depression (Polyakova, Sonnabend, Sander, Mergl, Schroeter, Schroeder & Schönknecht, 2014). Older adults living in a care home or nursing home have also been found to have lower levels of belonging which is associated with higher levels of depressive symptoms (McLaren, Turner, Gomez, McLachlan & Gibbs, 2013).While environmental mastery has been found to be a protective factor against depression, loss of independence, reduced autonomy, and lack of meaningful activity were also found to be contributing factors for depression in care home residents (Davison, McCabe, Knight & Mellor, 2012). Residential care in itself is a risk factor for depression (Ames, 1990; Blazer et al, 1991), and many of the risk factors for depression are also reasons older adults move into care homes (Milne, 2016). For example, Seitz, Purandare and Conn (2010) found that depression almost doubled the risk of an older adult moving to a care home.

Research has found various protective factors contributing to care home residents' quality of life and levels of depression. Depression has been found to be associated with loneliness in institutionalised and non-institutionalised older adults (Prieto-Flores, Foriaz, Fernandez-Mayoralas, Rojo-Perez & Martinez-Martin, 2011). Their study found that moving to a care home can contribute to loneliness in older adults, whilst spending time with family, friends, and neighbours had a significant positive effect on the institutionalised older adults in the study. Bowling et al. (2002) found feeling loved and safe was important to older adults QoL, and social capital, including trusting relationships, has been found to be a significant mental health resource for older adults (Forsman, Nyqvist, & Wahlbeck, 2011). While personal resources, social networks and social support are important factors in protecting mental health in later life (Milne, 2009). These findings indicate it is important not to underestimate the impact of social networks and support upon older adults. Care homes may be closed off from the community which can lead to residents feeling lonely and isolated from the community and outside world. Being socially isolated and disconnected from the outside world would have a significant impact on mental well-being. Research has found a lack of visitors to be a significant predictor of depression in 15 care homes in London, where residents who were assessed as being depressed were more isolated and had fewer visitors than residents who were not depressed (Weyerer, Häfner, Mann, Ames, & Graham, 1995). However, this study was conducted in 1986, and unfortunately many of the residents could not be interviewed at the eight-month follow-up. The experiences of care home residents are likely to have changed since 1986 for example, due to legislation and care quality standards improving the quality of care residents receive and the move towards more person-centred care that focuses on resident involvement (Health Foundation, 2016).

In addition to living with the impact of depressive symptoms, care home residents with major depression have been found to be at a greater risk of mortality compared to non-depressed residents (Rovner et al., 1991). Specifically, de Araujo et al (2016) found a 59% increased mortality risk and residents were also found to have lower levels of QoL. Depression has a serious negative impact on an individual, for example, older adults with depression have also been found to have similar symptoms and levels of cognitive functioning as older adults with dementia (Stiles & McGarrahan, 1998). Memory issues are also often one of the first symptoms reported for depression (Yesavage, Brink, Rose, Lum, Huang, Adey & Leirer, 1982). Therefore, these overlapping symptoms can make assessing and differentiating between dementia and depression a complex task.

To summarise, research on the prevalence of depression in care has found that 77.4% of participants had clinically significant symptoms of depression, and 11% were found to have subsyndromal symptoms of depression (Teresi et al, 2001). These figures are higher than those found in similar research which found that 44% of care home residents who participated in the research met diagnostic criteria for major or minor depression. One reason for the conflicting prevalence rates may be that depression is often not detected in those living in care homes (Davidson et al., 2006) and older adults living in care homes having different depression predictors to older adults living in the community (Reker, 1997). This may be due to issues with the assessment tools for depression as many are not designed for older adults in care homes. Care home staff have also been found to be inaccurate at recognising depression in the residents that they care for (Bagley et al., 2000). An important consideration when reviewing literature on depression in care homes is that much of the research involving care home residents and measuring or treating depression is relatively small scale (Milne, 2020), which may account for the conflicting findings between studies.

Overall, there is conflicting evidence on prevalence of depression in care home residents and older adults living at home. For example, a study conducted in English and Welsh care homes found that 27% of residents were depressed compared to 9.3% of older adults living at home in England and Wales (McDougall et al., 2007). This could be due to older adults living in care homes experiencing different symptoms of depression compared to those living in the community (McDougall et al., 2007). Nursing home residents have been found to experience more feelings of hopelessness, helplessness, and depression (Ron, 2004). Similar findings have been found in research comparing nursing home residents in Japan (Nagatomo et al., 1993), and Pakistan (Shyam & Yadev, 2006). However, the opposite has been found in research conducted in Spain where older adults living in the community were found to have lower levels of well-being compared to those living in a care home (Rodriguez-Blazquez et al., 2012). These differences may be due to the assessment used or due to the fact that care home residents were interviewed by staff who cared for them, which introduced the possibility of residents giving socially desirable answers. It may also be due to some older adults living at home being more physically impaired which impacts their autonomy and levels of depression (Boyle, 2005). The differences seen between older care home residents and older adults living in the community may be due to several reasons. For example, in Boyle's (2005) study the care home population sample was much smaller than the community dwelling population which makes true comparisons difficult. It is also difficult to establish which residents were depressed before moving to a care home and which have become depressed since moving (Boyle, 2005). As mentioned earlier, research has also found that older adults living in care homes may have different indicators of depression and display different symptoms to those living in the community (Reker, 1997; Davidson et al., 2006).

2.4.2 Institutionalisation

The risk of older adults becoming institutionalised when living in a care home was identified in the literature included in the literature review. Institutionalisation can occur in any system where individual differences are reduced in how people are dealt with. All institutions have rules, norms, and expectations, and when this is coupled with reduced contact with the outside world and dependence on the institution for basic needs such as food and care then there is a risk that individuals become institutionalised. Goffman (1961) referred to institutionalisation in his concept of 'total institution' which is "*a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life"* (Goffman, 1961: xiii). Goffman's work focused on the dehumanising impact of institutionalisation which can occur in any social system that reduces an individual to a role (Mac Suibhne, 2011).

The concept of institutional neurosis was also coined by Russell Barton (1959) and defined as:

> *"Institutional neurosis is a disease characterized by apathy, lack of initiative, loss of interest more marked in things and events not immediately personal or present, submissiveness, and sometimes no expression of feelings of resentments at harsh or unfair orders. There is also lack of interest in the future and an apparent inability to make practical plans for it, a deterioration in personal habits, toilet and standards generally, a loss of individuality, and a resigned that things will go on as they are -unchangingly, inevitably and indefinitely."* (Barton, 1959, pp. 2-3).

In his book, Barton (1959) proposes that the cause of institutional neurosis is uncertain, and likely to be due to many factors such as environment, loss of contact with the outside world, enforced idleness, staff interactions, and loss of friends, possessions, and personal events. These factors are experienced by many care home residents in the UK and therefore put them at risk of institutionalisation.

One of the key conclusions from the Older People's Commissioner for Wales' (OPCW) report 'A Place to Call Home?' (Older People's Commissioner, 2014) was that older adults become institutionalised when living in care homes. The report found that older care home residents who were interviewed for the report, lost their personal identity and individuality, and often felt a lack of control over their lives (Older People's Commissioner, 2014). Being in this kind of environment would significantly impact an older adult's mental health and well-being. Which is why research needs to be carried out in this area, focusing on finding ways to understand and promote the mental well-being of older adults in care homes.

Examples of institutionalisation in care homes are seen in Forbes-Thompson and Gessert’s (2006) study. A case study approach was used incorporating observations, interviews, and document review to focus on the psychosocial and existential suffering that many nursing home residents experienced at the end-of-life. Residents were found to experience many losses including physical, psychological losses and losses such as privacy, possessions, control, and sense of purpose since moving to a nursing home (Forbes-Thompson & Gessert (2006). The residents included in the study felt that death was preferable to life in a nursing home. This research is an example of how institutionalisation causes decontextualization due to the loss and separation from the resident’s previous roles, relationships and identity that help give the resident’s life meaning and contribute to their self-identity (Forbes-Thompson & Gessert, 2006). In this study, residents found themselves to be isolated from the outside world and experiencing multiple losses that were important to their identity, memories, and mental well-being (Forbes-Thompson & Gessert, 2006). In nursing and care homes, residents often must comply with the institutions structured routine of care which causes helplessness and hopelessness, and also leads to institutionalisation.

There are only a small number of studies that consider the institutionalisation of older adults. Treating older adults as a homogenous group instead of individuals can disempower them, in addition to a structured routine, can further lead to becoming institutionalised (Forbes-Thompson & Gessert, 2006; Haugan, Innstranf & Moksnes, 2013; Lee et al., 2009). Staffing levels and the focus on task-orientated and physical care needs can mean that staff do not have enough time to interact with residents beyond seeing to their personal care (Oleson, Heading, Shadick & Bistodeau, 1994; Haugan, Innstrand & Moksnes, 2013; OPCW 2014). It has also been noted that pet names or calling residents by nicknames can also damage residents' sense of self. It can be seen as patronising and disrespectful, especially if they have never been called by that name before (OPCW, 2014). These findings highlight the role care home culture plays in contributing to feelings of institutionalisation and undermining the mental well-being of care home residents.

To combat institutionalisation, it is crucial that residents hold on to a sense of identity and that they can have a say in decisions that affect them (Kroger & Adair, 2008; (Minney & Ranzijn, 2016). The importance of details and feeling listened to is often underappreciated such as residents being able to have a cup of tea or coffee the way they like it, and the importance of selfhood is often lost (Kroger & Adair, 2008; (Minney & Ranzijn, 2016).

2.4.3 Research on mental well-being in care homes

Historically the mental well-being of older adults in care homes has not been the focus of care. Instead, the focus has been upon meeting residents' physical needs and avoiding instances of neglect and abuse. However, merely focusing on avoiding instances of neglect or abuse does not necessarily mean that residents' mental well-being is cared for. Hancock, Woods, Challis & Orrell, (2006) found that even though residents' physical care needs were met, their mental health needs and social needs were often not considered a priority. In their study the Camberwell Assessment of Needs for the Elderly (CANE) was used to assess the needs of 238 care home residents with dementia, which found that resident environmental and physical health needs were usually met. However, resident mental health needs, social needs and sensory or physical disability needs were less likely to be met by staff (Hancock et al., 2006). One explanation of this task-orientated approach to care and focusing on meeting residents' physical needs is that it has also been found to be a coping mechanism amongst staff, to deal with challenging and sometimes upsetting work, which can lead to a decrease in their ability to provide person-centred care (Wood, 2008). An example of care homes not prioritising resident well-being is also seen in a study of admission assessment documents of care homes in North West England, which found that the majority of care homes did not assess resident well-being on admission (Worden, Challis, & Pedersen, 2006). These findings suggest that the assessment and monitoring of resident well-being are low on the assessment priority list and are often overlooked, or that perhaps assumptions about older adults and ageing lead people to assume that low mood and mental well-being are a normal part of ageing (Milne, 2016). The assumptions made about ageing and the assessment of older adults' mental well-being being low on priority lists indicates that there is a need to better understand mental well-being from the perspective of the older care home resident. By understanding the care home resident's perspective, it is possible to challenge these ageing assumptions and find ways to promote and maintain older adult mental well-being.

As stated earlier in the thesis the care home population can be a difficult population to access for research, and limited research has been conducted on older adults' experiences in care homes (Dening & Milne, 2011). There have been small studies which focus on the experiences of residents from one care home or a small number of care homes with a small sample of care home residents (Owen & Meyer, 2012; Netten et al., 2010). Several research studies on resident experiences have also focused on observational and proxy measurements of resident QoL or well-being instead of involving the residents directly in the research and asking them about their feelings and experiences (Parker et al., 2004). However, using observational or proxy measurements may introduce bias, in addition to not collecting the data directly from the participants.

2.4.3.1 Promoting and maintaining mental well-being

One study that has looked at the mental well-being of care home residents is Chipps and Jarvis (2016), which looked at the association between mental well-being and social capital in care home residents in South Africa. Their study confirmed the association between social capital and mental well-being and found that the strongest predictor of mental well-being was participation in activities outside of the care home. There was a significant difference between the network structures of residents who were mentally well compared to those who were mentally unwell (Chipps & Jarvis, 2016). The study did include 103 residents; however, they were from a single care home. This resulted in responses only being drawn from one institution, whereby all participants were subject to similar experiences and protocols, for example, compared to older people living in different care homes who may have different experiences. The authors also acknowledge the risk of social desirability bias occurring with self-report measures and residents underreporting negative ratings, especially when residents needed support in completing the self-report measures (Chipps & Jarvis, 2016). Conversely to earlier research (Petrillo et al., 2015; Shyam & Yadev, 2006) men showed significantly higher levels of psychological distress than women (Chipps & Jarvis, 2016).

The importance of involving residents in decisions is a common finding in the literature on QoL and mental well-being. Residents who are involved in decisions and feel more empowered have been found to have higher levels of well-being (Knight, Haslam & Haslam, 2010). Residents who felt empowered were more engaged with their environment and the people around them and were happier than residents who felt less empowered and who had not been involved in decisions (Knight, Haslam & Haslam, 2010). Allowing residents some control and input over the design of their living space gave them ownership of that space, and made it feel more like their home and empowering residents also had a positive impact on staff (Knight, Haslam & Haslam, 2010). Knight, Haslam, and Haslam's findings (2010) also support the connection between empowerment, social identity, and well-being.

The importance of meaningful activity and social interactions, and choice have been identified as being important to care home residents' well-being in multiple research studies. Gleibs, Sonnenberg and Haslam (2014) conducted a gender based social activity intervention and interviewed residents to explore care home residents' experiences of life in long term residential care. Their findings suggest that adjustment and positive interactions and relationships with care staff had a positive impact on resident's well-being. The second theme identified in the analysis was 'being stuck' which describes the sense of confinement and lack of control many older adults experience while living in long term care. Their findings suggest that group activities are needed to support and promote autonomy and perceived control, this has a positive impact on resident well-being (Gleibs, Sonnenberg & Haslam, 2014). They also found that social interactions had a positive impact on adjusting to life in the care home which is another study that highlights the need for better resident and staff interactions (Gleibs, Sonnenberg & Haslam, 2014). The importance of social interactions in care homes has also been found in Mikelyte and Milne's (2016) scoping review which looked at the micro-cultures in long term care settings for older adults. The findings from the review emphasised the importance of staff resident interactions and micro-cultures on care home resident mental health and well-being (Mikelyte & Milne, 2016). Their review also highlighted the need for more research in this area and the importance of understanding micro-cultures in care homes to help promote and maintain mental health and well-being (Mikelyte & Milne, 2016).

Activities can also provide residents with a means to socialise with others inside the care home and those outside the care home. Social engagement has been found to correlate with higher levels of well-being (Gilbart & Hirdes, 2000). Social groups within care homes provide residents with opportunities to socialise through meaningful activity which has been found to improve and maintain well-being and social identification with others, particularly with men living in care homes (Gleibs, Haslam, Jones, Haslam, McNeill & Connolly, 2011). While physical and leisure activities have been found to improve depression and psychological health in residential care homes in China (Ouyang, Chong, Ng & Liu, 2015). Also, leisure activities are related to lowering levels of ill-being of older adults in long term care (Duncan, Killan & Lucier-Greer, 2017). As previously outlined, religion and spirituality have been found to be important contributing factors in the well-being of older adults in care homes. Religion and spirituality contribute to personal meaning and identity and provide older adults with the support and comfort they may need in navigating later life and the stresses and losses that they endure (Fry, 2000). Another study on activity in care homes was Windle, Hughes, Linck, Russell and Woods' (2010) study, which looked at the evidence of the effect of exercise on mental well-being in older adults in general and found that overall exercise and physical activity had a positive effect on the mental well-being of older adults. These studies provide further evidence that a holistic approach to understanding older adult's experience of living in a care home and what contributes to their mental well-being is needed.

An intersecting concept or component of mental well-being is psychosocial well-being. Self-concept, particularly physical self-concept has been found to be an important predictor of psychosocial well-being in care home residents and care home residents have also been found to have lower scores on self-concept domains to the norm (Grace & Toukhsati, 2014). Even the environment in care homes has an impact on older adults' QoL and mental well-being. Views of green spaces and nature as well as open-plan layouts and practical, easily accessible design have been found to have a positive impact on well-being (Burton & Sheehan, 2010). A recent study in the UK exploring the relationship between the care home environment and residents' depressive symptoms found that the overall physical environment of care homes did not predict depression scores on the GDS-15 (Potter, Sheehan, Cain, Griffin & Jennings, 2017). However, residents not having access to outdoor space did significantly predict depressive symptoms (Potter et al., 2017). During the interview stage of the research residents reported that their access to outdoor space was restricted for many reasons, including locked doors, uneven terrain, and needing permission or support to access the outdoor space (Potter et al., 2017). These findings suggest that taking a holistic approach to mental health and well-being, and considering the whole experience of care home living, would have a positive impact on older adult mental well-being.

2.4.3.2 Impact of care home transitions on mental well-being

Moving to a care home can be a difficult transition for many older adults and signify a period of loss in the older person's life. The majority of older adults move to a care home following a crisis, such as hospital admission, death of a spouse or carer, or sudden decline in their own physical or mental health (Bebbington, Darton & Netten, 2001), which makes a difficult transition even more difficult as it occurs at such a distressing time. Unsuitable housing, in-adequate community-based care or a collapse in family care arrangements are also often reasons for a move to a care home

(Forder & Fernandez, 2011). Moving to a care home is often seen as a last resort for family and older adults, as most residents will not return home once they have moved to a care home. Consequently, moving to a care home can signify a period of loss, loss of independence, home, and family members, which has an impact on the mental well-being of older people. Research has highlighted that a move to a care home is an emotional process in addition to a physical and practical one (Tanner, Glasby & McIver, 2015). It is also important to consider the perspective that low mood and feelings of sadness are also appropriate responses to such a life changing event as moving into a care home (Milne, 2016). It may be more appropriate to look at way at helping older adults settle in care homes than giving them labels and monitoring their mood over the first few months after the move.

A more resident-centred understanding of transitions has been suggested to help improve older people’s transition into a care home (Tanner et al., 2015). One way to implement this is and to support residents when moving to a care home and to improve and maintain their well-being was to involve residents in the decision-making process when making the decision to move to a care home. When making the decision to move to a care home, residents who felt supported in making the decision themselves have been found to have higher QoL scores (Wilkinson et al., 2012). This suggests that residents who feel disconnected from the decision-making process, and not in control or given a choice about an important decision in their lives are more likely to feel pessimistic about moving to a care home and subsequently score lower on QoL measures. Therefore, it is crucial to understand the circumstances around older adult's move to a care home and how this impacts their QoL and mental well-being, in addition to understanding how they can best be supported throughout this transition.

A study of reasons residents move to a nursing home and the impact of the move on their psychopathological and cognitive profile, dependency and perceived quality of life found that the main reason older adults moved to a nursing home was due to there being no caregiver available, only a small percentage of the study population had moved to the care home by their own choice (Scocco, Rapattoni & Fantoni., 2006). Many residents felt lonely and marginalised, and most participants experienced psychiatric symptoms and cognitive decline at the six month follow up, perceived QoL also worsened after admission to the nursing home.

2.4.3.3 Quality of life and intersecting concepts in care homes

Quality of life (QoL) has been used as a synonym for mental well-being, life satisfaction, and mental health, while QoL in old age has been described as a sense of well-being (Sarvimäki & Stenbock-Hult, 2000). Through the use of structured interviews with three hundred older adults over the age of 75 in Finland, Sarvimäki and Stenbock-Hult (2000) presented their definition of QoL as a sense of well-being, meaning, and value or self-worth. In comparison, Edwards, Courtney, and O'Reilly (2003) identified the key themes of autonomy, control, and staff resident interactions in their research on residents' views on what contributes to their QoL. They also highlighted the need to enable residents to make big and small choices to help encourage and maintain a sense of control and autonomy while living in a care home (Edwards, Courtney & O'Reilly, 2003).

Studies have also found that residents and staff view QoL differently, which means that using staff perspectives can lead to confusion or misrepresentation of what is important to older adults. Berglund and Ericsson (2003) compared the perspectives of older adult residents and care home staff on what was important to resident QoL. They found that residents and staff differed in their responses to what was important to resident QoL. Staff were found to over emphasise the importance of health and social network on resident QoL while residents placed more importance on being appreciated and living a good life in the care home. Providing further evidence supporting the importance of including residents' voices in research about their experiences. Kane (2003) also maintained the importance of including residents' voices and experiences in research and also in defining concepts such as QoL. Kane's (2003) research identified the challenges in defining and measuring QoL in care homes and found that QoL in care homes was influenced by care home policies and practices, environments and through the care home's approaches to family and community. These research findings further highlight the complexity of defining and measuring key concepts such as QoL, mental well-being and well-being in the care home population.

Murphy, O’Shea, and Cooney’s (2007) research into QoL included the perspectives of staff in addition to the perspectives of residents on what was important to their QoL. Four themes were identified from the analysis, these were: care environment and ethos of care, personal identity, connectedness to family and community, and activities and therapies. Their study included 101 care home residents and identified four themes from their grounded theory study. These were: ethos of care, sense of self and identity, connectedness, and activities and therapy, similarly to the themes identified in earlier studies (Murphy et al., 2007). A tension between routine and resident choice was found at each of the long-stay care settings in Ireland included in the study, which has also been found in subsequent studies (Cooney, Murphy & O’Shea, 2009). Murphy et al.’s (2007) research also highlighted the need for QoL indicators to be developed and QoL in care homes to be given the recognition it deserves.

Cooney, Murphy, and O’Shea (2009) also looked at residents’ perspectives of QoL in care homes in Ireland and like other related concepts asserted that QoL for older people is a complex, multidimensional construct. Their study argued the importance of choice and participation in decisions for residents, this was not usually the case in most care homes and has been found to have a negative impact on QoL due to the structured care routine in care homes. Care routines are structured for the benefit of the organisation rather than the benefit of the residents (Cooney, Murphy & O’Shea, 2009). However, to better maintain a sense of self and personal identity, it is important that care homes and their staff are responsive to residents’ needs and are flexible and adaptable to those needs. The study also found that privacy was an important component of residents’ QoL. Findings also indicated that being able to express their identity through their personal appearance, possessions, spirituality, and preferences for personal space was important to residents (Cooney et al., 2009). The majority of the residents who participated in the research discussed wanting to be better connected with the world outside the care home, as this would allow them to keep in touch with the local community and life outside the care home. Residents talked about the days in the care home being long and boring, and valued the importance of meaningful activity to help pass the time and maintain their QoL (Conney et al., 2009).

Several literature reviews were found in the literature searches. Lee, Yu and Kwong (2009) conducted a review of the current literature on QoL of older adults in care homes. They included 18 studies in their review and identified three aspects of QoL in care homes from the studies. These were ‘views of residential care home elders on quality of life’, ‘factors affecting quality of life of residential care home elders’, and ‘methods to improve quality of life in care home elders’. Maintaining residents’ independence, autonomy, and individuality were identified as being most important to QoL. QoL may be influenced by quality of residential care and the facilities of the care home and environmental modification appeared to improve QoL from the studies included in the review. As the majority of reviews on QoL have found, the authors asserted that QoL is a complex and multi-faceted construct and studies often refer to different domains and components of QoL in their research, adding to the evidence that concepts such as QoL and well-being are difficult to define and compare. However, domains of QoL that consistently appeared in the literature were perceived independence, autonomy and individuality. Comparably to Murphy et al., (2007) and Cooney et al., (2009) the authors concluded that these components of QoL were difficult to maintain because of the structured routine of care that is provided in care homes which can also lead to institutionalisation (Lee et al., 2009).

There are very few high-quality studies available that have looked at understanding older adults' mental well-being in care homes and aim to offer recommendations on improving residents' mental well-being and quality of life as many studies use small samples or have high dropout rates and only look specifically at QoL (Murphy et al., 2014). A systematic review of research on quality of life in care homes, including older adults, identified four key themes that residents felt contributed to their quality of life, which were acceptance and adaptation, connectedness with others, a home-like environment, and caring practices (Bradshaw, Playford, & Riazi, 2012). In the studies included in Bradshaw et al.’s (2012) review, residents were concerned about the lack of autonomy and difficulty forming relationships with others since moving to a care home. Connectedness and interacting with others were found to be vital for positive care home life, in addition to a reciprocal relationship with care home staff. Residents who were more accepting of their move to a care home had a more positive outlook, which helped their levels of independence and resilience in adapting to new surroundings. Studies where residents felt more connected to others and felt they had reciprocal relationships with staff have found better QoL for residents (Cooney et al., 2014). Bradshaw et al.'s (2012) review aimed to offer practical recommendations on how to enhance resident's QoL in care homes and highlights the need for more research that considers the resident's perspective in understanding QoL in a care home and the need for relationship-centred approaches to care. Only eight of the thirty-one studies included in the review met all seven of the quality criteria set by the reviewers, which supports the claim that there is limited high quality research looking at the experience of care home residents (Lee et al., 2009; Van Malderen et al., 2013; Murphy et al., 2014). An issue identified in the review was that staff selected participants to participate in the studies which introduces the risk of selection bias. Selection bias is a risk when conducting research with care home residents as researchers rely on staff to allow access to the care home and often act as gatekeepers. However, their review supports the need for understanding the residents' experiences and perspectives of living in a care home and how this can be used to improve life in a care home.

Many of the studies discussed above on QoL and well-being cite autonomy as being important to residents. Rodgers, Welford, Murphy, and Frauenlob's (2012) review of the factors that impact autonomy in care homes found that the three key factors related to autonomy were the organisations approach to care, person-centred care, and life planning. Providing residents with choice and options where possible was vital to maintaining and promoting residents' autonomy. Many of the research studies on QoL, well-being and autonomy emphasise the importance of choice to care home residents. Rogers et al. (2012) also suggest that future generations of older adults may not be as passive as current generations and may want to be consulted and involved in decisions. This suggestion is also echoed in earlier and later research, that it is possible that future generations of older adults will not accept the same limitations on their choices and agency compared to the current generations of older adults living in care homes (Bowling, Banister, Sutton, Evans & Windsor, 2002; Murphy, Cooney & Casey, 2014).

Murphy et al. (2014) also reviewed studies that aimed to improve older adults' QoL in long-term care. Their findings echoed Bradshaw et al.’s (2012) findings and identified a number of common components of QoL in long-term care across the studies that were included. Components such as autonomy, the ethos of care, home-like environment, independence, connectedness, purposeful activity, and maintaining a sense of self were identified as important components in the literature for contributing to resident QoL (Murphey et al., 2014). In addition, research that focused only on the residents also identified health and functional abilities, security, spirituality, and finances as being important to their QoL. The systematic review only included studies that looked at QoL, therefore, studies that used a different term but measured a similar construct or components of QoL were not included. As research has found, and well-being models suggest, there are large overlaps between the components of QoL and what is important and contributes to positive mental health and mental well-being. This is reflected in an issue the systematic review discovered, which was that there were too many different measures of QoL all measuring different components of QoL. This made it difficult to compare and review each study, as there, likewise to similar constructs such as well-being and mental well-being, no clear, definitive definition of what is covered in QoL measures. Consequently, there is a need for further research to understand the importance of different QoL components in care homes and a consistent way of measuring those components.

Research has been conducted into how the lives of care home residents could be improved in Wales. My Home Life Cymru has reviewed residents' lives in care homes across Wales (Moore, 2013) and the review identified eight best-practice themes that were important to residents. The themes identified from the review were; maintaining identity, sharing decision making, creating community, managing transitions, improving health and healthcare, supporting good end-of-life, promoting positive culture, and keeping the workforce fit for purpose (Moore, 2013). These themes all contribute to maintaining and promoting QoL and the mental well-being of care home residents and provides the framework for care homes to focus on resident well-being rather than a more task-orientated approach to care.

The concept of ‘thriving’ has also been researched in relation to older adult QoL and well-being. Bergland and Kirkevold’s (2006) study looked at the concept of ‘thriving’ in nursing homes in Norway and investigated residents’ perspective on what contributes to ‘thriving’ while living in a nursing home. The study sample was relatively small with 26 residents from two nursing homes in Norway. They found that resident’s mental attitude was important to whether they were ‘thriving’ and the factors that contributed to ‘thriving’ were the resident’s attitude towards living in a nursing home, the quality of care and caregivers and also positive peer relationships, participation in meaningful activities, opportunities to go outside, positive relationships with family, and qualities of the physical environment. These findings are similar to those found in studies on QoL and well-being (Murphy et al., 2007; Lee et al., 2009; Bradshaw et al., 2012; Ward, 2012; Murphy et al., 2014; Bowbowick et al., 2015; Joshanloo, 2016). An interesting finding was that residents who adapted to the move to the care home and changed their goals about what could be achieved were more likely to experience ‘thriving’. The ability to make the unfavourable, favourable contributed significantly to residents’ ability to accept their life in a nursing home and to experience ‘thriving’. Kahn (1999) also discusses the importance of ‘making the best of it’ and the adaptive strategies used by older adults in order to maintain their well-being in light of the losses and challenges experienced in later life. This concept has also been discussed by Baltes and Baltes (1990) and Brandtstädter and Rothermund (2002). In addition, QoL and thriving have also been linked in other studies. A study of nursing home residents in Sweden found that residents who had higher levels functioning, higher QoL and who were less cognitively and physically impaired experienced ‘thriving’ (Patomella, Sandman, Bergland & Evardsson, 2016). These studies reflect the intersecting concepts and overlapping constructs in relation to mental well-being and QoL.

Research has used different measures to assess and understand QoL. For example, Wilkinson et al. (2012) looked at QoL of older adults in long term residential facilities in New Zealand using a life satisfaction measure. Interestingly, residents’ QoL was found to be associated with the QoL of co-residents. The study found that older adults who moved into care homes with residents with higher levels of QoL were more likely to have or maintain higher levels of QoL once they had relocated to the care home. This suggests that ‘happiness is contagious’ and that others’ behaviours, and attitude are contributing factors to maintaining and promoting our QoL. Similarly, to the findings of Bergland and Kirkevold (2006) residents who were more positive about moving to the care home had higher levels of QoL. QoL was also higher for residents who were more physically able, not depressed and those who had more family and emotional support (Wilkinson et al., 2012).

The components found to impact gerotranscendence are also similar to those found to impact QoL and mental health and well-being. Wang (2011) examined the bio-psycho-socio-spiritual factors that influenced care home residents’ development towards gerotranscendance. The theory of gerotranscendence asserts that individual development continues as we age, going beyond the duality of active and disengagement theories of ageing and ageing has its own meaning with significant changes in self-perception and relationships with oneself and others (Lars, 2005). Through structured interviews with 195 care home residents, Wang’s (2011) study identified how social support, life satisfaction and meaning of life impacted upon gerotransendence in older adults in care homes in Taiwan, indicating that the model gerotranscendence of healthy ageing is applicable to their study population in Taiwan.

Research has demonstrated the importance of positive social relationships to care home residents’ QoL and mental well-being. Another study by Robichaud, Durand, Bédard and Ouellet (2006) that looked at the interpersonal and environmental characteristic for care homes when residents move to the care home, and again after six months, including in the research both residents and family perspectives. The most important QoL indicators were being treated with respect, sympathetic involvement in relationships, and perceived competency through technical acts and attitudes. Interestingly, the environment seemed more important to families than it was to residents (Robichaud, Durand, Bédard & Ouellet, 2006).

A small qualitative study explored and compared the perceptions of QoL of older LTC residents and nurses who worked there (Oleson, Heading, Shadick & Bistodeau, 1994). The study used a relatively small sample of ten residents and nine nurses in three LTC institutions in England. The analysis of the interviews identified individuality, professionalism, connectedness, and physical functioning as common themes staff and residents discussed. Interview responses from residents were more personal and occasionally more negative compared to the interview responses from nurses (Oleson, Heading, Shadick & Bistodeau, 1994), highlighting the issue with relying on data from staff. Residents who participated in the study placed value on their ability to create meaning in their lives while coping and adapting to the changes that came with ageing and living in and institution, to residents their ability to adapt to their new living situation and still create meaning was important to their QoL (Oleson, Heading, Shadick & Bistodeau, 1994). While later research by McKinley and Adler (2006) identified four themes on what was important to QoL in nursing homes which were similar to the themes identified in the research literature. The themes identified that were important to their QoL in the nursing home were generativity, spiritual well-being, homelike environment, and privacy. In a small Australian study of six care home residents, poor health, family, the care home facility, staffing, transportation, and geography influenced residents' social interaction and participation in meaningful activities which impacted upon QoL and well-being (Thomas, O'Connell & Gaskin, 2013).

Care home residents have also been included in research on whether 'a good life' is possible while living in a care home. The small sample of thirteen care home residents indicated that physical, social and psychological well-being in addition to maintaining their sense of identity were important to a 'good life' while living in a care home (Minney & Ranzijn, 2016). Five themes were identified from semi-structured interviews with the residents, these were a better life, optimal functioning, continuity, acceptance and adaptation, and active ageing (Minney & Ranzijn, 2016). Conversely to some research, residents within this study felt that their lives had improved since moving to a care home, they had felt lonely, socially isolated, immobile, worried about their own health and safety and concerned about their family’s piece of mind before moving to a care home (Minney & Ranzijn, 2016). The move had addressed these issues and the others suggested that the residents felt happier since moving to the care home due to the person-centred model of care that was implemented at the home (Minney & Ranzijn, 2016). These findings reflect the importance of a person-centred and holistic approach to care.

Lundin, Berg and Hellström Muhli (2016) looked at the perspectives of care home staff on supporting resident’s well-being in Swedish care homes. They found that there needed to be a balance between the needs of the residents and the ‘conditions’ of the care home organisation, which are similar to findings in earlier studies. Three themes were identified from the interviews with twelve care home staff, including freedom of choice for the older person vs. institutional constraints, the residents’ need for activation vs. wanting not to be activated, and the residents’ need for routine vs. the eldercares not knowing what the resident needs. The struggle of how residents are treated impacted upon their mental well-being and QoL (Lundin, Berg & Hellström Muhli., 2016). The way staff perceive residents can have an impact on the experiences of residents and their QoL and well-being. Research has also found that labelling and treating residents differently can mean that residents have different experiences when living in a care home (Herzberg, 1997). Herzberg (1997) research found that residents experience the care home differently depending on what ‘label’ they have been given. In the study, assumptions were made based on which unit the resident was staying on. It was found that staff treated residents differently depending on which unit of the nursing home the residents lived on (Herzberg, 1997). More recent research has also found that the way staff interact and behave towards residents has an impact upon them. Haugan, Innstrand and Mokesnes (2013) study of nurse-patient interaction in nursing homes found that there was a significant relationship between residents’ interactions with nurses and their levels of depression and anxiety. The better the nurse-patient interaction there was, the lower levels of depression residents had. These studies highlight the importance of positive interactions between residents and staff, and the impact these relationships and interactions can have on residents.

Duncan-Meyers and Huebner (2000) looked at care home residents' perceptions of personal control and their impact on QoL, finding a significant positive correlation between the amount of choice residents perceive they have and their QoL score. Although this was a small sample of volunteers the study adds to the evidence that giving residents choice and enhancing their control has a positive effect on QoL. Important QoL domains for older adults in care homes have been found to be leisure activities, family, relationships, social life, independence, and peace and contentment (Hall, Opio, Dodd & Higginson, 2011). These domains reflect how important social connectedness and social interactions are to care home residents.

Experiencing connectedness, which is the experience of belonging to others, to a social group (Lee & Robbins, 1995) has been found to have a positive impact on older adult care home residents' QoL (Cooney, Dowling, Gannon, Dempsey & Murphy, 2014). Their review of research on QoL in care homes found that self-awareness, meaningful relationships with family and friends, involvement in meaningful activities and connections with outside society are important to connectedness for older adults. Living in a care home makes many of these social components of QoL difficult to maintain. Belonging to a group and having meaningful activity and sense of purpose has been linked to improving well-being for older adults in residential care. For example, older care home residents who identify with a religion and are part of a religious group show fewer depressive symptoms and are more likely to be members of other groups that improve their socialisation (Yesseldyk, Haslam & Haslam, 2013). Additionally, it is an example of how social capital is important to older adult well-being and how memberships of social groups improves relatedness and self-identity. Social support also has a positive impact on QoL, self-esteem and depression, residents who had more frequent visits from families were found to have higher levels of QoL, self-esteem and lower levels of depression (Sun, Zhang, Yang, Wu, Xie, Zhang, Jia & Su, 2017).

Enhanced comfort, a concept defined as 'not worrying about practical tasks or being a burden' (Cho, Kim, Kim, Lee, Meghani & Chang, 2017) has been found to be encouraged by aspiring to maintain physical and cognitive functions as human beings, desire for meaningful interpersonal relationships, feelings of confinement and limited autonomy, and acceptance of and adaptation to life in a facility were the themes identified in research exploring older adult nursing home residents' perspectives on their daily lives (Cho et al., 2017). In Cho et al's, (2017) study residents compared the negative impact on their autonomy and feelings of confinement to institutionalisation and experienced loneliness from a lack of connectedness. They felt a lack of autonomy from having to ask permission to do things such as go out or plan their days (Cho, et al., 2017). Nursing homes included in Cho et al's (2017) study had high quality ratings, it would be interesting to include nursing homes with lower quality ratings to see how those residents would respond and whether they would have a different perspective on their daily lives. Relatedness and need satisfaction have been found to be significantly and positively related to personal growth, purpose in life and autonomy in care home residents (Ferrand, Martinent & Durmaz, 2014). Concepts such as 'enhanced comfort' and 'thriving', are often created from similar and overlapping themes to constructs such as QoL and mental well-being. For example, Cooney (2012) undertook research into understanding older care home residents' perceptions of 'being at home'. Residents within this study indicated that continuity, preserving personal identity, belonging, and being active and working are important to feeling at home in a care home. The Theory of Finding Home (ToFH), feeling at home has also been linked to better QoL (Cooney, 2012). These themes that are important to residents' 'being at home' have also appeared in research on QoL and mental well-being, which makes defining these concepts complex and multi-faceted.

Many of the studies looking at the experiences of older adults in care homes have very small sample sizes. For example, Aller and Van Ess Coeling (1995) interviewed eight care home residents about their QoL while living in a long-term care facility. They found that 'caring for oneself' and 'the importance of helping others' were two new contributing factors that had not been identified in earlier research. A weakness of many of the studies including care home residents is the small sample size. For example, in Aller and Van Ess Coeling's (1995) only right care home residents participated. Even though their experiences are still valid and valuable, there is a need for studies with more robust and larger sample sizes to build a completer and more accurate picture.

From reviewing the literature on mental well-being, QoL and their intersecting concepts it is possible to see where there are similarities in the concepts and constructs when conducting research with older care home residents. Common components of QoL identified in the literature were autonomy (Edwards, Courtney & O'Reilly, 2003; Lee, Yu & Kwong, 2009; Bradshaw, Playford, & Riazi, 2012; Murphy et al. 2014; Hall, Opio, Dodd & Higginson, 2011), control (Edwards, Courtney & O'Reilly, 2003; Duncan-Meyers & Huebner, 2000), privacy (Cooney, Murphy & O'Shea, 2009; McKinley & Adler, 2006), maintaining identity (Cooney, Murphy & O'Shea, 2009; Lee, Yu & Kwong, 2009; Murphy et al., 2014; Moore, 2013; Oleson, Heading, Shadick & Bistodeau, 1994; Cooney, 2012), meaningful activity (Cooney, Murphy & O'Shea, 2009; Murphy et al., 2014; Thomas, O'Connell & Gaskin, 2013; Hall, Opio, Dodd & Higginson, 2011), acceptance and adaptation (Bradshaw, Playford, & Riazi, 2012; Oleson, Heading, Shadick & Bistodeau, 1994), connectedness and positive relationships (Bradshaw, Playford, & Riazi, 2012; Murphy et al., 2014; Moore, 2013; Oleson, Heading, Shadick & Bistodeau, 1994; Hall, Opio, Dodd & Higginson, 2011; Lee & Robbins, 1995; Sun, Zhang, Yang, Wu, Xie, Zhang, Jia & Su, 2017; Cooney, 2012), environment (Bradshaw, Playford, & Riazi, 2012; Murphy et al., 2014; McKinley & Adler, 2006; Burton & Sheehan, 2010), and caring practices (Bradshaw, Playford, & Riazi, 2012; Murphy et al., 2014; Moore, 2013). Similar themes were also identified as being important to older adult mental well-being in the literature, for example choice and control (Knight, Haslam & Haslam, 2010; Lundin, Berg & Hellström Muhli, 2016; Gleibs, Sonnenberg & Haslam, 2014), acceptance and adaptation (Gleibs, Sonnenberg & Haslam, 2014), autonomy (Gleibs, Sonnenberg & Haslam, 2014), connectedness and social interactions (Gleibs, Sonnenberg & Haslam, 2014; Gilbart & Hirdes, 2000; Gleibs, Haslam, Jones, Haslam, McNeill & Connolly, 2011), and environment (Burton & Sheehan, 2010). In addition, a study by Windle et al. (2010) also found that exercise was important to the mental well-being of older adults in care homes.

Many of the studies included in this narrative literature review demonstrate that research with older adults is often carried out with professionals or family members answering on behalf of the older adults. There is, at times, an assumption that professionals are able to speak on behalf of an older adult with high needs and say what that individual wants or needs (Bowers et al., 2009). In a study of older adults' experiences of care Bowers et al. (2009) conducted research with older adults living in seven care homes in England and Scotland. They found that older adults' voices and choices were often absent from the decision to move to a care home, and subsequently after the move to the care home. The decision to move to the care home was made usually after a crisis and most of the older adults they spoke to did not choose to move but felt pressure from social workers, GPs and their families to move to a care home. The research highlighted the fact, that despite efforts made at policy and organisational levels, care homes are still environments with an imbalance of power (Bowers et al., 2009), and residents as well as professionals, staff and families have a low expectation of their life in a care home. The areas that residents related as most important to their experience of living in a care home were people knowing and caring about you; the importance of belonging, relationships and links with the community, being able to contribute to family, social, community life and being valued for what you do, being treated as an equal and as an adults; respect for your routines and commitments; being able to choose how to spend your time; a sense of self and personal identity; getting out and about (Bowers et al., 2009). Their study sample included eighty-four older adults, however, this included older adults who lived in extra care housing and supported family placements in addition to care homes in England and Scotland (Bowers et al., 2009). The areas that residents highlighted as being important to their experience of living in a care home echo those found in the QoL, mental health, and well-being research included in this literature review. This highlights the intersectionality of concepts such as QoL, mental health, and well-being. Due to the limited research focusing on the views and experiences of care home residents research focusing solely on the experiences of older care home residents in Wales would be beneficial to understanding what is important to the mental well-being of older adults living in care home in South Wales.

2.4.3.4 Mental health, mental well-being, and dementia in care homes

Due to the high prevalence of cognitive impairment and dementia in care homes it is important to consider the research on mental health and well-being and dementia in care homes. Significant coexistence of cognitive impairment and depressive symptoms has been found in care home residents (Sutcliffe, Burns, Challis, Mozley, Cordingley, Bagley, & Huxley, 2007). While symptoms of anxiety and depression have been found to impact any individual's functioning, which can have a greater impact on those already with a dementia diagnosis. Kahn et al. (1975) proposed that this was excess disability, where an individual's functioning is impacted by depression and not their dementia diagnosis. People with dementia continue to have other needs that need to be looked after, often these are forgotten, and the primary diagnosis of dementia is focused on (Kahn et al. 1975). This can lead to issues, such as symptoms of depression, being put down to a person's dementia and not appropriately addressed. People with dementia nevertheless have social, psychological, emotional needs that would benefit from being understood and promoted. Developing a better understanding of mental well-being and how it may be improved would also benefit the population of care home residents living with dementia. Even if an individual has a diagnosis of dementia, it is important to not only focus on treating or managing symptoms and behaviours but to also focus on promoting and maintaining their mental well-being (Livingstone et al., 2008; Milne, 2009).

Neufeld, Freeman, Jolin and Hirdes (2014) investigated the prevalence of depressive symptoms in older adults who had been admitted to long-term care facilities. Their study was a large cross-sectional and longitudinal study that found depressive symptoms to be present in 54.3% of residents on admission, which then increased to 60.8% at follow-up. This figure is nearly twice as much as the prevalence found in Seitz et al's (2010) study which found a 29% prevalence of depressive symptoms among residents in long term care. They also found that residents with severe cognitive impairment were two and a half times more likely to suffer from depressive symptoms at the follow up assessment. The authors stated that it can be very difficult to clearly differentiate between symptoms of depression and symptoms of dementia (Neufeld, Freeman, Jolin & Hirdes, 2014).

2.5 MEASURING MENTAL WELL-BEING

I reviewed the evidence on measuring mental well-being to help identify the range of measures being used in the current literature and to determine which measure was most suitable for this study. In a field where concepts such as well-being are contested and disputed it was difficult to select the most appropriate measure for use in this study. There are also issues to consider in measuring mental health and well-being in the older adult population, for example Johnston, Reid, Wilson, Levesque and Driver (2007) stated that depression can be difficult to detect in older adults as it can be masked by co-morbid medical illness and also the possibility that the older generation is even less likely to discuss their mental well-being and the stigmatisation of mental health. Whereas Adams (2001) has posited a depletion syndrome in older adults, which resembles 'depression without sadness', which makes assessing and identifying depression more complex in the older adult population. These are some of the issues that need to be considered when selecting a measure to use with older adults.

From the literature searches on mental well-being and similar constructs I found that symptoms of mental health disorders such as anxiety and depression are often used as indicators and in developing well-being measures as the absence of these symptoms is seen as being mentally well or having high levels of mental well-being. When measuring mental health and well-being instruments often do not ask the older adult about their experiences or how they feel but rely on others' observations and opinions to assess their well-being. Research has found that often older adults do not place the same level of importance on the same issues as staff do (Dröes et al., 2006). Dröes et al.'s (2006) research found that instruments did not contain items that older care home residents thought were important to their well-being. Also, when others speak on the behalf of older adults it disempowers them and increases the risk of older adults becoming institutionalised (Scourfield, 2007). Therefore, as the research literature has found that it is possible to use self-report measures in research with older adults in care homes (Kane et al., 2003), it is important that older adults are given an opportunity to voice their experiences and feelings when assessing mental health and well-being.

2.6 REVIEWING THE LITERATURE AND SELECTING A SCALE

A comprehensive literature search was carried out to find prospective well-being scales to administer during the first data collection stage. The aim was to review measures that assess well-being and systematically identify measures suitable for measuring older adults' mental well-being in care homes. PsychINFO, EMBASE, MEDLINE, Web of Science and CINHAL databases were searched for well-being measures, and existing reviews of well-being measures were also drawn upon. Measures were included if they were designed for adults over eighteen and stated that they measured a type of well-being such as psychological well-being, emotional well-being, mental well-being, or global well-being, this included measures of quality of life and life satisfaction. A narrative literature review approach was used to give an overview of the measures found and to also better understand the factors that are necessary to consider when measuring older adults' mental well-being in care homes.

From the literature searches I identified 114 prospective measures (see Appendix 2 for table of prospective well-being measures) and I began to review each measure and exclude ones that were unsuitable for use in this PhD research study. The diagram below (figure 2.2) shows the selection process and how the number of measures was reduced at each stage.

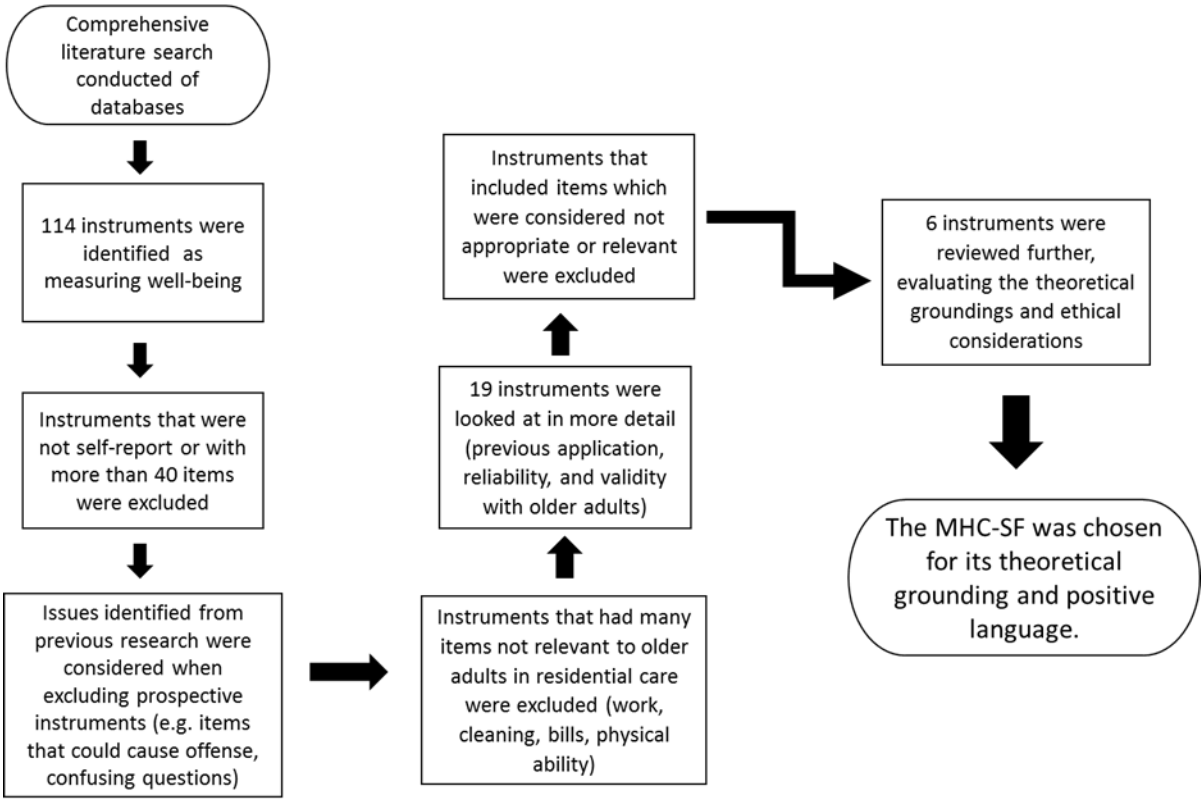

Figure 2.2 Scale selection flow chart

Firstly, a self-report measure was needed for the research study, therefore measures that were not self-report measures were excluded. For example, the Hamilton Depression Rating Scale (HAM-D) was not suitable for this study because it needed to be completed by a trained observer after a 30-minute clinical interview. Measures were also excluded if they were longer than 40 items as the literature had found measures containing many items were less likely to be completed fully by older adults (McNair, 1979), and therefore may be too onerous for the research population of my PhD research. Measures that contained items that the literature found to be unsuitable or raise issues with older adults, such as questions that could cause offence, questions that were irrelevant, length, and wording (Katz & Parmelee, 1997; Lichtenberg, 1994; Suija et al., 2012), were also excluded. For example, Hammond (2004) noted that some healthcare professionals did not like using the Geriatric Depression Scale (GDS) as some the items were negative and depressing.

The World Health Organisation Quality of Life Brief scale (QHOQOL-BREF) has been found to be valid in Norwegian and Canadian older adult samples (Kalfoss, Low & Molzahn, 2008). However, there have been issues with certain items on the scale.

Questions about medication, pain, working capacity, and sexual activity were found to cause issues and studies have reported issues with items that cover topics that could be different for older adults compared to other age groups such as body image, and support from friends (Liang et al., 2009). In Laing et al.'s (2009) study many of the participants found the question on sexual activity was not relevant to them and it made them uncomfortable. The same issue was also encountered in Jefferson, Powers, and Pope (2001) study when several participants did not respond to questions about sexual interests on the Beck Depression Inventory-II (BDI-II).

The remaining measures were reviewed in more detail to establish their suitability for use with older adults in care homes. Issues found in earlier research were considered, and the list of instruments was gradually reduced. For example, false positives have been an issue when measuring depression in the older adult population. Papassotiropoulos and Heun (1999) found high rates of false positives when using the GHQ-12 with older adults. The GDS-15 and the GDS-12R, which were designed specifically for older adults in care homes, have also been found to have high rates of false positives (Graham, 2004). The GDS has also been found to have validity issues with older adults who are cognitively impaired (McGivney, Mulvihill & Taylor, 1994), and since it is probable that a high proportion of the care home population has some cognitive impairment (Matthews et al., 2013) this was another reason to remove the GDS from the list of possible measures to be used in this study. The Hospital Anxiety and Depression Scale (HADS) was also found to be unreliable when used with older adults (Flint & Rifat, 1996).

The Beck Depression Inventory (BDI) was found to be reliable for use with older adults (Gallagher, 1986). However, more recent studies have found issues with somatic symptoms commonly found in the older adult population inflating depression scores and that the format was too complex and therefore not the most suitable depression measure to use in the older adult population in care homes (Snowden, Sato, Roy-Byrne, 2003).

One of the issues found when measuring concepts such as mental well-being was that different cultures and generations often have different words to describe feelings and thoughts compared to other generations and cultures. For example, Lawrence et al. (2006) found that Asian and Black Caribbean older adults used the words 'worrying' or 'thinking too much' when they described symptoms of low mood and depression. These issues that may arise when measuring mental well-being in the older adult population need to be considered when selecting a scale for use with older care home residents.

During the selection process, consideration was also given to the theories and models behind the measures to ensure the most suitable instrument was chosen as many of the measures were based on diagnostic criteria from diagnostic manuals where the focus is on whether or not the respondent meets the diagnostic criteria for a mood disorder. For the purpose of this study psychopathology was not considered, instead measures that would aid in trying to find ways to assess and understand what was important to mental well-being were considered to be more appropriate given the study aims and the scope of the research. Research on life satisfaction measures has found that when well-being is measured with a life satisfaction measure important information is lost (Huppert, 2013). Therefore, from further reading of the literature on the definition and structure of well-being, comparing the theoretical grounding and ethical considerations of the remaining well-being scales, the Mental Health Continuum Short Form (MHC-SF) (Keyes, 2009) was chosen. The Mental Health Continuum-Short Form (MHC-SF) uses positive language compared to many other well-being measures and did not contain many of the issues that previous research had found with other well-being measures. The MHC-SF also incorporates the eudaimonic and hedonic perspectives and two-continua model of mental well-being. The two-continua model also includes both the hedonic and eudaimonic perspectives, stating that positive mental health consists of emotional, psychological and social well-being (Keyes, 2009). The model is also consistent with the WHO (2004) definition of positive mental well-being, which asserts that positive mental health is related to but distinct from mental illness.

2.6.1 The Mental Health Continuum Short Form

The MHC-SF is a self-report 14 item scale developed by Keyes (2009) and incorporates the two-continua model of mental well-being, which states that positive mental health does not necessarily mean the absence of mental illness. This definition is appropriate for use in this study as my aim is not to measure how many residents meet diagnostic criteria but to assess and better understand what contributes to their mental well-being.

The MHC-SF is designed to measure emotional, psychological, and social well-being and was developed from the MHC-LF version, which consisted of forty items. The original, longer version of the scale incorporated Ryff's (1989) model of psychological well-being, Keyes' (1998) model of social well-being, Bradburn's (1969) affect balance scale, and Cantril's (1965) self-anchoring items. The MHC-SF was developed in the United States (Keyes, 2002, 2005) and has been used in South Africa (Keyes et al. 2008), Canada (Peter, Roberts, & Dengate 2011), the Netherlands (Westerhof & Keyes, 2010), Italy (Petrillo, Capone, Caso, & Keyes, 2015) Iran (Joshanloo & Nosratabadi, 2009) and Brazil (Machado & Bandeira, 2015). The MHC-SF has been used to measure the well-being of a wide range of ages, and studies have included adults between the ages of 18-89 (Petrillo et al., 2015; Raiefy et al, 2016; Snowden et al, 2010; Joshanloo & Lamers, 2016; Westerhof & Keyes, 2010; Salama-Younes, 2011; Keyes et al, 2008 & Keyes, 2005). It has also been translated into different languages (Keyes, 1998; Karaś, Cieciuch & Keyes, 2014).

In many studies social, emotional, and psychological well-being have been studied separately. Keyes' MHC-SF measure of well-being incorporates all three components of well-being of social, emotional, and psychological well-being which contribute to an individual’s overall well-being. Critics have suggested that psychological and emotional components of well-being are too similar and often overlap (Jovanović, 2015). They are closely related as both psychological and emotional well-being components focus on how individuals think and feel, however, they are distinct from each other (Joshanloo & Lamers, 2016). Salama-Younes and Ismaïl’s (2011) study aimed to validate the MHC-SF structure in physically active older adults in France. The internal consistency was found to be acceptable, however, the internal consistency score of the psychological and social well-being domains was not acceptable. This, however, did not affect the overall score of the MHC-SF.

Research has found a difference in performance on the MHC-SF by age. A Dutch study of adults between the ages of 18 and 88 found a difference in performance on two psychological well-being questions in different ages. However, Lamers, Glas, Westerhof, and Bohlmeijer (2012) found it to be a reliable and valid instrument for measuring positive mental health. Cultural differences have been found in participant scores in each well-being domain, while the factor structure has been applied successfully in different countries and cultures (Joshanloo, Wissing, Khumalo & Lamers, 2013). More individualistic countries may score differently in each domain than more collectivist cultures. It has also been found that women usually score higher in the emotional well-being domain compared to men (Graham and Chattopadhyay, 2013; Arrindell, Heesink, & Feij, 1999).

2.7 CHAPTER SUMMARY

The available literature suggests that older adults in care homes are a forgotten in population. Much of the work around mental health and well-being of older adults has focused on measuring and assessing levels of depression, anxiety, well-being, quality of life, rather than understanding older adults' experiences and what is important to them and how their mental well-being can be maintained and promoted.

The literature demonstrates that there are many ways to measure and assess mental well-being and similar constructs. Several studies use diagnostic criteria as a way of assessing mental well-being, suggesting that the absence of diagnostic symptoms equates to positive mental well-being. The models and definitions of well-being discussed in chapter one suggest that it is more complex than this and in order to maintain and promote well-being we should not only by looking at how to treat mental ill health but also how to prevent mental ill health and maintain mental well-being.

The literature reviewed identified that care home resident mental well-being is often not assessed when moving into a care home, indicating that it is not a priority (Worden et al., 2006). Supporting residents to make their own decisions is beneficial and the happiness of other residents living in the home is important (Wilkinson et al., 2012). When looking at interventions to improve life in a care home there are limited high quality studies available. Terms and concepts are used interchangeably, and many different instruments used (van Maldren et al., 2013). While maintaining identity, sharing decision making, creating, community, managing transitions, promoting positive culture and focus on quality of life issues rather than task-orientated care were identified as being important to deinstitutionalise care homes (Moore, 2013).

After reviewing existing measures and the current literature I selected the MHC-SF because it is congruent with the WHO definition, does not focus on psychopathology, incorporates the two-continua model and both hedonic and eudaimonic perspectives of mental well-being and earlier literature had not found issues with using it in older adults. In the next chapter I discuss the methodological and theoretical approaches that underpin the thesis and the research methods used to conduct the quantitative and qualitative stages of this research study.

3 CHAPTER 3: METHODOLOGY AND METHODS

3.1 INTRODUCTION

This chapter aims to provide a detailed account of the methodological approaches used in this research study. The purpose of this study was to develop a better understanding of the mental well-being of older adults living in care homes in South Wales. The study also aimed to explore ways to promote and maintain their mental well-being and quality of life and offer recommendations for best practice regarding maintaining and promoting their mental well-being.

In this chapter I discuss the methodology and methods used in this PhD research. To begin with I discuss the epistemology of pragmatism that underpins this mixed methods research, the integration of mixed methods, the research approach and design, and the ethical considerations of conducting research. The theoretical underpinning that mental well-being is a concept that is real and measurable but also complex and based on important experiential and contextual factors. Therefore, using a pragmatic mixed methods design to measure mental well-being and also in-depth research interviews to learn about the experience and the contexts of these experiences is in keeping with the theoretical stance of this thesis. The mixed methods approach allows the researcher to connect different elements of the experience and bring them together to build a more comprehensive picture than would otherwise be gained by only selecting one approach.

The chapter also provides an overview of the research approach and design that was developed, the research materials, sampling strategies and participant recruitment, details of the data collection procedures for the quantitative and qualitative stage of data collection and details of the analysis conducted after each stage of data collection.

Before beginning the second stage of data collection, a semi-structured interview schedule was developed with the aid of findings from the first stage. An interview schedule was developed to ensure that questions on each component of mental well-being were included in the interview. The qualitative section of this chapter details the methods implemented to collect data during the second stage of data collection.

An explanation of the sampling strategy and participant recruitment is also included, and a detailed description of the data collection process is explained. Lastly, a description of the reflexive thematic analysis of the interview data.

3.2 EPISTEMOLOGY OF PRAGMATISM FOR MIXED METHODS RESEARCH

Epistemology is the theory of knowledge, and the methods used to gain and understand knowledge (Creswell & Plano Clark, 2018 p.37). Crotty (1998) suggests that there are four elements to the research process, these four elements are the researcher's epistemology, theoretical perspective, methodology and methods. He asserts that our epistemology informs the theoretical perspective which guides the methodology and directs the choice of methods we use to answer our research question (Crotty, 1998). Therefore, our epistemology and theoretical perspective plays a key role in how we conduct research and answer our research questions.

Within epistemology there are positivist and interpretivist stances which are associated with quantitative or qualitative approaches to collecting and analysing research data. Whilst positivism and post-positivism are considered opposing epistemological stances, paradigms, or world views to constructivism and interpretivism (Creswell & Plano Clark, 2018), much of the literature presents these stances as dichotomous, that they are different ways of seeing and knowing the world around us. For example, positivists propose that there is a singular reality that can be uncovered using objective quantitative research methods. In contrast, interpretivists believe that knowledge and reality are subjective and believe qualitative research methods are the most effective way of researching. Mixing these two data collection approaches requires a different epistemology that is compatible with the assertion that we need different types of knowledge in combination to better understand a phenomenon. Pragmatism is an underpinning epistemological and theoretical stance in relation to the social world that allows us to make use of these different types of knowing in combination. It is based on the idea that an ideology or proposition is true if it works satisfactorily and accepts that different realities are 'open to empirical inquiry' and focuses on 'solving' "real world" issues (Creswell & Plano Clark, 2018 pp. 39-40), which gives the researcher freedom in choosing the most appropriate research tools available to them to answer the research question. Therefore, researchers are not restricted by the practical constraints of a solely positivist or constructionist paradigm.

Key individuals in the development of pragmatism were Charles Sanders Peirce, William James, and John Dewey. Unlike other philosophies, pragmatism highlights the importance of the nature of experiences instead of the nature of reality (Patton, 2015). This does not suggest that pragmatism proposes that experiences are not reality; the pragmatic approach focuses on experiences that are the individual's reality, rather than discovering what reality is. Pragmatists also recognise that knowledge is fallible (Biesta & Burubles, 2003). Therefore, the main focus of pragmatic research is not to validate the nature of reality but to find practical and useful answers that can offer solutions to real-world issues.

The pragmatic world view also argues that researchers do not need to position themselves as either post-positivist or constructivist. Pragmatism argues that the emphasis should move away from finding truth and reality and placed on finding the most appropriate methods to answer the research question and offer answers that can be applied in real-world settings (Creswell & Plano Clark, 2018). Furthermore, the practical constraints of conducting research such as finances and time constraints also play a part in deciding the most appropriate methods to use. Researchers choose the methods that best suit the question they wish to address for real world relevance while also allowing flexibility in the methods used, instead of being tied to a philosophical paradigm with an explicit research design on carrying out research.

Pragmatism has been criticised for its lack of credibility and validity compared to scientific inquiry (Pawson, 2013). One of the criticisms of pragmatism is that it does not make a commitment to the use of a specific methodology or method and would end up becoming unmanageable, impractical, and unfeasible and produce '*endless answers to never-ending problems'* (Pawson, 2013, p.72). However, pragmatism is one approach associated with mixed methods research that underpins and allows components from both quantitative and qualitative research methods and integrates both qualitative and quantitative research methods. Because pragmatism values both subjective and objective knowledge, a mixed methods research design is compatible with the pragmatic paradigm, it could be argued that using mixed methods is combining two opposing forms of knowledge. However, using a mixed methods approach and combining objective and subjective knowledge which each contribute knowledge to the picture of older adult mental well-being. Using both methods provides a fuller picture of the research area, and using complementary methods contributes something to the knowledge the researcher is building.

A pragmatic paradigm was used as the research paradigm of the research methodology. The pragmatic approach aims to use the most appropriate methods available to the researcher to answer the research question and offer solutions to real-world issues. The research aims to better understand older adult mental well-being in care homes and offer recommendations on how older adult mental well-being can be promoted and maintained in care home settings. Pragmatism is an appropriate world view for this PhD research as it is pluralistic and emphasises the importance of using what works in real-world practice (Creswell & Plano Clark, 2018), which enables the researcher to choose the combination of quantitative and qualitative methods that are most appropriate at answering the research question (Johnson & Onwuegbuzie, 2004; Tashakkori & Teddlie, 1998; Bryman, 2006). This paradigm also fits with this PhD research as it considers the time and financial constraints of researching as a lone researcher while the research question is based on real-world concerns that previous research has found.

3.3 A MIXED METHODS APPROACH

Mixed methods research has been defined as research that "*combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purpose of breadth and depth of understanding and corroboration.*" (Johnson, Onwuegbuzie, & Turner, 2007, p.123). Mixed methods can be viewed as a methodology with a thorough philosophical background with rules to follow to conduct research and answer the research questions. Alternatively, it can be used as a method, where the focus is on the research methods used and the analysis and interpretation of data (Creswell, 2015).

It has been argued that an advantage of using mixed methods is that through combining two opposing methods, it is possible to offset the weaknesses of each method (Creswell & Plano Clark, 2018). For example, quantitative methods are seen as lacking in context, and the individual voices of the participants are often lost in the data collected. In contrast, qualitative methods offer a solution and help balance these weaknesses by providing rich data, including context and participant voices (Creswell & Plano Clark, 2018). Furthermore, it is difficult to generalise the findings of qualitative research or conduct studies with large samples of a population. Through the use of quantitative methods, it is possible to address these weaknesses found in using qualitative methods, as it can be argued that data gathered through quantitative methods are more generalisable. By offering solutions to each other's weaknesses, quantitative and qualitative methods in mixed methods research can provide a better understanding by approaching the research question from two different perspectives and developing a fuller picture of the real-world issues.

3.3.1 Integration in mixed methods

An important aspect of mixed methods research is the integration of the quantitative and qualitative methods (Creswell, 2015). Brannen (1995, p.16) proposes a theoretical case for combining methods to explore different aspects of the same issue and states *"that it is important to treat the data sets produced by each method as complementary to one another rather than to integrate them unproblematically"* (Brannen, 1995, p.xiii). Therefore, meaningful integration occurs when researchers amalgamate qualitative research and quantitative research, instead of simply using both quantitative and qualitative research methods within the same study to produce separate qualitative and quantitative results (Creswell & Plano Clark, 2018).

Integration in mixed methods can occur in different ways, for example, additional insight can be gained through a convergent research design where statistical results are integrated with participant experience, or when participant experience is used to assist in explaining statistical findings in an explanatory sequential design, or when the findings of a quantitative measure are used to inform the development of a qualitative interview schedule (Creswell & Plano Clark, 2018). Creswell and Plano Clark (2018) suggest that the integration process used is dependent on the type of mixed method design employed in a study. They assert that there are four elements to address in planning and implementing the integrative analysis of their research data. These are the integration intent, what researchers wish to accomplish though mixed methods integration; the integration data analysis procedures, how the integration intent has been accomplished; the representation of the integration results, how the findings of the integration are reported; and the interpretation of the integration results, how the researcher has interpreted the combined data and how this interpretation addresses the research question (Creswell & Plano Clark, 2018 p.220). Information of the integration of this PhD and how I plan to incorporate these four key elements into the integration is detailed in the section below and in table 3.2.

3.3.2 Integration of mixed methods in this study

Brannen (1995, p.22) argues that combining qualitative and quantitative approaches is especially useful when researching under-represented groups. The qualitative methods can help to give voice and a better understanding of the under-represented group and their experiences, while the quantitative methods can reflect the patterns seen in this social group. In addition to Brannen's (1995) argument for the use of mixed methods in research of under-represented groups Oakley (1981) suggests that qualitative semi or unstructured interviews can help mitigate some of the inequality between the researcher and the researched. Therefore, these methods are appropriate for use with older adults living in care homes who are an under-represented and vulnerable group (Dening & Milne, 2011; Section 126(1) of the Social Services Well-being (Wales) Act 2014)

There are several different ways in which quantitative and qualitative methods can be combined in mixed methods research. Bryman summarised eight different approaches to combining mixed methods (Bryman, 1995, p.59). One method suggested by Bryman was "*Quantitative research facilitates qualitative research"* (Bryman, 1995, p.60), where quantitative analysis aids the choice of topics covered in the qualitative investigation. This research study used a sequential design which meant that integration between the two methods occurred at multiple points, illustrated in table 3.2 below. The first point of integration occurred after collecting and analysing the quantitative data, the quantitative data was used to guide the development of the qualitative interview schedule for the second stage of data collection. Integration took place a second time after the analysis of the qualitative interviews, when the qualitative analysis and findings from the quantitative results were integrated and discussed in the discussion chapter of this thesis.

Table 3.2 Table of mixed methods integration

Integration intent
A better understanding of the mental well-being of older adults in care homes through combining a standardised quantitative measure and semi-structured qualitative interviews
Integration data analysis procedures
• Using quantitative findings to highlight areas that need to be explored further and to guide the interview schedule for the qualitative interviews • Comparing the quantitative and qualitative findings in the discussion chapter
Representation of the integration results
• Quantitative findings are used to guide the development of the qualitative interview schedule • Where the quantitative and qualitative data converge and diverge will be discussed in the discussion chapter of the thesis
Interpretation of the integration results
• There are similarities and differences between the findings of the two different data collection methods. • Factors that are important or relevant to older adults who live in care homes were not covered or captured in the standardised measure used.

3.4 RESEARCH APPROACH AND DESIGN

The research design was a sequential mixed methods design involving quantitative well-being measures of a sample of care home residents recruited from care homes for older people in South Wales. By using a mixed-method design, I intended to develop a richer and more holistic understanding, in addition to developing a detailed view of the meaning of mental well-being for older adults in care homes. The use of quantitative approaches alone would only allow for the mental well-being of care home residents to be measured. Qualitative research aims to add rich detail of individual experiences to be used as data. Bryman (1995) argued that qualitative methods could be used to help explain and understand the relationships between variables assessed using quantitative methods. Therefore, using qualitative interviews in addition to quantitative methods, it is possible to better understand what is important to the mental well-being of older adults in care homes.

Residents were recruited from care homes who agreed to participate in the research. The aim of the quantitative measure, the Mental Health Continuum Short Form (MHC-SF) (Keyes, 2002) was to measure Overall well-being (OWB), Emotional well-being (EWB), Psychological well-being (PWB) and social well-being (SWB) in this sample. The quantitative stage of data collection was followed by a qualitative research interviewing approach of a sample of older care home residents recruited from residents who participated in the quantitative stage of data collection, with the aim of exploring the quantitative findings and to better understand mental well-being in care homes. Decisions on the specifics of the qualitative approach such as focus, and topics were developed based on the analysis of the quantitative stage. Using a quantitative measure alone does not provide in-depth information about people’s lived experiences. Therefore, by using the quantitative measure to begin, it was possible to build on the findings to develop interview questions that focused on areas where care home residents scored lower, and the areas of mental well-being that needed to be explored further to better understand the experiences of care home residents and how their experiences impact their mental well-being. Below, in figure 3.3 is a research design flow chart of the order in which each stage of this mixed methods PhD research project was carried out.

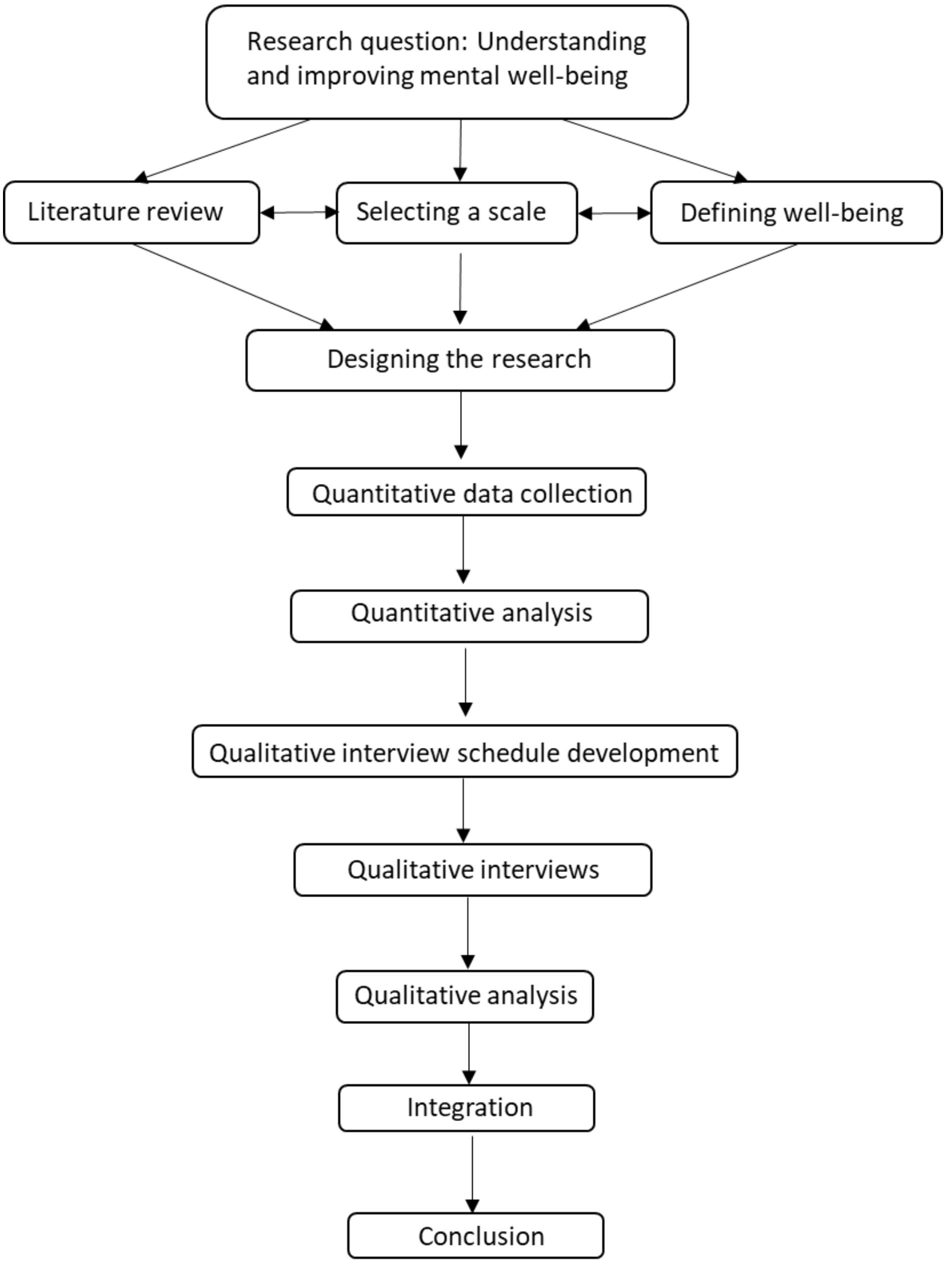

Figure 3.3 Research design flow chart

3.5 ETHICAL CONSIDERATIONS

Ethics in research is important to ensure participants are able to give informed consent and are protected from harm or risk. Ethics in research has a long history, most notably The Declaration of Helskinki was established in 1964 to guide medical doctors in biomedical research involving human participants. The Declaration set out guiding principles including that participants are afforded informed consent, privacy and confidentiality, and that risks and burdens do not outweigh the benefits. These guiding principles also echo earlier recommendations given by the Nuremberg Code (1948), which was established after the discovery of human experiments carried out by German doctors during the Second World War. The British Psychological Society has its own ethical principles for social science researchers and defines research ethics as *'the moral principles guiding research from its inception through to completion and publication of results'* (British Psychological Society, 2021, p.5) and has developed four principles to consider when carrying out research ethically. The first principle is respect for the autonomy, privacy and dignity of individuals, groups, and communities, scientific integrity and social responsibility are the second and third key principles and lastly research should aim to 'maximise benefit and minimise harm' (British Psychological Society, 2021, p. 6). These guiding principles are an essential part of planning and conducting research ethically with human participants.

3.5.1 Ethics applications

Research with human participants needs to be conducted ethically in order to minimise the risk of harm to participants. Before conducting any research with human participants ethical approval from a research ethics committee needs to be granted. Through the process of ethical approval participants can be assured that any research they participate in has been properly scrutinised (British Psychological Society, 2021).

In order to conduct research with care home residents, ethical approval was sought from Swansea University's College of Human and Health Science's Research Ethics Committee. I applied for ethical approval in two stages, the first application was for the data collection using the Mental Health Continuum Health Short Form (MHC-SF). Because the qualitative interview schedule was developed from the findings of the

MHC-SF, it was not possible to apply for ethical approval at the same time. Ethical approval was granted for the first quantitative stage of data collection. After the data from the first stage was analysed, a qualitative interview schedule was developed from the findings. Once the schedule had been developed, a separate ethics application was submitted for the second qualitative data collection stage. Discussed below are the ethical issues that needed to be considered when conducting research in care homes for both stages of data collection.

At the time the ethical approval was sought ethical approval from local authority research governance was not required in Wales. At the time of data collection college ethical approval was sufficient.

3.5.2 Research in care homes

There are many ethical issues to consider when conducting research with older adults living in care homes. Older adults, especially older adults living in care homes, may be considered as adults vulnerable or ‘at risk’. In the Social Services and Well-being Act 2014 the Welsh Government defines an ‘at risk’ adult as:

> *An adult who: is experiencing or is at risk of abuse or neglect; has needs for care and support (whether or not the authority is meeting any of those needs); and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.* (Section 126(1) of the Social Services Well-being (Wales) Act 2014)

Therefore, as older adults living in care homes are considered an ‘at risk’ adult a Disclosure and Barring (DBS) check is needed when carrying out research with them. Before recruiting residents to participate in the study, I applied for an enhanced Disclosure and Barring Service (DBS) check which provides a comprehensive criminal record check and any relevant information the police hold on an individual.

3.5.3 Mental capacity

Mental capacity may be an issue when conducting research with older adults in care home. Mental capacity is the ability of an individual to make and communicate decisions themselves, some individuals may lack capacity to take in information and make an informed decision themselves due to reasons such as dementia, learning disability, mental health illness or brain injury or stroke (Mental Capacity Act, 2005). Individuals may be able to make decisions about certain things but find it difficult to make informed decisions about more complex issues such as managing finances, mental capacity can also be fluctuation and individuals should be supported to make decisions themselves wherever possible (Mental Capacity Act, 2005).

Residents were assumed to have capacity to consent to participate in the research unless they proved otherwise (Mental Capacity Act, 2005). In accordance with Sections 30-34 of the Mental Capacity Act 2005 and the British Psychological Society Code of Human Research Ethics (2021), the consent form was worded to promote and assess understanding and had been designed to incorporate the five key principles from the Mental Capacity Act 2005 to help prospective participants understand the information, retain the information, use or weigh the information and communicate their decision. If there was any doubt that a participant could not give informed consent, they were not included in the research. I also discussed the information sheet and research with each participant before collecting data to ensure residents had fully understood and considered what was being asked of them. This also provided them with another opportunity to ask any questions.

The care home managers helped facilitate participant recruitment for both stages of data collection (care home managers and owners acting as gatekeepers is discussed later in section 3.9). They approached residents who had mental capacity to participate in the research in order to avoid recruiting participants who might not be able to give informed consent. As the care home managers were asked to approach residents to participate in the research, there was a risk of selection bias. However, care home managers were asked to approach as many residents as possible to try and recruit a variety of residents and ensure all residents who had capacity to participate had the opportunity.

The basis for my agreements of access for the study was that care homes reserved the right to approve or deny my entry. They did this based on the reassurance that on each occasion I as the researcher would make clear that I was present and planning to talk to residents. The residents were informed prior to my arrival based on the participant information sheets. When I arrived care home managers advised me if there was anyone who did not wish to participate or who was unable on that particular day. It was on this basis that judgements about participation were made.

It would not have been right for me as the researcher to make a judgement about mental capacity because this would conflict with my desire to collect data and also because I did not know residents sufficiently well to make that judgement. Care homes wished to ensure they retained some oversight of my research as part of their due diligence and governance. This I saw as a reasonable compromise and trade-off to ensure access to the sample. Care homes did suggest that people with severe cognitive impairment should be excluded, and this was within the requirements of my research ethics approval and again a reasonable and a practical step given that these individuals would likely struggle to engage and answer questions on the scale. No other exclusions applied, and it is likely that some participants may have had mild or early forms of dementia that did not prevent them from participating.

3.5.4 Confidentiality and anonymity, and informed consent

To maintain anonymity during the quantitative data collection stage no names were recorded on the MHC-SF each participant completed. Only the age and gender of the resident was recorded on the MHC-SF, each resident who completed the MHC-SF was given a participant number which ensured their anonymity.

MHC-SF completion and interviews took place in either an empty room, residents' bedrooms, or quiet areas of the care home to maintain confidentiality. The interview content was also confidential and then made anonymous through the coding of data and giving participants pseudonyms. No names were recorded with the data, only age and gender. Other potentially identifying information on the completed written transcripts (for example, the mention of care home name, specific individuals, locations, or events) were removed or modified.

To ensure confidentiality and anonymity all consent forms were stored separately from completed MHC-SF in a locked cabinet in the first supervisor's office and the interview recordings and transcripts were kept digitally on a password-protected computer. The interviews were recorded using a digital audio recorder, and encrypted files were transferred securely to a confidential professional transcription agency. Confidentiality complied with the and General Data Protection (GDPR) Act 2018. In line with Swansea University guidelines, all data will be kept ten years after the final thesis is submitted and disposed of securely after this time.

3.5.5 Managing risk – participant and researcher

I judged that there were minimal risks to participants in the study because previous research had not found the MHC-SF to be distressing for respondents. The MHC-SF is a short measure that uses positive language. However, there is always a risk that participants might find some questions sensitive, embarrassing or upsetting. These factors were considered during the selection process of the well-being scale. To avoid distress, upset or causing offence, scales that the literature found to be too negative, upsetting or offensive to older adults were excluded. For example, the Perceived Well-being Scale (PWBS) contained the item *'no one really cares if I'm dead or alive'*. Scales that used negative language were also excluded, and only standardised, psychometrically robust measures were considered during the selection process.

I took care when developing the interview schedule to limit possible distress caused to participants. However, there is always a risk that some participants might become distressed during any research study. Questions were worded using positive language and aimed to be open in order to let the participant dictate what they wanted to talk about and how much detail they were happy to go into, questions were not designed to be intrusive or probing but to allow the participant to talk about what was important to them.

To prepare for any distressing situations I asked care home if there were any cues that suggest a resident was distressed or anxious and any particular topics that the resident liked to talk about. I also confirmed the availability of care home staff to ensure someone was available if a resident did become distressed or upset. To accommodate residents and care home staff the research did not take place during busy times such as mealtimes, activities, or when staff were busy helping residents get ready for the day, medication time etc. None of the residents became distressed or upset during data collection. However, if a resident felt distressed, I would have encouraged them to speak with their key worker or a member of staff that they felt comfortable speaking to. There was also information on the debrief sheet (appendix 8 and 12) about other agencies that offer support and advocacy. Participants were also reminded that they had the right to withdraw from the study without penalty before, during, and straight after completing the MHC-SF or interview if needed.

Although the research is important, gatekeepers and participants were reassured that it was the resident's welfare that was the priority.

To manage any distress, I might experience as a researcher the research was thoroughly planned with regular supervision if any issues needed to be addressed or if residents disclosed upsetting or distressing events in anticipation of any risks. No residents disclosed any information that they were at risk of harm, however, a plan was in place that if resident were at risk of harm, I would report the information to the research supervisor and the relevant authorities. I had access to a peer support group available with other PhD candidates researching similar areas, and the university counselling service and counselling services through my place of work were also available for support.

3.6 RESEARCH DESIGN

3.6.1 Sequential Quan → Qual mixed methods design

A mixed methods design is used as a framework to guide researchers through the design, implementation, analysis and integration of their research when using quantitative and qualitative methods (Plano Clark & Ivankova, 2016). There are several kinds of mixed methods designs to choose from, with many variations on the same basic mixed method design (Plano Clark & Ivankova, 2016). Drawing on the explanation given by Plano Clark and Ivankova (2016, pp.106-116) and Tashakkori and Teddlie (2009, p.288) a sequential mixed methods design was adopted. Sequential mixed methods design involves one type of research method being completed before the next type begins. For example, the quantitative strand is completed before the qualitative strand begins. These two strands are then connected or integrated at two different points. Researchers use the findings form the quantitative strand to inform the next, qualitative strand to elaborate, explain, or confirm initial quantitative findings (Plano Clark & Ivankova, 2016). The two strands are then connected again after both sets of data have been collected and analysed and inferences are drawn from the two methods (Plano Clark & Ivankova, 2016).

The diagram below in figure 3.4, shows a procedural diagram of the sequential quantitative qualitative research design I used in this PhD research project. Where the purpose of the qualitative data collection is to clarify or extend a survey finding, then it needs to be conducted after the survey. In this PhD research I used qualitative interviews in addition to a quantitative measure of well-being to add subjective depth to the understanding of the experiences of older adults in care homes. Through this process, it is possible to improve and focus resources in the areas that would have the greatest impact for older adults in care homes.

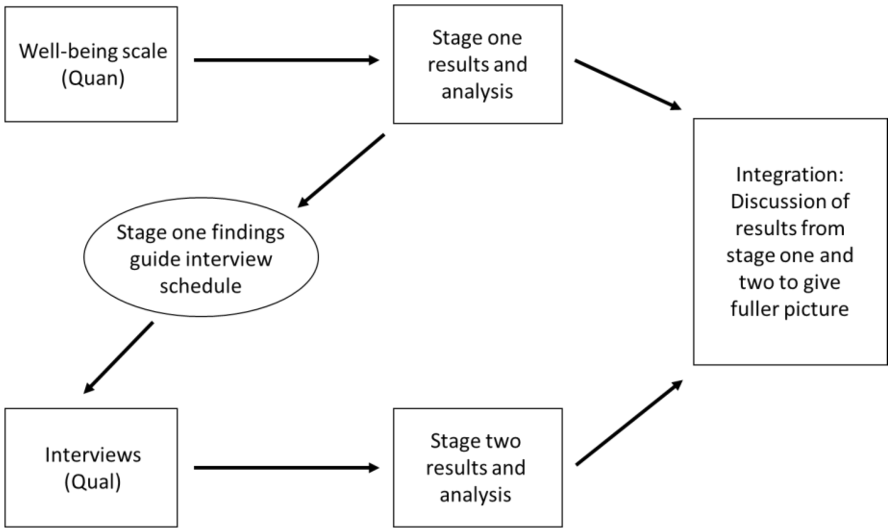

Figure 3.4 A Procedural Diagram of Sequential Quantitative Qualitative Research Design

The diagram below (figure 3.5) shows the timeline of the PhD and when each stage of data collection took place.

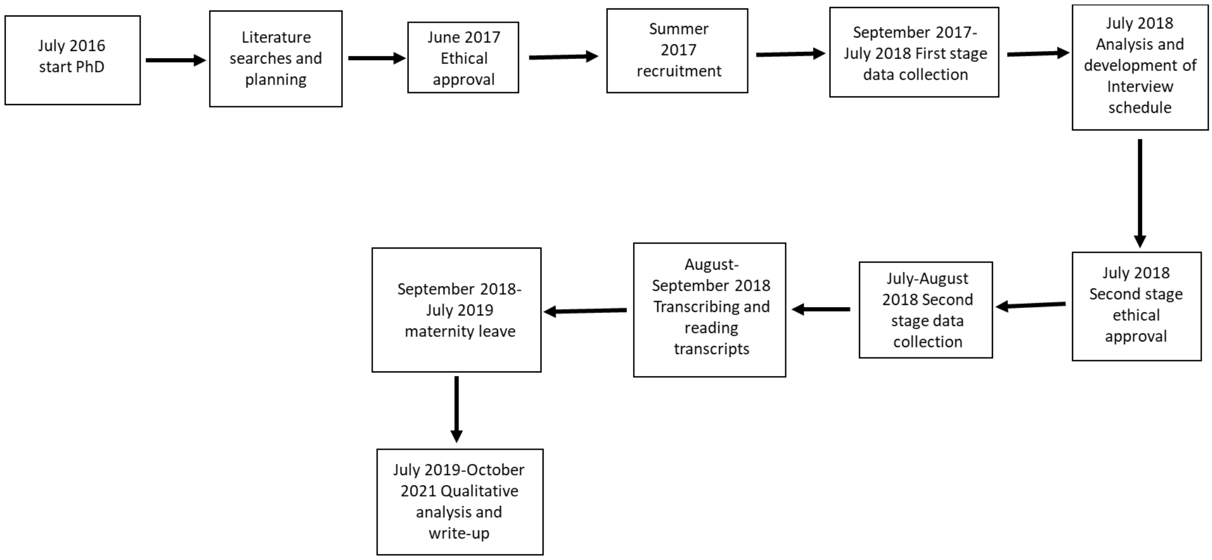

Figure 3.5 PhD Timeline

3.7 RESEARCH MATERIALS

All participant materials were written in size 16 font as recommended by the National Research Ethics Service (NRES) for research with older adults to ensure that residents were able to read and understand the information. The information was also provided verbally throughout the study, and participants were given copies of information and debrief sheets that they were able to consult at any time.

3.7.1 First stage: Quantitative data collection research materials

Following on from agreement from the ethics committee, for the first stage of data collection care home manager consent forms (appendix 4) were given to all care home managers and care homeowners interested in taking part in the research when initial contact was made via letter, email, and phone. The consent form contained information about the research, what was required of care homes, and contact information for the research supervisors and myself. Once consent from care home managers was obtained, all prospective participants were given a participant information sheet (PIS) (appendix 5) explaining the research in clear and non-technical language. The PIS gave details of potential risks, their right to withdraw from the study, and my contact details should they have any questions or concerns. Participants were all encouraged to discuss the research with their friends, family, staff, and co-residents. Consent forms (appendix 6) summarised what the research entailed and the participant's right to withdraw from the study without penalty. The participants signed these before the research was carried out. All participants were given a debrief sheet (appendix 8) that gave a summary of the research aims and a list of external support agencies that participants might find helpful if needed. Contact information for the research supervisors and myself were also provided on participant information sheets and participant debrief sheets.

3.7.1.1 The Mental Health Continuum Short Form (MHC-SF)

The MHC-SF is a 14-item self-report measure rated on a five-point Likert-type scale that aims to measure emotional, psychological and social components of well-being (Keyes, 2009). Keyes (2009) found reliability over .80 for all subscales as well as the global scale. The MHC-SF has been found to have adequate reliability and construct validity in South Africa, India, the Netherlands, Iran, Poland, Italy, America and France (Joshanloo, Wissing, Khumalo, and Lamers, 2013; Karaś, Cieciuch, and Keyes, 2014;

Keyes et al., 2008; Lamers, Westerhof, Bohlmeijer, ten Klooster, and Keyes, 2011; Singh & Junnarkar, 2015; Salama-Younes, 2011). At the time of data collection, the MHC-SF had not been used in the Welsh care home population. The scale has been used with older adults but has not been used within a care home population or within a Welsh care home population. Indicating that this research study is the first to use the MHC-SF in a care home population in Wales.

The factor structure of the MHC-SF has been evaluated in different cultures. Confirmatory factor analysis (CFA) has been used to confirm the 3-factor structure of the MHC-SF in many of the studies (Joshanloo et al., 2013; Karaś et al, 2014 Lamers et al., 2011). Using Exploratory Structural Equation Modelling (ESEM) to evaluate the MHC-SF factor structure is more accurate than using CFA (Joshanloo, 2016, 2017), which has been used in New Zealand, Iran, and American samples (Joshanloo, 2016). Through using ESEM to evaluate factor structure, it is possible to detect the minor distinction between hedonic and eudaimonic components of well-being. While research has found the CFA inflates the estimated shared variance between the eudaimonic and hedonic components (Joshanloo & Lamers, 2016). Lamers et al. (2011) CFA supported the three-factor structure of mental well-being as well as the two continua model of mental well-being.

The scale has been found to show divergent validity and has correlated negatively and moderately with mental illness measures (Petrillo, 2015). The exploratory factor analysis from the same study also supported the two-continua of mental health. The study did not find any gender differences in the MHC-SF scores. Karaś et al. (2014) also found that the MHC-SF was reliable with good external validity. The study results also supported the three-factor structure of subjective well-being and the two-continua model of mental well-being and having subjective well-being does not mean that it is not possible to have a mental health disorder also.

3.7.1.2 Reliability and validity

The literature has reported good internal consistency, with a Cronbach alpha coefficient of >.08 (Keyes, 2005b, 2006; Keyes et al., 2008; Lamers et al., 2011; Westerhof & Keyes, 2009). This research study found an overall Cronbach alpha coefficient of .84. The Cronbach coefficient score for EWB subscale was .67, the SWB subscale .63 and the PWB subscale .72. Scales with fewer than 10 items often have lower Cronbach alpha scores which may explain the lower scores on the subscales.

3.7.2 Second stage: Qualitative data collection research materials

Care home managers were provided with new care home manager consent forms (appendix 9) to renegotiate access to the care home and residents. The new form described the second stage of the research and provided managers with a summary of what was required of them for the second stage of data collection. Once written consent had been obtained, prospective participants were given the Participant Information Sheet (PIS) (Appendix 10), which described the study, what was required of them, potential risks, their right to withdraw and researcher and supervisor contact information. All participants were provided with a debrief sheet (Appendix 12) once the interviews had finished. The debrief sheet informed participants of the nature and outcome of the research and the contact details of external support agencies. The debrief sheet also contained the contact details of the researcher and the research supervisors should they have any further questions or concerns about the research. Nineteen of the interviews were recorded on a digital recorded and uploaded to my computer. One participant refused to have their interview recorded, I made sure to take detail notes during the interview and wrote down any meaningful quotes verbatim.

I developed an interview schedule (appendix 13) for the qualitative interviews during the second stage of data collection. The development of the interview schedule was guided by the findings from the MHC-SF completed during the first stage of data collection. The development of the interview schedule is discussed in more detail in section 4.6.

3.7.2.1 Qualitative interview schedule

After completing the first stage of data collection, the completed MHC-SF were analysed, and an interview topic schedule (Appendix 13) was developed from the findings and experiences of the first stage of data collection to explore residents' experiences and allow them to expand on the topics from the MHC-SF. The interview schedule contained 27 possible questions and prompts to ask participants, to ensure that each of the topic areas was covered thoroughly and possible follow up questions were also included on the interview topic schedule in case participants needed a prompt to expand on their answer. Questions such as ‘what is your daily routine like?’ were also included in the list of questions, these questions were used to help ease the participants into the interview. Some of the key questions used in the interviews have been highlighted in bold in Appendix 13. The majority of the qualitative interview schedule questions were open-ended to encourage participants to give longer more descriptive answers and to help facilitate a conversation about the topic rather then closed questions that could be answered using a single word. I also included prompts in the interview schedule such as asking participants to provide an example, to tell me more or ask what that was like to them. The questions focused on life in the care home, the environment, social aspects of being in a care home, society and the outside world, relationships, inclusion, and exclusion. Questions at the beginning of the interview schedule were designed to encourage stories of everyday life and to allow the participant time to feel comfortable being interviewed.

3.8 SAMPLING STRATEGY AND PARTICIPANT RECRUITMENT

3.8.1 Quantitative sampling strategy and participant recruitment

A non-probabilistic convenience sampling technique was used for the quantitative stage of data collection, which involved recruiting residents who were available and able to participate from care homes that had also agreed to participate. Non-probabilistic convenience sampling is used when researchers use individuals who are available and agree to participate in the research (Creswell & Plano Clark, 2018). This was an appropriate sampling method to use as I relied firstly on care homes to agree to participate in the research, and then residents who had capacity to consent and who wanted to participate in the research. To determine an adequate sample size target, a sampling error formula was used. In 2017-2018, there were 15,371 older care home residents in Wales (Welsh Government, 2019), a sample size target of 149 participants was calculated at a 95% confidence level with a margin of error of 8 using an online sample size calculator (Roasoft). Using an 8% margin of error and a 95% confidence level means that I am 95% confident that the MHC-SF findings reflects the population studied within plus or minus 8% of the true value.

A pragmatic approach was used to identify prospective care homes in South Wales. The contact details of Local Authority care homes were obtained from council websites, and private care homes were identified through the regulator Care Inspectorate Wales (CIW) website, which also had contact details and information about the care homes within an easily commutable distance. This information was also used to identify and exclude care homes. Care homes were included in the recruitment if they were registered as offering residential, nursing, or dual registered care to older adults. Care homes were excluded from recruitment if they were for older adults with severe cognitive impairments and high dependency needs, and therefore residents would not be able to participate in the research. Ninety-two care homes were identified, and letters and emails seeking expressions of interest (Appendix 3) were sent to them. The invitation letters and emails were designed to give a brief introduction to the research and seek expressions of interest from the care home managers, care home owners, parent companies, and local councils to identify potential research sites.

Residents were included in the research if they were over 65, were able to give informed consent and were able to understand English or Welsh. If a resident wished to participate but was physically unable to fill in the MHC-SF, I was on hand to talk them through the questions and assist them with filling in the MHC-SF. Unfortunately, the study was not funded to accommodate severe impairments. Due to the high prevalence of cognitive impairment and dementia in care homes it was possible that some of the participants had cognitive impairment or dementia. Residents with a mild cognitive impairment that the gatekeeper had identified as suitable to take part in the research were also assisted with filling out the MHC-SF if they wished to take part, were able to understand what the study involved, what was being asked of them, and were able to give informed consent.

Out of the 92 care homes contacted, I arranged to meet with 25 care home owners and managers. Out of the 25 care homes I met with, 22 resulted in returning to collect data. The 23rd care home was recruited when the ENRICH Wales Co-ordinator met with a care home manager and passed on the details of the study. A chart of the total number of care homes contacted, met with, and who participated can be seen in figure 3.6 below. The three care homes that I met with to discuss the research with but who did not participate either did not return follow up phone calls or emails, or said they felt their residents were not suitable for the research study.

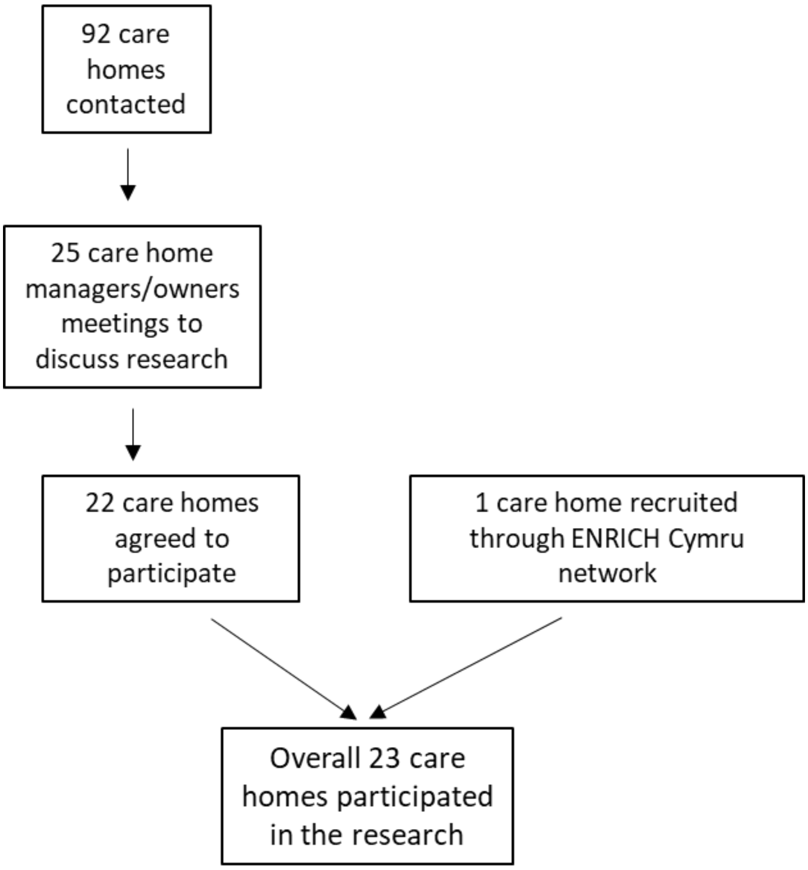

Figure 3.6 Chart of number of care homes approached, met with, and recruited

Once initial contact and expressions of interest had been made, I met with care home management to discuss the research in more detail and explain care home managers' requirement to identify residents within the home and act as gatekeepers. During this meeting I provided care home managers with a pack containing the research materials to discuss with them and answer any question they had. The care home managers were reminded of the need for privacy for the research and that potential participation should occur from all residents who met the inclusion criteria and should not be selected differently.

Once written consent had been obtained from the care home manager, they were given participant information sheets (Appendix 5) and participant consent forms (Appendix 6) to give to all prospective participants that care home managers viewed as being able to participate in the research. Participants were given approximately a week, before I arranged to revisit the care home to collect data, to understand the nature and outcomes of the research they were considering participating in and to ensure they had an opportunity to discuss the research with family, friends, and staff.

All participants who wished to participate in the research were asked to read and sign the consent form to show that they had read the information about the research and that they were giving their informed consent to participate. If a prospective participant could not read the information sheet or consent form, I read the forms to the participant to ensure residents that were visually impaired but otherwise able to participate were given the opportunity to participate in the research. It was made clear on all participant literature and care home consent forms that their decision to participate would not affect their care. I also reiterated this to staff and residents in person. The welfare of the resident was the highest priority. To eliminate the risk of residents feeling 'put on the spot' or pressured by my presence, to agreeing to take part, the care home manager, whom they were more familiar with, asked them about the research when I was not present. There is of course potential for bias through recruiting care homes and participants this way, as there are with any other type of recruitment method. Care homes and participants who are willing are possibly more likely to be fitter which could introduced bias. However, health varies from resident to resident and from week to week and the population is not static.

3.8.2 Qualitative sampling strategy and participant recruitment

A purposive sampling strategy was used (Creswell & Plano Clark, 2018; Patton, 2002) based on the information from the quantitative stage of data collection. In purposive sampling participants are purposefully selected on the basis of whether they can help you understand the research phenomenon that is being explored (Creswell, 2015). One purposive sampling strategy is critical sampling, where specific criteria is used to select participants that will contribute the further understanding of how they experience the research phenomenon (Creswell, 2015). Through critical sampling I endeavoured to reflect the demographics of the quantitative sample and made every effort to represent residents from different age groups, different care homes, and male and female participants within the narrow time frame. Care homes that had already taken part in the first stage were contacted again, inviting them to participate in the second stage of the research. Potential participants were male and female care home residents over the age of 65. The aim was to achieve a sample of approximately 20 residents from different care homes across South Wales to be interviewed. There are no precise rationales for a specific number of qualitative interviews for a research study, however, Braun and Clarke (2013) suggest that twenty interviews are an acceptable number of qualitative interviews for a mixed methods PhD level research study. The population from which participants were invited to participate consisted of residents who completed the MHC-SF during the first data collection stage. Residents were also approached if they had expressed an interest in taking part in interviews and felt that they had more to say than the MHC-SF could record.

3.8.3 Sample information

Twenty residents were recruited to take part in the second stage of the research study. Once 20 residents had been recruited, no further care homes were contacted. Unfortunately, some residents who I wished to speak to again had either moved on to a different care home or had died. None of the residents that were asked to interview declined to participate.

3.9 NEGOTIATING ACCESS

Because care homes are private organisations, permission must be obtained to access and conduct research on their premises. This meant that care home managers or owners needed to be contacted before residents could be approached. Even though there is a risk of selection bias through using gatekeepers to approach participants, by asking care home managers to act as gatekeepers, it has been found to help facilitate the research and participant recruitment (Luff et al., 2011).

I contacted care home managers and owners separately for each stage of data collection. Access was renegotiated for the second stage of data collection because the involvement of the staff and residents was different from the first stage of data collection. The residents were spoken to for longer, and I needed a suitable space to conduct interviews with each resident, which would take longer than completing the MHC-SF during the first stage of data collection. The care home managers were given new information sheets and consent forms (Appendix 9) that listed what I would need from the care home and staff while conducting interviews and information about their right to withdraw and whom to contact if they had any questions or concerns. This was particularly useful if there had been a change in care home management and provided the new manager with information about the research and the consent form for the second stage of data.

3.10 First Stage: Quantitative data collection

In September 2017 I began data collection for the first quantitative stage. Below in figure 3.7 is a chart of the overall timeline of fieldwork.

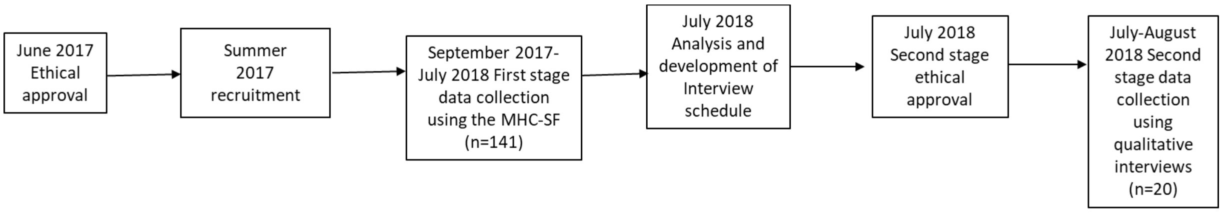

Figure 3.7 Timeline of quantitative and qualitative fieldwork

3.10.1 Quantitative data collection procedure

I visited care homes that had agreed to take part in the researcher and was introduced to residents by the care home manager. I asked if the participant had read and understood the information sheet and whether they had any questions. If the consent form had not been signed, I went through the consent form with the resident before asking if they were happy to sign. Participants who consented were given the self-report MHC-SF (Appendix 7) to complete to assess their emotional, psychological, social, and overall well-being. Individual time was allocated to each participant taking part; if the participant was able to fill in the measure without assistance, I left the participant to fill out the scale unassisted but remained in the room in case the participant had any questions, needed help, or wanted to withdraw from the study. Completing the MHC-SF took approximately ten minutes, depending on how quickly participants worked their way through the questions. Participants were reminded that they could withdraw from the study at any time, up until the MHC-SF were collected and anonymised. Participant age and gender were noted, but no names were recorded during data collection. Data collection took place in private areas of the care home, for example, the resident’s room or an empty dining room or lounge and each MHC-SF was completed one at a time.

After completing the MHC-SF, participants were given the debrief information sheet (Appendix 8) to inform them of the nature and outcomes of the research and the potential risks. If the participant could not complete the MHC-SF or wished to withdraw from the study, they were also given the debrief sheet and thanked for their time. During data collection there was only one participant who did not complete the MHC-SF as they struggled to answer the questions and preferred to talk about events from their past. I sat and listened with them for some time and then thanked them for their help and left a participant debrief sheet with them.

3.10.2 Quantitative data preparation and analysis

Each completed MHC-SF was scored manually using Keyes' (2009) scoring system, and each participant was given scores for Overall well-being (OWB), Emotional well-being (EWB), Social well-being (SWB), and Psychological well-being (PWB). The manual also provided criteria on how each respondent should be categorised into one of three categories depending on how they scored on items in each of the subscales. The categories were 'Flourishing', 'Moderately mentally healthy', and 'Languishing'.

IBM SPSS 22 was used to conduct statistical analysis on the data. Initial descriptive statistical analysis showed that the data were not normally distributed. P-plot normality tests also showed data were not normally distributed. Therefore, non-parametric tests were used to analyse the data. Cronbach's alpha was carried out to assess the overall scale and subscales' internal consistency and reliability compared to other studies. From the findings of the descriptive analysis, a multinomial logistic regression was used to establish whether there was a link between age and gender and which category participants were placed in by the MHC-SF scoring. A Spearman's rho correlation was then used to see if there was a relationship between age and overall scale score, subscale score and item score.

The findings from the analysis of the first stage of data collection was then used to inform and develop a qualitative interview schedule. Areas where residents had indicated that they did not experience positive feelings very often were included in the qualitative interview schedule. Questions where participants had scored lower on, which indicated that they did not experience these positive aspects of mental well-being very often in their day-to-day life were also included in the qualitative interview schedule to allow participants and opportunity to elaborate and give further insight to why this might be the case. The development of the qualitative interview schedule is discussed further in section 4.6.

3.11 SECOND STAGE: QUALITATIVE DATA COLLECTION

3.11.1 Qualitative data collection procedure

In July 2018, I returned to six care homes in South Wales, 20 semi-structured audio-recorded face-to-face interviews were conducted with care home residents who agreed and consented to participate in the research. Interviews lasted between twenty minutes to just over an hour, depending on how much the resident wanted to say. The interview that only last 22 minutes was ended early by the resident, they found discussing aspects of their experience of living in a care home frustrating and asked if we could end the interview. I respected their decision to end the interview, however, this did mean that I did not have the opportunity to cover each of the topic areas from the interview schedule. The data collection took place in a mutually convenient space in the care home, for example, a vacant office, private room, or part of the residents' lounge or dining room. The interviews were conducted during the day at a convenient time for residents and the care home and avoided mealtimes and activities. All interviews were recorded using a digital voice recorder except for one, where the participant declined to have the interview recorded. In this instance, detailed notes were taken, and meaningful quotes were noted down. I made occasional notes during each interview but mainly focused on speaking and listening to the participant.

3.12 QUALITATIVE DATA PREPARATION AND ANALYSIS

3.12.1 Reflexive thematic analysis and coding

Thematic analysis is an umbrella term that includes a range of different approaches to identifying patterns and themes in qualitative data. Thematic analysis (TA) grew in popularity during the 1980s and 1990s as a way of analysing qualitative data (Braun, Clarke, Hayfield & Terry, 2019). It has received heavy criticism for researchers not referencing an established methodological approach to TA, Braun, and Clarke (2006) called it a *'poorly demarcated and rarely acknowledged, yet widely used qualitative analytic method'* (Braun & Clarke, 2006, p.77). However, in recent years, TA has been widely recognised innovative qualitative approach to analysis and there are many different approaches to TA for researchers to choose from (Willig, 2013).

For the analysis of the qualitative interviews, I have chosen to use Braun and Clarke's approach to Reflexive Thematic Analysis (RTA) (2014, 2019, 2020). In their most recent publications Braun and Clarke encourage researchers who are using their approach to TA to read their current version of the approach to TA (Braun & Clarke 2014, 2019, 2020). In their more recent works Braun and Clarke elaborate, expand, and clarify some common misconception of their 2006 approach to TA. Braun and Clarke's Reflexive TA uses qualitative philosophy or paradigm to underpin the whole research process, from data collection right through to the analysis techniques and references the big "Q" approach from Kidder and Fine (1987).

RTA is a method and does not have a specific theoretically informed methodology to follow when collecting and analysing data. Therefore, it can be used with different research paradigms and methods. As it is a more flexible method that may answer many different types of research question, RTA as an analysis method is congruent with the pragmatic paradigm of using the most appropriate research tools available at the time to best answer the research question.

Braun and Clarke's reflexive approach to TA emphasises the importance of the researcher's active role in the analysis by interpreting patterns and meaning from the data and in generating codes and themes from the datasets (Braun & Clarke, 2019). The main focus is that the codes and themes are meaningful and help address the research question (Braun & Clarke, 2013). In their approach to TA codes are generated from the researcher's reflective engagement with the data and are then organised together to develop a theme around one, common 'central organising concept' (Braun & Clarke, 2019).

3.12.1.1 Transcription

In total, 681 minutes of interview data was collected and transcribed. The first two steps of the Braun and Clarke method of reflexive thematic analysis are familiarisation of the data and transcribing (see figure 3.8). Due to time constraints, a professional transcription agency was used. There is a disadvantage to having research data transcribed by a professional transcription agency, Lapadat and Lindsay (1999) state that analysis begins during transcription and Braun and Clarke (2006) agree that the transcription process informs the early stage of reflexive analysis, however, they also suggest that if a transcription service is used that the researcher spends time reading each transcript while listening to the audio in order to check for accuracy. To address this issue once the transcriptions had been returned, the interviews were listened to, and each transcription was checked for errors. Interviews were requested to be transcribed full verbatim to include any mumbles, utterances, pauses, and laughter that were recorded and add to the meaning of what was said. This allowed me to spend more time on the analysis. Every effort was made to ensure that the transcriptions were an accurate reproduction of the contents of the interviews.

3.12.1.2 How transcripts were coded and how codes were developed

Braun and Clarke (2006, 2014, 2019, 2020) six-stage approach to Reflexive Thematic Analysis (RTA) was followed to analyse each qualitative interview. Below in figure 3.8 is a diagram of their six-stage approach I followed, even though the steps shown in the diagram are linear I revisited earlier steps to ensure I was familiar with the data and that each theme reflected the codes that I had generated at earlier stages of the analysis. Braun and Clarke (2014) also stated that the six steps are not linear and step 6 ‘write up’ was used during step 3 and as a way of developing and generating the themes.

Step 1	Familiarising with the data: Interviews have been transcribed and double checked against audio interviews. Transcriptions have been read and initial ideas generated.
Step 2	Generate initial codes – systematically working through each transcript.
Step 3	Conceptualisation of themes – generated from codes
Step 4	Review themes

Step 5	Define themes
Step 6	Write-up

Figure 3.8 Braun and Clarke's (2006) six-step approach to Reflexive Thematic Analysis (RTA)

3.12.1.3 Step one: Familiarising with the data

In the first, familiarisation phase the data is read and re-read to immerse oneself in the data. Through familiarisation it is possible to start to identify possible codes and areas for further analysis. Because the qualitative interviews were transcribed by a professional agency I also listened and re-listened to the interview audio while reading each of the transcripts. This allowed me to familiarise myself with the data and gain a contextual understanding of the data, which would have happened during transcription. Each interview was listened to a minimum of three times, I returned to some interviews again to check or listen for tone while coding and collating extracts. I then formatted each transcript into a Word document with a column on each side of the interview transcript. The first column was for coding, the second for the transcribed data, and the third column for notes.

3.12.1.4 Step two: Generate initial codes

Codes are used to label data extracts that are relevant to the research question, each code can be a concise descriptive or an interpretative label of a data extract (Byrne, 2021). These codes are then used to help build and generate themes with a common meaning. A predominantly inductive approach was adopted as codes and themes were not determined beforehand but were generated from reading and analysing the data. The data were open-coded and focused on participant and data-based meanings. In addition to an inductive approach to the analysis, some deductive analysis was also employed. Including some deductive analysis helps to ensure the focus of the analysis remains on the research question (Braun & Clarke, 2019; Byrne, 2021). During coding I used both semantic and latent coding, neither were prioritised over the other as semantic codes were used when the data extracts, I interpreted contained meaningful semantic, descriptive information and latent codes were used when the data contained meaningful latent information and focused on the meaning constructed and communicated by the participant and my interpretation of this meaning as a researcher (Byrne, 2021). The semantic coding focused on the explicit or surface meaning of the data, while the latent coding went further and looked at the meaning, underlying assumptions, or ideas behind what was being communicated in the data. Coding was done manually and systematically as I read through a printed copy of each transcript carefully and made a note with a code of any extract that might address the research question. I then reread and recoded each transcript to ensure there was consistency in the coding. The research question was kept in mind while coding each transcript. After coding was completed, all coded data extracts were collated under their relevant code in a table.

3.12.1.5 Step three: Generating of themes

Once all interview transcripts had been coded, I began to gather different codes together that shared underlying meaning to generate potential themes or sub-themes. Codes that shared a similar underlying concept or meaning were compiled under one code, sub-theme, or theme depending on how salient the theme or sub-theme was in the data and how relevant it was to the research question as Braun and Clarke (2006) emphasise how important it is that the themes generated through RTA answer the research question. Therefore, when developing the themes and sub-themes I continued to refer back to the research question and ensured that the themes reflected concepts that were important to the mental well-being of older adults living in care homes. I produced a thematic map of initial candidate themes at this point to group each code under a sub-theme and theme which can be seen in figure 5.10 in chapter five.

3.12.1.6 Step four: Review themes

The transcripts were then reread with the generated themes in mind to ensure that each theme represented what was being said in the datasets and to check whether the themes were clearly separate from each other without too much overlap but were also still related. Braun and Clarke (2006) also emphasise the importance of each theme being underpinned by a central organising concept, a shared meaning, as the themes are part of a coherent narrative that tells a story about the data and the people who participated in the research. This was also an opportunity to further develop an overarching theme of the data.

3.12.1.7 Step five: Define themes

During step five each theme and sub-theme was reviewed to see if they represented the dataset and were relevant to the research question. Themes were also reviewed to see if they were an internally consistent representation of the data which could not be represented by the other themes generated during analysis (Byrne, 2021). Each theme was underlined by many data items, and I began identifying which data extracts from the interviews would be used in the writing up of the analysis to illustrate and support the theme. During analysis I endeavoured to go beyond describing and summarising the data extract and aimed to present and report each data extract analytically in relation to its constitutive theme and in the context of the literature and the research question, in accordance with Braun and Clarke's (2020, 2021) approach to RTA. When naming themes Braun and Clarke (2013, 2014, 2020) encourage researchers to be creative while capturing the important aspect of the particular theme.

3.12.1.8 Step six: Write up

Step five and step six often occur simultaneously as the analytical write up of the data aids the defining and refining of each theme and sub-theme. During step six I established the structure of the analysis and the order that themes and extracts should be reported in that fitted best with analysis I was presenting. The analysis was reported along with the findings of the qualitative interviews, Braun and Clarke (2013) recommend synthesising and contextualising the data within the same chapter, as it is being reported.

3.13 CHAPTER SUMMARY

In this chapter I have discussed the philosophical underpinning of pragmatism that underpins this research study and how it is congruent with the mixed methods research design. I have outlined the purpose of using mixed methods research and how it was used in this research and the importance of integration when undertaking mixed methods research. The ethical issues of conducting research with care home residents was also addressed and how I addressed each issue in the contact of this research study with older care home residents. Later in the chapter I outlined the sampling strategy and recruitment process for each data collection stage and discussed the need to negotiate access when conducting research in care homes. A detailed explanation of the research materials and data collection procedures for both stages of data collection in addition a description of the data preparation and analysis for both stages. In the next chapter I present the findings from the quantitative stage of data collection.

4 CHAPTER 4: QUANTITATIVE FINDINGS

4.1 INTRODUCTION

The first stage of data collection took place from September 2016 until July 2017. A hundred and forty-one participants were recruited from 23 care homes in South Wales. The following chapter presents the key findings from the 141 Mental Health Continuum Short Form (MHC-SF) collected during the first stage of data collection. The results presented here include the descriptive analysis of the study population and the data generated from the administration of the MHC-SF. I then present the inferential statistics used to explore the data generated from the administration of the MHC-SF. The data gathered from the administration of the MHC-SF showed that on average residents scored lower on the psychological well-being and social well-being subscales compared to the emotional well-being subscale. Residents mean overall well-being scores also showed that they did not experience particularly high levels of overall well-being. Keyes (2009) provided instructions on scoring the MHC-SF and how each completed MHC-SF should be scored and categorised into one of three categories, ‘languishing’, ‘moderately mentally healthy’, and ‘flourishing’ which I used to categorise each completed MHC-SF. Categorising each completed MHC-SF showed that the mean age of residents in the ‘languishing’ category was lower than the mean age of residents in the ‘moderately mentally healthy’ and ‘flourishing category’. Twice as many men were also categorised as ‘languishing’ compared to women. A Multinomial Logistic Regression was carried out to establish whether age or gender was a predictor of how participants were categorised according to the MHC-SF scoring guidelines, the analysis showed that younger residents were more likely to be categorised as ‘languishing’ according to the MHC-SF guidance. A correlational analysis was then used to analyse relationships between age, overall scale score, subscale score, and item score to explore the relationship between participant age and overall MHC-SF score and subscale score. Correlational analysis showed that there was no correlational relationship between age and overall scale or subscale scores.

4.2 DESCRIPTIVE ANALYSIS OF STUDY POPULATION

One hundred forty-one residents from 23 care homes in South Wales participated in the first quantitative data collection stage. The majority of participants were women, 71% women (N=100), and 29% were men (N=41), with 63.83% (N=90) of participants over 85 years old. The percentage of participants over 85 years is marginally higher than the England and Wales care home population, where 59.2% of residents were above 85 years old (Office for National Statistics, 2014). The mean age of participants was 86.16 years (*SD*= 7.84). Both men and women had similar mean ages, the mean age for men was 85.54 years (*SD*=7.44), and women had a mean age of 86.41 years (*SD*=8.01).

Table 4.3 below shows the number of residents who completed the MHC-SF and took part in the qualitative interviews from each care home. In the first care home that agreed to participate in the research, only one resident was able and willing to participate. Care home number two and four completed the largest number of MHC-SF (N=13 and N=14). As shown in table 4.3 below, care homes number two and four were among the largest care homes in the research. They were also already involved with other research projects, were part of the ENRICH network, and considered 'research ready', which could account for higher recruitment rates from these care homes.

Table 4.3 Distribution of MHC-SF collected

Care home number	Care home type	Number of resident places/capacity.	Number of MHC-SF collected	Number who took part in qualitative interviews
1	Private	74	1	0
2	Private	107	13	1
3	Private	31	3	0
4	Private	125	14	0

5	Private	21	2	0
6	Local Authority	19	7	5
7	Private	32	4	0
8	Local Authority	29	10	0
9	Private (religious)	28	5	2
10	Private	35	7	0
11	Local Authority	33	2	0
12	Local Authority	38	10	6
13	Private	32	3	2
14	Private	30	2	0
15	Private	34	11	0
16	Private (religious)	21	8	4
17	Private	34	6	0
18	Private (non-profit group)	30	9	0
19	Private	35	6	0
20	Private (non-profit group)	40	4	0
21	Private	91	6	0
22	Private	120	4	0
23	Private	28	4	0

Only one resident that a care home manager had approached and who consented to participate in the research did not complete the MHC-SF. Their data was not included as they were only able to answer the first two questions. They could not focus on answering further questions, and instead reminisced about their childhood when asked any further questions. I sat with them for some time and listened to their anecdotes before thanking them for their help and time.

4.3 DESCRIPTIVE ANALYSIS OF THE MHC-SF

The descriptive analysis provides a meaningful summary of the data set collected from the MHC-SF. Descriptive analysis of the data is also an essential step in determining which statistical techniques to use that best address the research questions. The mean Overall Well-being score (OWB) from the sample of 141 participants was 46.65 out of 70 (*SD*= 12.83) 66.64% which suggests that, on average, participants did not have very high levels of Overall Well-being. For the subscales, the mean Emotional Well-being (EWB) score was 11.67 out of 15 (*SD*=3.05) 77.8%, mean Social Well-being (SWB) score was 15.47 out of 25 (*SD*=5.13) 61.88%, and the mean Psychological Well-being (PWB) score was 19.9 out of 30 (*SD*=6.50) 66.3%. This indicates that overall, residents had lower SWB and PWB scores than EWB scores on average and therefore, did not experience positive feelings from these components of mental well-being very often. It also suggests that these components could be explored further to see where residents were scoring lower and why this may be. Male and female mean OWB and subscale scores did not differ greatly. In previous research using the MHC-SF it has been found that women usually score higher in the emotional well-being domain compared to men (Joshanloo & Lamers 2016; Graham & Chattopadhyay, 2013; Arrindell, Heesink, & Feij, 1999).

Guidance on how participants are categorised based on their score is included in the MHC-SF pack by Keyes (2009). Keyes' (2009) instructions on participant categorisation are shown in table 4.4 below. Participants were placed into one of three categories depending on how they answered questions in each subscale. They were either categorised as 'languishing', 'moderately mentally healthy' or 'flourishing'. Those who were 'flourishing' experienced more hedonic components of well-being and positive functioning regularly, those who were 'languishing' rarely felt hedonic components of well-being or positive functioning, and those who were in-between were categorised as ‘moderately mentally healthy’ (Keyes, 2009).

Table 4.4 Instructions on MHC-SF categorisation taken from Keyes (2009)

Flourishing	Languishing	Moderately mentally healthy
Categorical Diagnosis: a diagnosis of flourishing is made if someone feels 1 of the 3 hedonic well-being symptoms (items 1-3) "every day" or "almost every day" and feels 6 of the 11 positive functioning symptoms (items 4-14) "every day" or "almost every day" in the past month.	Languishing is the diagnosis when someone feels 1 of the 3 hedonic well-being symptoms (items 1-3) "never" or "once or twice" and feels 6 of the 11 positive functioning symptoms (items 4-8 are indicators of Social well-being and 9-14 are indicators of Psychological well-being) "never" or "once or twice" in the past month.	Individuals who are neither “languishing” nor “flourishing” are then coded as “moderately mentally healthy.”

The mean age of participants categorised as ‘languishing’ was much lower than those categorised as ‘moderately mentally healthy’ or ‘flourishing’. Those categorised as ‘languishing’ had a mean age of 77.33 years (*SD*=11.46), compared to a mean age of 86.76 years (*SD*=8.21) for participants in the ‘moderately mentally healthy’ and ‘flourishing’ categories (*SD*=6.57). Using the Keyes (2009) guidance on categorising participant, overall, 6.4% of participants were ‘languishing’, 34.8% were ‘moderately mentally healthy’, and 57.5% were ‘flourishing’. Twice as many men were categorised as ‘languishing’, 10% of male participants fell into the ‘languishing’ category compared to 5% of the female participants. In contrast, 38% of female participants were categorised as 'moderately mentally healthy compared' to 29% male participants. Furthermore, 57% of female participants were categorised as 'flourishing' compared to 61 % of male participants. The majority of the literature that used the MHC-SF did not publish the categorisations of their participants (Salama-Younes, 2011; Westerhof & Keyes, 2010; Snowden et al., 2010) but have focused on the analysis of the subscale scores. For example, a South African sample found that 12.2% were languishing, 67.8% were MMH and 20% were flourishing (Keyes et al., 2008). A US study found 18% were flourishing, 17% were languishing and 65% were MMH (Keyes, 2005). And an Italian sample 10.5% were languishing, 52.9% were moderately mentally healthy, and 28.5% were flourishing in an Italian population study (Petrillo et al., 2015).

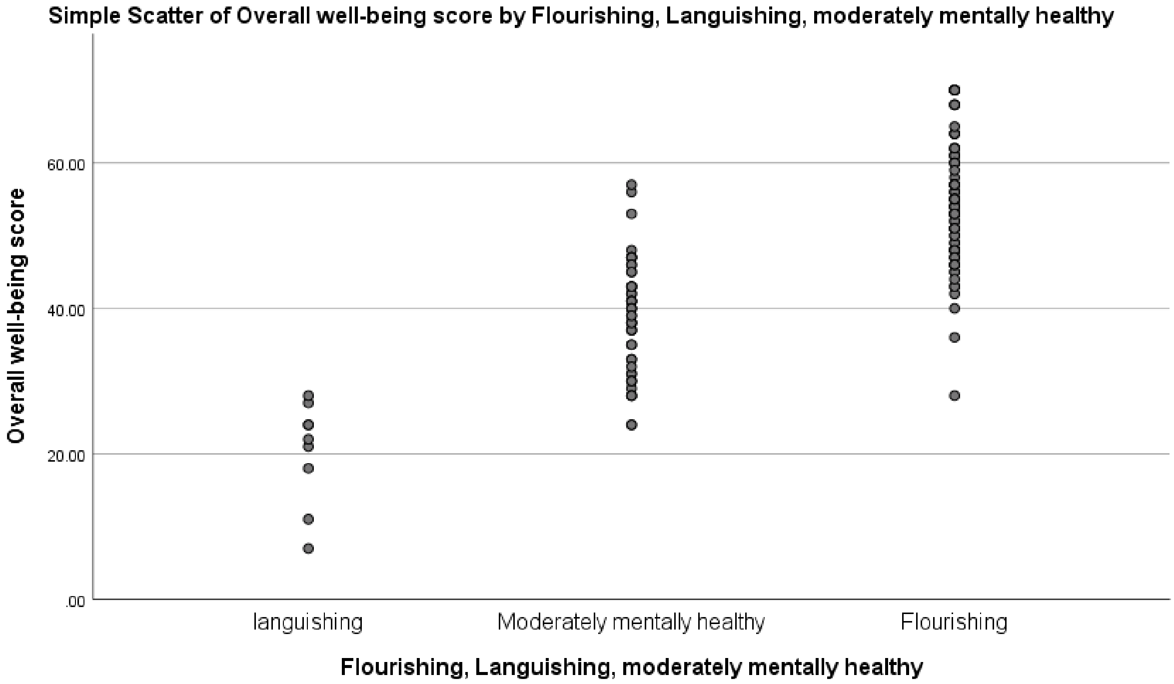

Figure 4.9 Participant overall well-being score compared to Flourishing, Languishing, and Moderately mentally healthy categorisation

Figure 4.9 above shows the distribution of the OWB scores, and the categories participants were placed in using Keyes' (2009) criteria. As seen from the graph, there is an overlap of scores for the 'flourishing', 'moderately mentally healthy' and 'languishing' groups. The categorisation was dependent on how participants rated questions in the subscales and not their OWB score. This categorisation method meant that some participants who had similar OWB scores were categorised differently. Some participants who had higher scores than those in the ‘flourishing’ and ‘moderately mentally healthy’ categories were placed in the ‘languishing’ category. For example, two participants with the same OWB score could be placed in either the ‘flourishing’ or ‘moderately mentally healthy’ category. It is also possible that participants with the same OWB could be placed in either the ‘languishing’ or ‘flourishing’ category. An example of this from the data is seen in participant six and seven who both scored 56 overall (OWB), however, participant six was categorised as ‘flourishing’ and participant seven was categorised as ‘moderately mentally healthy’, participant 124 scored 28 on the OWB scale and was categorised as ‘languishing’, whereas participant 88 scored 24 on the OWB and was categorised as ‘moderately mentally healthy’. Participant 88 also scored zero on the EWB scale, it is difficult to understand how an individual can say that they have not experienced feeling happy, interested in life or satisfied in the last two weeks as an individual who is ‘moderately mentally healthy’.

Table 4.5 Mean scores of MHC-SF

During the past two weeks, how often did you feel …	Participant mean scores
1. happy	3.9
2. interested in life	4.0
3. satisfied	3.7
4. that you had something important to contribute to society	1.7
5. that you belonged to a community (like a social group, or your neighbourhood)	3.8
6. that our society is becoming a better place for people like you	3.0

7. that people are basically good	4.2
8. that the way our society works makes sense to you	2.6
9. that you liked most parts of your personality	3.4
10. good at managing the responsibilities of your daily life	2.9
11. that you had warm and trusting relationships with others	4.1
12. that you had experiences that challenged you to grow and become a better person	2.3
13. confident to think or express your own ideas and opinions	3.8
14. that your life has a sense of direction or meaning to it	3.1

By looking at the mean scores in Table 4.5, it is possible to see which questions, on average, participants scored higher or lower on. The average scores help give an overview of how often care home residents felt they experienced these feelings and an indication of which areas to focus the qualitative interview topic schedule. A low score shows that, on average, residents did not feel or experience these well-being indicators very often. A number of questions had lower mean scores, which indicates that on average participants did not experience these items very often and therefore could be areas to explore further during the qualitative interview stage of data collection. Several mean scores for questions were 4 or 5, which indicates, on average, participants felt on most days, for example, that they had warm and trusting relationships. The mean score for question four, ‘do you feel you have something important to contribute to society’ was 1.72, which is lower than the mean scores of other questions. This indicates that, on average, participants did not feel that they had something important to contribute to society very often as a score of one indicates that they only felt they had something to contribute to society once or twice over the past fortnight. A score of two means that the respondent felt that they felt they had something to contribute to society ‘about once a week’ over the past fortnight. The mean score for question 8, ‘the way society works makes sense to you’, was 2.60, which indicates, on average, residents felt that in the past two weeks, society made sense to them between once a week and two or three times a week.

Mean scores for question 10, ‘Good at managing the responsibilities of your daily life’, was 2.90, which shows that residents felt good at managing their responsibilities of their daily lives two or three times a week on average. The mean score for question 12, ‘That you had experiences that challenged you to grow and become a better person’, was 2.32, which indicates that on average, residents felt that they had experiences that challenged them to grow to become a better person ‘about once a week’. Therefore, participants’ lower mean score on question twelve indicates that, on average, participants did not feel that they had experiences that challenged them to grow and become a better person which may indicate that participants do not engage in meaningful activities.

To determine whether to use parametric or non-parametric statistical analysis to explore the data further, I performed normality tests to assess the data distribution. The Explore function in IBM SPSS 22 was used to assess the normality of the distribution. Using the skewness and kurtosis scores of the data is one way of assessing whether the data is normally distributed. These were checked on the descriptive analysis output from SPSS and the Kolmogorov- Smirnov statistic, which assesses the normality of the distribution, EWB, PWB, and SWB subscale were not normally distributed. In contrast, scores on the OWB (overall scale score) were normally distributed. Histograms, normal probability plots, Detrended Normal Q-Q Plots, and boxplots generated in the SPSS output were also checked for normality distribution. The 5% trimmed Mean statistic did not differ greatly from the original mean for each subscale score, and each of the fourteen items in the MHC-SF which indicates that any extreme scores or outliers in the data set did not impact the overall mean score. The 5% trimmed mean removes the 5% highest and lowest data scores, and if the 5% trimmed mean is the same, then the outliers have not impacted the mean (Pallant, 2016). The normality tests showed that the overall well-being score was normally distributed. However, the emotional well-being score, social well-being score and psychological well-being score were not normally distributed. Therefore, non-parametric tests were chosen for analysis. Non-parametric tests are used when the exploratory analysis shows that the data are not normally distributed. Parametric statistical techniques can still be used on data that is not normally distributed;

however, there is a risk that the findings would be invalid. Therefore, non-parametric tests can be used which have less stringent assumptions. Each parametric test has a corresponding non-parametric test that can be used in its place if the data does not fit the parametric assumptions. Non-parametric tests are not as powerful as parametric statistical tests if the sampling distribution is not normally distributed. However, there are fewer strict assumptions that the data needs to meet for them to be used, which is more appropriate for use on data that is not normally distributed (Pallant, 2016).

4.4 MULTINOMIAL LOGISTIC REGRESSION

Initial descriptive statistical analysis showed that the mean age of participants in the 'languishing' category was lower than the mean age of those in the 'moderately mentally healthy' and 'flourishing' category, which suggests that younger residents were more likely to have lower levels of mental well-being and be categorised as either 'languishing' or 'moderately mentally healthy'. The descriptive statistical analysis also showed twice as many men in the 'languishing' category as women. To explore this further, a Multinomial logistic regression was carried out to establish whether age or gender was a predictor of how participants were categorised according to the MHC-SF scoring guidelines. Multinomial logistic regression was chosen because it extends the logistic regression model and can be used to predict the membership of more than two categories (Languishing, Moderately Mentally Healthy, Flourishing) (Field, 2018).

The model contained two independent variables (gender and age). The full model containing both predictors was statistically significant, χ^2 (4, N=141)=151.97, $p<.05$ against the null model (no predictors). The age of the residents significantly predicted which category they would be placed in. The model coefficient showed that the older care home residents in the study were more likely to be categorised as 'moderately mentally healthy' than 'languishing' b=.138, Wald χ^2 (1) = 8.68, p=.003 (see table 4.6). The odds ratio of 1.15 indicates that for every one unit increase of age, the odds of a resident being categorised as 'moderately mentally healthy' increased by a factor of 1.15. The age of residents was found to predict the likelihood of being categorised as 'flourishing' compared to 'languishing', b=.138, Wald χ^2(1) = 9.40, p=.002. The odds ratio of 1.15 indicates that as age increases, the odds of a resident being categorised as ‘flourishing’ increases. Therefore, younger residents were more likely to be categorised as ‘languishing’. As shown in table 4.6 below, gender did not significantly predict which category residents were more likely to be placed in. Age was the only significant predictor of categorisation; from earlier descriptive analysis and previous research I expected men to be significantly more likely to be categorised as ‘languishing’. However, there is also conflicting evidence on whether older men or women have lower levels of well-being in the research literature. For example, Petrillo et al. (2015) found women to have worse levels of well-being than men. While earlier research in Pakistan has found men to have better general well-being than women (Shyam & Yadev (2006). The sample of care home residents included in this study was also relatively small, this may have had an impact on the significance of the findings, or perhaps with a larger sample there would be no difference seen between men and women and how they were categorised.

Table 4.6 Multinomial Logistic Regression findings

Parameter Estimates

Flourishing, Languishing, moderately mentally healthy		B	Std. Error	Wald	df	Sig.	Exp(B)	95% Confidence Interval for Exp(B)	
								Lower Bound	Upper Bound
Moderately mentally healthy	Intercept	-9.260	3.713	6.218	1	.013			
	Age	.138	.047	8.682	1	.003	1.147	1.047	1.257
	Gender	-.991	.796	1.550	1	.213	.371	.078	1.767
Flourishing	Intercept	-8.909	3.561	6.258	1	.012			
	Age	.138	.045	9.404	1	.002	1.148	1.051	1.254
	Gender	-.662	.763	.753	1	.386	.516	.116	2.301

a. The reference category is: languishing.

Note. R^2 =.09 (Cox-Snell), .10 (Nagelkerke). Model $\chi^2(4)$)=151.97, *p*<.05

4.5 CORRELATIONS

Correlation analysis determines the strength and direction of the relationship between two variables; if there is a positive correlation between two variables, as one variable increases, so does the second variable. There is a negative correlation if one variable decreases, the second variable increases. Exploratory analysis and multinomial regression analysis showed that younger participants were more likely to be categorised as 'languishing'. A Spearman's rho correlation was used to analyse relationships between age, overall scale score, subscale score, and item score to explore the relationship between participant age and MHC-SF score and subscale score. Because the data were not normally distributed and therefore did not meet the criteria for Pearson correlation, the non-parametric Spearman Rank Order correlation (rho) was used (Pallant, 2016). Spearman's rho is being used more in social research to analyse scales to avoid any issues that could arise when assuming that ordinal level ratings such as Likert scales are the equivalent to interval level scaling (Pallant, 2016, p.129). The data met the assumptions for a Spearman Rank Order correlation (rho) as the data were ordinal and the variables were monotonically related (Field, 2018).

No correlational relationship was found between age and overall scale scores (rho=-.017, n=141, p>0.05) or subscales score (see table 4.8 below). This indicates that participant age did not affect a rise or fall in the OWB score or subscale scores and suggests that older participants were not significantly more likely to score higher or lower on each subscale or have a higher or lower OWB score than younger participants. This finding is not aligned with the findings from the multinomial logistic regression that age was a predictor of how residents were categorised, with younger residents being more likely to be categorised as 'languishing'. The reason for this difference is due to categorisation not being based on overall score or subscale score, but on how respondents have rated items in each subscale and how many times lower ratings have been chosen. Therefore, lower overall and subscale scores do not necessarily mean that participants will be categorised as 'languishing', which is shown in figure 4.9 above.

As can be seen from table 4.8 on the next page significant correlations were found between subscale scores which means that higher scores on one subscale correlated with higher scores on the remaining subscales. This to be expected and meets the expected norms for the use of the MHC-SF and suggests that the MHC-SF has been administered and completed correctly in this study.

Table 4.7 Spearman's rho correlation between age, OWB, and subscale scores

			Care home No.	Age	Emotional well-being score	Social well-being score	Psychological well-being score	Overall well-being score
Spearman's rho	Age	Correlation Coefficient	-.065	1.000	-.050	-.032	-.051	-.017
		Sig. (2-tailed)	.441	.	.560	.710	.551	.840
		N	141	141	141	141	141	141
	Emotional well-being score	Correlation Coefficient	-.061	-.050	1.000	.516**	.485**	.683**
		Sig. (2-tailed)	.472	.560	.	.000	.000	.000
		N	141	141	141	141	141	141
	Social well-being score	Correlation Coefficient	-.104	-.032	.516**	1.000	.629**	.850**
		Sig. (2-tailed)	.218	.710	.000	.	.000	.000
		N	141	141	141	141	141	141
		Correlation Coefficient	-.177*	-.051	.485**	.629**	1.000	.885**

			Care home No.	Age	Emotional well-being score	Social well-being score	Psychological well-being score	Overall well-being score
	Psychological well-being score	Sig. (2-tailed)	.036	.551	.000	.000	.	.000
		N	141	141	141	141	141	141
	Overall well-being score	Correlation Coefficient	-.142	-.017	.683**	.850**	.885**	1.000
		Sig. (2-tailed)	.093	.840	.000	.000	.000	.
		N	141	141	141	141	141	141
	Overall well-being score	Correlation Coefficient	-.142	-.017	.683**	.850**	.885**	1.000
		Sig. (2-tailed)	.093	.840	.000	.000	.000	.

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Correlational analysis found that there was a large correlation between emotional well-being and social well-being (*rho*=.516, *n*=141, *p*<.01). There was also a large correlation between Emotional well-being scores and psychological well-being (*rho*=.485, *n*=141, *p*<.01). The correlation between social well-being and Psychological well-being was also large (*rho*=.629, *n*=141, *p*<.01). This indicates that participants who scored higher on the EWB and SWB subscale were more likely to score higher on the PWB subscale. Suggesting there was a relationship between the EWB, SWB and the PWB subscale and highlights how each subscale is related and intersects.

A small positive correlation between age and item 5 (*rho*=.13, *n*=141, *p*<.132) and age and item 7 (*rho*=.120, *n*=141, *p*<.155) was found, which were not significant. This may suggest that as residents grow older, they may be more likely to experience feelings of belonging to a community and that people are basically good. There was also a small negative correlation between age and item 12 (*rho*=-.117, *n*=141, *p*<.169), which was not significant. This might indicate that older residents were less likely to feel they had experiences that challenged them to grow and become better people compared to younger care home residents. Unfortunately, these correlations were not significant, however, they do give an indication of areas that could be explored further in the qualitative stage of this study.

4.6 INTERVIEW SCHEDULE DEVELOPMENT

The findings from the analysis were used to help develop a qualitative interview schedule for the second stage of data collection (Appendix 13). Participant scores were lower on items in the Social Well-being (SWB) subscale than on items in the Emotional Well-being (EWB) and Psychological Well-being subscale; therefore, the qualitative interview schedule included questions on social aspects of mental well-being and the impact of living in a care home on social mental well-being. Questions from the MHC-SF that participants commented were too open to be answered on a Likert-type scale were also included to allow participants an opportunity to expand and elaborate on the questions and to answer in their own words if they felt that the options on the MHC-SF did not capture what they wanted to say. The interview schedule also included questions about the social, emotional, and psychological aspects of mental well-being.

Due to the lower mean scores on items relating to society, a sense of purpose and responsibilities questions covering these were included in the interview schedule (Appendix 13) to explore these topic areas further. The lower mean scores on these items indicate that, on average, participants experienced positive feelings relating to these areas of well-being less often. For example, on average, participants only felt that they had experiences that challenged them to grow and become a better person ‘About once a week’, that their life has a sense of direction or meaning ‘About 2 or 3 times a week’, that the way society works makes sense to them and they felt like society was becoming a better place for people like them ‘About 2 or 3 times a week’.

Multinomial logistic regression of the data showed that younger residents were more likely to be categorised as languishing. Participants of varying ages were recruited for the second data collection stage to ensure that I also captured the younger residents' perspectives.

In addition to the findings from the MHC-SF I also used the topic areas of the items on the MHC-SF in the qualitative interview schedule to aid the data integration stage of the mixed methods research. By doing this during integration I would then be able to compare where the quantitative and qualitative data converged, diverged, or where there was complementarity between the two data sets. This also allowed me to explore several of the topic areas the MHC-SF covered in further detail and gave residents an opportunity to give more in depth responses.

During the first stage of data collection, I kept a research log of each care home visit. Thoughts about how the data collection had gone were noted down and any comments of interest made by the residents were noted down. These were then used to help inform the topic areas and questions for the interview in addition to the MHC-SF responses.

4.7 SUMMARY

In this chapter I presented the analysis and findings of the data collected during the first stage of data collection. The descriptive analysis demonstrated that on average residents had lower SWB and PWB scores than EWB scores, indicating that on average residents experienced feelings of social and psychological well-being and functioning well less often that emotional, hedonic feelings of well-being such as feeling happy, interested in life and satisfied with life. Overall, participants did not have very high mean OWB scores (66.64%). After categorising each completed MHC-SF using Keyes' (2009) criteria, initial analysis showed twice as many men were categorised as 'languishing' than women. However, further analysis found no significant difference between gender and categorisation. I carried out a Multinomial Logistic Regression to determine whether there was a relationship between age and which category participants were more likely to be placed in following Keyes' (2009) criteria. The analysis showed that the younger care home residents were significantly more likely to be categorised as 'languishing' by the MHC-SF scoring criteria than older care home residents. Indicating that younger residents that participated had lower levels of mental well-being than older care home residents. To explore the relationship between age and well-being further I used a correlational analysis to analyse the relationship between, overall scale score, and item score. The correlational analysis found that there was no significant relationship between age and overall scale or subscale scores. Lastly, I described the development of the interview schedule for the qualitative stage of data collection from the findings of the quantitative analysis.

There were limitations to using the MHC-SF that became apparent when using the scale and during analysis. While administering the MHC-SF residents commented that they did not understand what was meant by the question 'that you had experiences that challenged you to grow and become a better person', many residents felt that they had already done all the 'growing' that they needed to do. During analysis and categorisation of each of the MHC-SF scales I noticed that the categorisation was dependent on how participants rated questions in the subscales and not their OWB or subscale scores. This categorisation method meant that some participants who had similar OWB scores were categorised differently. Some participants who had higher scores than those in the 'flourishing' and 'moderately mentally healthy' categories were placed in the 'languishing' category. For example, two participants with the same OWB score could be placed in either the ‘flourishing’ or ‘moderately mentally healthy’ category. It is also possible that participants with the same OWB could be placed in either the ‘languishing’ or ‘flourishing’ category. An extreme example of this is seen the data from participant 88 who scored zero on the EWB scale but was categorised as ‘moderately mentally healthy’. It is difficult to understand that an individual can say that they have not experienced feeling happy, interested in life or satisfied in the last two weeks as an individual who is ‘moderately mentally healthy’.

In the next chapter I will present the Reflexive Thematic Analysis (RTA) of the qualitative interviews with extracts taken from resident interviews.

5 CHAPTER 5: QUALITATIVE ANALYSIS

5.1 INTRODUCTION

This chapter presents the analysis of the qualitative interviews conducted with 20 care home residents. In this chapter I explore residents' experiences of moving to a care home and what they described as important contributing factors to their mental well-being. An important theme that I first noticed was that the residents I interviewed described the different types of loss they experienced in later life, such as through bereavement and illness and in addition to the losses experienced as a result of moving to a care home and how this had an impact on their mental well-being. After further analysis and the development of the three themes which I discuss below I decided that loss was a common thread that ran through each interview, and therefore, should be the overarching theme identified in the analysis. Verbatim data extracts from the interviews have been used throughout the chapter to retain originality. The data extracts included in this analysis chapter are reported analytically which will allow the data to be synthesised and contextualised as and when they are reported in the chapter, as recommended by Braun and Clarke (2013, 2019).

5.2 SAMPLE

Twenty residents from six care homes in South Wales participated in the qualitative interviews during July and August 2018. Once the interviews had been completed each participant was given a pseudonym to protect their anonymity, these are the names that are used in this thesis when referring to participants from the qualitative stage of data collection. Table 5.9 below displays each participant's pseudonym, gender, age, and the number of years they had lived in the care home, and includes information on the type of care home they lived in.

Table 5.8 Qualitative interview participant information

Participant No.	Participant pseudonym	Gender	Age	Care Home	Years living in the care home
1	Marilyn	Female	81	Local Authority	10 years
2	Shirley	Female	90	Local Authority	2 years
3	Barbara	Female	98	Local Authority	1 year 10 months
4	Joan	Female	78	Religious	7-8 months
5	Patricia	Female	88	Religious	2 years
6	Helen	Female	93	Local Authority	8 years
7	Mary	Female	87	Local Authority	3-4 years
8	Betty	Female	91	Local Authority	13 years
9	Dorothy	Female	91	Local Authority	18 months
10	Virginia	Female	86	Local Authority	1 year
11	Jean	Female	95	Local Authority	18 months
12	Robert	Male	75	Local Authority	11 years

13	Anna	Female	96	Religious	4 years
14	Nancy	Female	71	Religious	3 years
15	Joseph	Male	85	Religious	4 years
16	Frances	Female	94	Local Authority	2 years 6 months
17	Doris	Female	94	Private	18 months
18	Beverley	Female	92	Private	1 year 3 months
19	George	Male	92	Religious	18 months-2years
20	Bill	Male	89	Private	6 years

5.3 DEFINING OVERARCHING THEMES, THEMES AND SUB-THEMES

The overarching theme, themes, and sub-themes generated from the Reflexive Thematic Analysis (RTA) are defined, discussed, and analysed with supporting extracts from the data in the remainder of this chapter. After the data had been coded, I reviewed the codes to see how they could be combined into themes or sub-themes according to shared meaning. Each theme was carefully reviewed to ensure it was focused on one central organising concept and that they were related but distinct from each other. I generated three themes from the open-coding I used on the interview transcripts, these were 'challenges to liberty', 'changes in identity', and 'importance of relatedness'. Each theme included sub-themes which the main codes were organised into. Many of the themes and sub-themes were also inter-related and closely aligned, demonstrating how complex components of mental well-being are to residents in care homes, and how this effects their overall mental well-being. Details of the themes and sub-themes is described below in section 5.4 and can be seen in figure 5.10 of the thematic map on the next page.

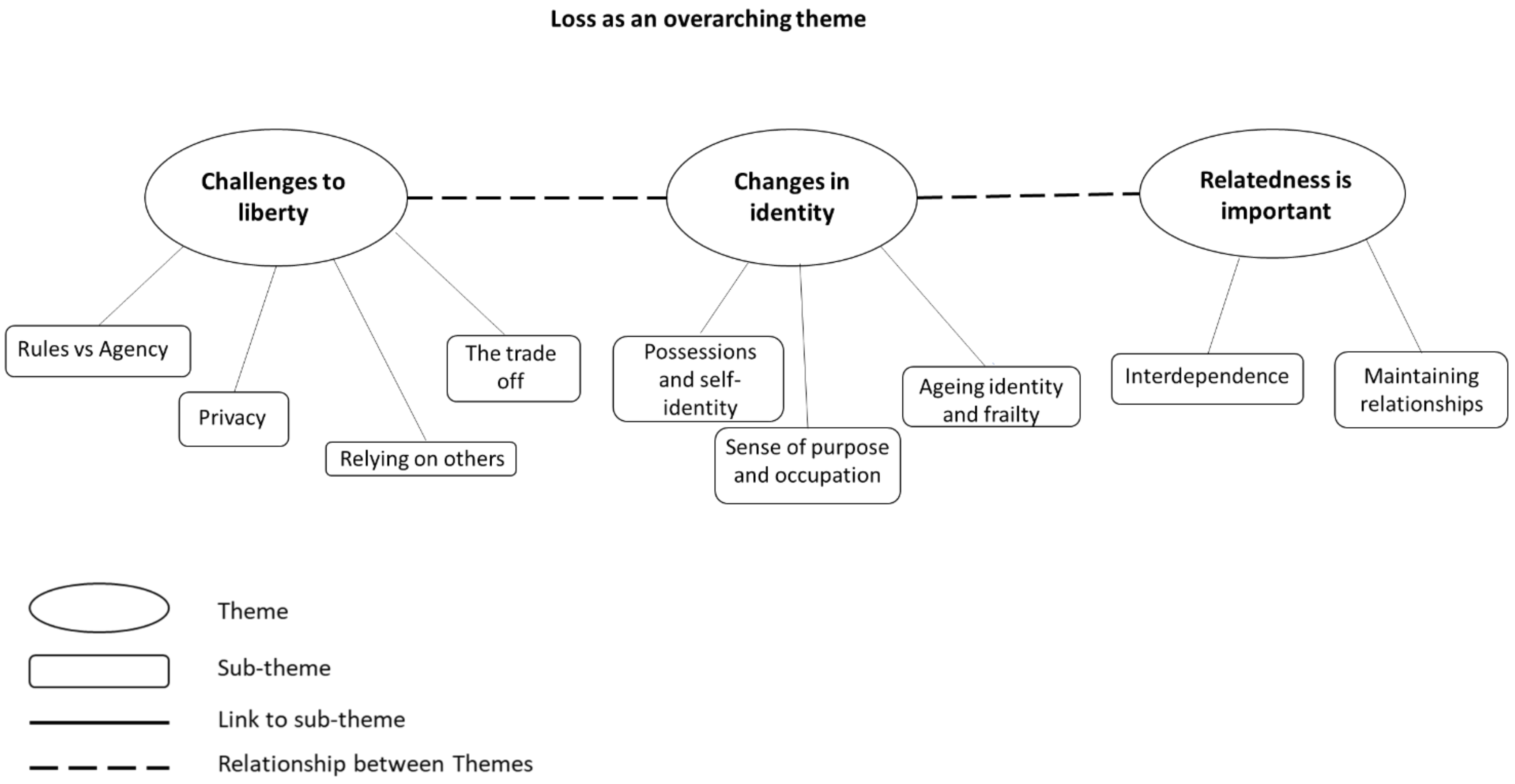

Figure 5.10 Thematic map of themes generated through reflexive thematic analysis

As suggested by Byrne (2021) and Braun and Clarke (2019) a thematic map of each theme generated from the data analysis was created to show each theme and sub-theme. The diagram above presents a thematic map of the themes and sub-themes I produced during the RTA (Reflexive Thematic Analysis) process of the qualitative interview data. Before moving on to describe and elaborate on the themes I will first outline the overall thematic structure generated from the analysis of these data. The main themes were 'Challenges to liberty', 'Changes in identity', and 'Importance of relatedness'.

Challenges to liberty – during the interviews residents discussed feelings and situations that had the shared meaning of challenges that impacted their liberty and freedom while living in a care home. The four sub-themes I identified within this theme were 'rules vs agency' where many residents spoke about the way the rules of the care home impacted their autonomy and what this meant to their agency and liberty; 'privacy' where residents discussed the changes in their privacy since moving to the care home; 'relying on others' where residents spoke of how having to rely on others impacted their liberty. The fourth sub-theme 'the trade-off' where many residents alluded to the 'trade-off' and compromise of their freedom that is made when moving to a care home.

Changes in identity – Many residents shared experiences where they experienced a change in their identity. Within this theme I developed three sub-themes, the first 'sense of purpose and occupation' contains analysis and extracts with the shared meaning of residents experiencing a lack of meaningful activities, sense of purpose and occupation and how this has contributed to a change in their identity since moving to the care home, and as they have grown older. The second sub-them, 'possessions and self-identity' explores residents experiences of losing and giving up possessions and the meaning these belongings hold and contribute to their self-identity in later life. The third sub-theme 'ageing identity and frailty' incudes extracts and analysis on residents' experiences of their identity as an older person and how this contributes to their mental well-being.

Importance of relatedness – During the interviews residents spoke about the impact their relationships with staff, professionals, family, and friends had on them. Within this theme I developed two sub-themes. The first ‘interdependence’ explored the way that residents are impacted by the relationships and interactions with other people, including family, friends, and staff within the care home. The second sub-theme, ‘maintaining relationships’ which explores extracts and analysis with a shared meaning of the difficulties in maintaining relationships while living in a care home and how these impact older adult mental well-being.

5.4 LOSS AS AN OVERARCHING THEME

During the familiarisation stage of the analysis, I noticed that loss was a thread that ran through each resident’s interview. Each resident I spoke to had experienced multiple losses either as a result of growing older or from moving to a care home. I chose loss as an overarching theme as it represented a commonality between each theme and was present in each of the qualitative interviews. The overarching theme of loss was experienced by residents from either their transition into a care home or through the process of ageing. Residents discussed several different forms of loss. This included the loss of people and possessions; loss of independence and agency; loss of sense of self, purpose, freedom; and their loss of choice. Residents also talked about physical, psychological, and relationship losses, as well as the loss of abilities, identity, and mobility and how these losses had an impact on their mental well-being. These are explored further in the analysis of the themes below.

5.5 THEME 1: CHALLENGES TO LIBERTY

The experiences, thoughts, and feelings discussed in the extracts in this section and sub-sections have a shared meaning and are underpinned by the central organising concept that liberty is important to the mental well-being of older adults living in care homes. Liberty is a word that encompasses independence, freedom, and autonomy, these are all components that residents discussed in their interviews and what is important to their mental well-being. Many of the experiences that residents discussed referred to the loss of liberty experienced while living in a care home and how this had affected them. The majority of the residents described experiences that had impacted on their liberty while living in the care home. Within the theme there are four sub-themes that I have organised the data relating to the importance of liberty on mental well-being into. Below is an analysis of the data extracts underlying this theme and sub-themes.

5.5.1 Sub-theme: Rules vs Agency

Residents often felt a loss of freedom and independence when moving into a care home, they found the rules and regulations in place within the care homes created a feeling of restriction with residents being unable to do what they wanted to do, when they wanted to do it. Several residents expanded upon this, noting that care home staff added to this feeling of restriction by reinforcing these care home policies and guidelines. This loss of freedom and sense of being restricted had an impact on residents' autonomy and agency which affected their liberty in the care home. An example of this is seen in the extract below. Helen, a 93-year-old resident talks about how the rules and regulations of the care home stopped her from going for a walk in the garden which has an impact on her liberty and mental well-being. Helen had been living in a religious care home for eight years, after making the decision to move to a care home when she began to struggle with her knee. When asked about how things were since moving to the home, she talked about how things had changed since she had been there.

RES: Yeah. But then gradually, I don't know, these…all these regulations, rules and regulations.
INT: They come in and people have their own…
RES: Rules and regulations and every…tied up in knots.
INT: So, what helped you settle down quickly?
RES: It's…taken…we have a manager now and other staff that are saying what should or should not be done.
INT: Does that make things difficult?
RES: At times. At times. You know, there's nothing like freedom, is there? [Laughs]
INT: Freedom is important, isn't it? So, you said that you settled down quickly here.
RES: Very quickly.
INT: What do you think helped you to settle down so quickly?
RES: Well, erm, to begin with, after the operation and free from pain, that was the most…number one. And then a lot of residents I had met in the past, you know, in BLANK. I lived in BLANK for 50 years.
INT: Oh, wow.

RES: So, there I had met in BLANK and worked in BLANK.
INT: So, with all quite familiar people?
RES: Lots of it…lots of it familiar. Yeah. And the food was good.
INT: Oh, that always helps.
RES: Always helps, yeah, yeah.
INT: It's awful if the food is terrible.
RES: And the garden…the garden is beautiful.
INT: The garden is beautiful here.
RES: One of the…it needs some rain.
INT: Yeah, it does need some rain.
RES: But, as I said, there were so many things that…that helped, you know, yeah. And the company was good. Yes.
INT: That's good. Do you still get to go out in the garden much now?
RES: I do. But I was told before I went down to BLANK, that somebody should go with me when I go into the garden.
INT: How does that make you feel?
RES: It made me feel, well, I mean, I've never had to have anybody to…to lead me. Well, I'm…I want…I want to question it with the manager.
INT: No, that's understandable.
RES: Yeah. Because I…I just…I always…and when I went out, I always wrote where I was, the length of time I'd be out and that if…if a phone call came for me, just ask the name and then I would know and…and I'll ring back. *Helen, 93 years old.*

In the extract above it is clear that Helen is showing resistance to the care home proposing she needs to be accompanied when walking in the garden now and Helen uses the example of going out into the garden to illustrate her independent ability. Helen refers to having played by the rules and always letting staff know where she went and how she has not had time to question staff about it, this shows her resistance to what is being proposed by the care home and a comparison she is making to her past self. Feeling restricted by others and being told what she can and cannot do would influence her agency and autonomy. Helen is using her resistance to demonstrate her agency in a care home context where agency can be reduced or challenged due to the restrictive nature of environments such as care homes (Rubin, 2017). Helen is also demonstrating her agency and autonomy by describing her routine and referring to how she has always kept staff informed of her whereabouts in the past and also by stating she has not had time to raise the issue with the manager yet. By informing Helen that she is no longer able to go out to the garden on her own she feels she has lost her autonomy by having her independence and liberty restricted. This demonstrates the tension there often is between the rules of the care home and residents exerting and trying to maintain their agency.

In the extract Helen also talks about what made settling into the care home easier for her. She knew many of the people living in the home before she moved there, this meant she felt comfortable and at home quickly. She also mentioned the garden and how beautiful it is, having a pleasant environment that you can enjoy is important to mental well-being. Bhatti (2006) explored the importance of having green spaces, as they offer somewhere to walk and respite from spending all day indoors. Green spaces also offer an opportunity for hobbies and interests in gardening and plants, somewhere to sit and enjoy the flowers and the outside environment. Burton and Sheehan (2010) have also noted the importance of nature and greenery for the well-being of care home residents in their research and the opportunity to spend time outdoors in nature had been linked to higher levels of thriving (Patomella et al., 2016).

Older adults often face physical barriers because of their mobility and impairments which impact their freedom and independence. The rules and restrictions that are in place in care homes are often additional barriers for residents which impact their freedom and independence. When residents show agency in their resistance which can be interpreted as a concern about their freedom, they also refer to themselves, as can be seen in the extracts above from Helen and the extract below from Mary. Mary was 87 years old and lived in the same care home as Helen, according to Mary she had lived in the care home for three or four years.

> INT: So, what have you found to be the differences from not living in a care home to moving into a care home?
>
> RES: It's more structured. Organised. It's…it's the structure. You haven't got that freedom to do what you want. There's too many rules and regulations.
>
> INT: How does that make you feel having that structure and the rules?
>
> RES: Well, I have to adapt to it. It doesn't…it doesn't matter how…you know, you have to…to adjust to it and…and accept it.

INT: So, you feel you have to adapt to…?
RES: Oh, yes, you have to adapt. If you…if you…yeah, you have to, really. If you're to live life to the full. *Mary, 87 years old.*

In the data extract Mary also talks about how life in the care home was more structured with too many rules and regulations compared to her life beforehand, when living at home. From the extract it is clear to see that Mary feels resigned to life in a care home and that she must adapt and accept how things are in order to enjoy her life. This is an example of the care home and its effects on individuals, are these effects learned by hard experience or were they part of the package that Mary signed up to. Are they a compromise that individuals knowingly make for secondary gains of companionship, security, and care. Mary's extract is an example of an expression of agency, when residents talk about freedom, they communicate that they are not passive objects but remain full members with an ability to make their wants, desires and needs known and an expectation that these are addressed. Institutions breed passivity and people who are compos mentis usually can be expected to challenge, resist, and argue for things to be different. In articulating their needs or a different version of how things should be, these participants are establishing themselves as agentic and individuals with a position to argue. Later in the interview Mary talked about how her independence changed once she moved to the care home, which is illustrated in the extract below.

INT: Can you tell me how your responsibilities have changed since moving to the care home?
RES: Well, from being in London, very responsible, now I'm…what would you call it? Erm, well, I'm always in…I was always an independent person, doing my own thing. So, I try to, erm, they do respect me. Cos, in as far as I can, they respect my ability to do it. And I wouldn't be able to go down…wouldn't be allowed now to go down to the kitchen bring up a mug of tea to myself here. You know, that kind of thing. I'm restricted. I feel restricted. Because of my…my mobility. And there's so much…you know, you lose your independence, to a certain degree, from being a very, very independent person. There's a certain amount of independence. You lose your independence, as such, because you're controlled by rules and regulations and, you know. Keep your door closed. I don't. I keep my door open. Timed doors. You can't have them…You know, all these little rules. You can't go down for a mug of

tea. I better go down now and I'll bring up a mug and a little tiny drop and of course, you're not supposed to have a kettle in the room, you know, and all that kind of thing. So, anyway, that's it. You know, you are restricted. And you lose a certain amount of your independence. You can't make decisions. They're made for you. And you have to abide by the rule.

INT: How does all that make you feel?

RES: Well, it doesn't…I'm that much good at expressing what I feel. But the thing is it's what…there's no alternative. If there were an alternative to it. *Mary, 87 years old.*

This is another example of residents showing resistance and asserting their agency against the rules. In the data extract Mary refers to herself as being an independent person in the past, suggesting she no longer sees herself as being independent. Mary talks about how she feels restricted due to her mobility but also because she feels controlled by the rules and regulations of the care home which has a direct impact on her independence and autonomy. She refers to herself as being restricted and not being '*allowed*' to do things, even though she goes on to say she does those things she is not '*allowed*' to do anyway. She lists some of the rules that she is meant to follow in the care home. Interestingly, Mary also states that she does not follow these rules, she will leave her door open when it is meant to be closed and she will bring a mug of tea upstairs with her. Mary shows her resistance to these rules by referring to these acts in her interview, this could be seen as Mary trying to gain back some of the control in her life and trying to regain some of her agency and autonomy. These forms of asserting agency are also identity claims, how we like to see ourselves and be seen by others. In an institution where identity can be blunted or even lost, these claims are necessary so that individuals can maintain a sense of themselves, and others can be brought to understand the identity claims too. This is an instance where the themes generated in the analysis interlink, changes in identity are discussed further in section 5.6. Further examples of resistance and asserting agency were seen in the interviews. Many residents echoed Mary and Helen' sentiments that they had less '*power*' now that they had moved to the care home and that the management organised everything.

A significant contributor in imposing rules and restricting what residents are able to do is managing risk (Furness, 2011). It is important to maintain residents' rights to autonomy, independence, and choice whilst also managing an acceptable level of risk that does not encroach on their rights (Furness, 2011). Residents did understand and recognise the difficulty care homes face in maintaining residents' freedom, whilst also managing risk and ensuring more vulnerable residents are protected and safeguarded. However, autonomy, choice, and independence are key dimensions of quality of life and well-being for older adults (Walker & Hannessey, 2004) and need to be protected and maintained.

An example of loss of freedom since moving to the care home can be seen in Doris' data extract below. Doris was 94 years old and had been living in a religious care home for a year and a half. In the extract Doris compares the freedom she has to the freedom of being in her own home, of being *'completely free'*. Demonstrating that she does not feel completely free living in a care home.

> INT: So since moving to the care home how has the lifestyle change affected you?
> RES: Well I don't think, if you say affected, it sounds permanent. I don't really like living in a home.
> INT: So what have been the main differences from…?
> RES: Well you are sort of constrained by your behaviour for one thing. You can't just decide not to have dinner or go to bed for the afternoon and they like to know where you are going if you go out which is reasonable but you do feel there is a sort of lead.
> INT: Do you feel it has affected your independence?
> RES: Yeah but I think they do their absolute utmost to make it free. You're not quizzed about anything. It's just different from being completely free. I suppose it's impossible where you get a lot of people you know about 30 or 40. *Doris 94 years old*

Doris includes some examples of simple things she feels are constrained, for example, not being able to miss dinner and go to bed if she feels like it. She felt that she always had someone to answer to, that she had to justify or explain her behaviour which is an example of paternalism, loss of independence and autonomy, and agency having to justify your actions to someone else. She explicitly says that she does not like living in a care home and says that she does not like to think of it as a permanent situation. In the extract Doris also talked about the efforts the care homes make to maintain resident freedom and understands the difficulties this entails. At the end of the data extract Doris is referring to how she understands it from the care home's perspective that it must be difficult or even impossible to make residents feel *'absolutely free'* when there are 30 or 40 residents living in one care home. By indicating that she can see both sides of the argument Doris is showing that she is a reasonable individual and can see the situation from the care home's perspective also. However, the care home also needs to see the situation from the residents' perspective as it impacts their liberty.

In many ways the residents interviewed report having their choices and freedom restricted by the rules and regulations of the care home due to safety reasons and fear of risk. The data extracts included in this section show examples of resident resistance and residents trying to assert their agency. Choosing to speak about these examples of resistance and asserting agency in their interviews indicate that these acts or resistance against these rules and restrictions that impact their liberty are important to their mental well-being. By asserting their agency residents are trying to maintain their mental well-being. A risk averse care home that restricts residents' decision-making opportunities follows a paternalistic model of care. Therefore, restricting residents' choices and opportunities to have a say in decisions that impact them has a significant effect on their personhood and mental well-being. It is important that residents have control over their lives and for risks to be managed not eliminated (Furness, 2011) as autonomy should be a human right for older people (Boyle, 2008).

The research on care home residents and risk has mainly been conducted with residents with dementia. This often means that the same behaviours and treatment are experienced by care home residents who may not have dementia also. A blanket assumption that someone with dementia or someone who lives in a care home lacks the capacity to make care-related choices is not congruent with the SSWWA 2014. The assumption that once an individual is in a care home or over a certain age, they are no longer included in the decision-making processes about their care undermines the autonomy of the individual. Residents should be involved in the decision-making process and given a choice. Perhaps the resident will also come to the conclusion that it is not safe or appropriate for them to do something unsupported now, but they need to be involved in that decision. When the voices of members of a particular group, such as care home residents, are neglected or ignored this is an example of epistemic injustice (Fricker, 2007). Care homes have a responsibility for the safety of residents, but it also need to consider residents' wishes. By developing shared cooperative power through involving residents in the decision-making process resident's agency and autonomy are persevered and their liberty is less likely to be negatively affected (Tew, 2005; Furness and Torry, 2009).

5.5.2 Sub-theme: Privacy

Privacy can be an issue after moving to a care home and a right to privacy is a significant component of liberty. The loss of privacy in a care home can be a sharp contrast to the privacy of living in your own home. This sub-theme of privacy is primarily about the loss of privacy residents experienced when they moved to the care home and the impact it had on their liberty. When living in a care home residents experience members of staff entering their room, helping them with personal care tasks, washing their clothes, and discussing what they have spoken about with other members if staff. This can mean that it is difficult to maintain privacy which is illustrated in the extracts to follow has an impact on residents' liberty and mental well-being. During the interviews, residents gave examples of how their privacy had been impacted since moving to the care home. One resident, Bill illustrates this in the example he gives below. Bill was 89 years old and had lived in a private care home for six years.

INT What were the differences for you?

RES The difference was, Mr X when I first came here, he came to see me and he said now look Bill he said, I want you to treat this place as like your own home. I know that I said, but with limitations. You haven't got the freedom of being at home compared to this. You've got your freedom, but you've got to be very careful with what you say. You don't know what I mean?

INT No, I'm not sure I know what you mean.

RES You say one thing to one Carer and whoosh.

INT	Ah!
RES	It’s all over the shop.
INT	Oh dear.
RES	You have to be very careful with what you say. *Bill, 89 years old.*

In the example given by Bill he explains that he needs to be careful with what he says to members of staff, because things do not remain private in the care home. In addition to the limitations placed on his freedom since he came to the care home, he felt that he had to be careful what he said to staff as it would be discussed with others. In this extract Bill shows that he realises that he can no longer be free with the same things that he once was prior to moving to the care home. This also shows a lack of privacy that Bill feels. In the extract Bill is highlighting that while living in a care home anything he says can be taken as evidence of something and acted upon, once he shares something with a member of staff, he loses control of that information about himself. For example, anything he mentions to a member of staff could be written in his file or discussed with other members of staff, family, visitors, or medical professionals. Not living in a trusting environment where people feel safe to talk freely without their discussions being shared with other staff or recorded in their record or care plan has a negative impact on their liberty and mental well-being. Feeling safe and having the freedom to be oneself is an essential part of mental well-being. Having to be careful of what you say does not promote a trusting environment where individuals feel they can be themselves.

Loss of privacy was further elaborated upon by others who discussed how they felt a lack of privacy since moving to the care home. Anna who lived in a different care home to Bill talked about a different aspect to the lack of privacy she felt since moving to a care home. Anna was 96 years old and had lived in a private care home for four years. In the data extract below Anna gives an example of a time when she was ill and having a day in bed, while resting in her room staff entered throughout the day without knocking.

INT:	So, has anything stayed the same since you’ve moved to the care home?

RES: Yes, I don't know how, they got out of it eventually, over this side we don't have dementia everybody over there has dementia. So, if you get dementia you go over there, a Chinese Consultant was treating me for shingles in my eye and he said to me I am going to predict something he said, you will never have dementia. I said why ever not, he said because this what you're having now, so late in your life, so it means that you won't have dementia, so I hope he's right.

INT: Oh, that's something good.

RES: Yes, that's nice to think about as he predicted, but we're very lucky to be able to communicate, there's no doubt about it that is one of the main things. As I say, and I don't want to complain too much because the people have been nice but for instance they're supposed to knock on the door and you're supposed to say come in but if you don't say come in they come in to see why you haven't said anything.

INT: They're just checking on you.

RES: That little bit of privacy, you do not have, you cannot really keep anybody out of your room. You know, say you were wanting to do something, I don't know what you would want to do, but if you did you cannot expect anybody to stay out of your room. And so many people, when I wasn't feeling very well, they said have a day in bed. Do you know that 10 people had access to my room?

INT: Oh gosh.

RES: You just think of everybody, the lady with the laundry, the people with the food coming in, the people with the medicines coming in, the people bringing a newspaper in, people bringing letters in. And so, you couldn't believe it, I didn't have one minute. There was somebody coming in all the time. But of course, that's not a problem, I don't really want to make it as a complaint. *Anna, 96 years old.*

In Anna's interview extract she describes an occasion where staff have not respected her privacy and have walked into her room. Even though Anna states that she does not want to complain, twice, she then presents her complaint that staff are not acting as they are supposed to and knocking before entering her room. It is clear that she was perturbed by the lack of privacy she has in her room. By beginning and ending her grievance with saying she does not want to make a complaint and the specific detail and well-crafted structure suggests that Anna is rehearsing this argument. In addition, complaining to a researcher is less formal and carries little chance of retribution, therefore, in this way it is relatively safe to do. Anna may not want to complain for various reasons, but she has a complaint all the same.

5.5.3 Sub-theme: Relying on others

Residents' experiences related to loss of independence and liberty when having to rely on others and becoming dependent on staff and family members for even the most basic needs that might be taken for granted. Residents rely on others for many things, when they move to a care home, they give up much of their autonomy, independence, freedom, and control. For instance, if a resident needed anything brought into the care home, or for their social interaction with the outside world, they rely on other people to fulfil those needs.

In this sub-theme I present the data extracts of residents who talked about the different ways in which they rely on others now that they are older and living in a care home. Older care home residents often rely on others for many things, from personal care, finances, appointments, to bringing in items such as toiletries and books to the care home. Most residents are reliant on others outside the care home to bring things in for them. If a resident has no relatives or close friends living close by this can make it difficult to buy toiletries when they run out or purchase simple things such as chocolate or sweets when they feel like it. One way in which care homes can help support residents maintain some of their independence is by providing residents with a shop within the care home. By providing residents with a shop that they can buy toiletries and small items such as chocolate which helps preserve some of the independence and autonomy residents have lost either through ill health and ageing or from moving to the care home. In the extract below Betty provides an example of how residents rely on visitors to bring things in for them. Betty was 91 years old and had lived in a local authority run care home for 13 years. Betty had no family living close by and said that perhaps if she had family living locally, she may have been able to stay living at home for longer.

> INT: So, can you think of anything that would make things better for you here?
>
> RES: We have a shop here, but it hasn't been open recently because there was no one to see to it. There was one of the carers here who used to see to it. She had a child, so that kept her away then. It has been open

now this week and you can buy toiletries and chocolate and sweets, you know? That's very useful.

INT: So, it's nice to be able to go and buy your own things then?

RES: Yes. They're open. They usually announce it. I think it's just the once a week, yes, on a Wednesday I believe. You see how my memory works? It's not working very well. It's Friday today, isn't it? Yes, it must have been Wednesday. Whoever was here, BLANK, she opened the shop and anything you want you can buy there. I'm unlucky really, I don't have any relatives living anywhere near me. Most of the people here do have relatives and they shop and bring things in to whoever they've got in here, you see. *Betty, 91 years old*

Because Betty has no relatives nearby to bring items in for her having a shop within the care home ensures Betty is able to maintain some of her independence. Having no relatives living nearby also has other implications for older adults, Betty describes how this has affect her in the extract below.

INT: Was it your decision to move into a care home?

RES: Well, my health, yes. I had erm hip trouble and one or two other things, and in the end I did have a new hip, but the other one's troublesome but not bad enough to have an operation.

INT: Is that what made you decide to come to a care home?

RES: Yes, and I was 66 when I lost my husband. I was 66 and he was 72. I think there's a lot of hiraeth after him as well, you know? Of course, if I had relatives living near, perhaps I wouldn't have needed coming into a home. *Betty 91 years old*

Older adults often rely on relatives for informal care and support which can also help older adults to stay living at home or in the community for longer. Betty gives an example of this in her extract above where she states that if it was possible, she would have been able to stay at home if she had the support of relatives living nearby. Other residents had similar experiences of having to rely on others to carry out errands or simple tasks, they spoke about how relying on others impacted their independence and mental well-being.

Residents also gave accounts of where they relied on others for entertainment and meaningful activities. In the extracts below Barbara, who was 98 years old and had lived in a care home for one year and 10 months explains how she relies on others for meaningful activities and to go out.

> INT: So, what's the environment like here?
> RES: Well, it's very friendly. All the girls are very nice. Nice girls. And only you've got to sort of entertain yourself. That's the only thing. There's not a lot to do.
> INT: So, what would make things better for you then?
> RES: Make things better if somebody would come and teach me something. *Barbara, 98 years old.*

Later in the interview Barbara talks about a time when she is happy.

> INT: So, what makes you feel happy? Can you give me examples of times you felt happy?
> RES: Oh, I'm very happy when I go out. Very happy. I go out three days a week.
> INT: Oh, where do you go?
> RES: And I'm very happy. I go to my daughters on Thursdays and Sundays. And on Tuesdays, we go down to BLANK Bay. Do you know BLANK? BLANK?
> INT: Yeah.
> RES: We go down there and we have a snack. Then we go outside and sit right down looking over the rocks, right round the back where the fountain is, you know. And then we have ice cream round there. And I'm very happy when I'm down there. [Laughs] *Barbara, 98 years old.*

Barbara's extract above illustrates how care home residents are often reliant on others for meaningful activities and also opportunities to leave the care home and be out in the community. Research on the quality of life of older adults living in care homes has suggested that opportunities for meaningful activities and being out in the community are important to care home residents' well-being (Cooney et al., 2014). Relying on others to facilitate these activities is very frustrating and it is possible that many older adults miss opportunities for meaningful activities which impact on their liberty and mental well-being. An example of this is seen in Virginia's extract below. Virginia was 86 years old and had lived in a care home for a year.

> RES: I used to go every Monday and Thursday and I'd collect a tote for them. I loved that. I knew all the boys in the choir and some of them came up here, the melody boys. Well I must say, the ones I know in the choir, they all come on to me, you know? I think that's nice.

INT: That's good.

RES: Oh, yes. The musical director, I used to see him in Tesco and he'd say, 'Why don't you come to choir practice? Come and visit' I can't ask them to take me because they do things for me in the day, it's not fair to ask them in the night, you know? *Virginia, 86 years old.*

In the extract above Virginia illustrates that she feels that asking staff to arrange for her to go to the choir practice is too much to ask. Residents recognise that staff are busy and do not like to be a nuisance, however, having to rely on others and not wanting to disturb busy staff impacts the liberty of residents.

Reliance on others is important for older adults in care homes, having family close by can keep people at home for longer, as well as providing support with bringing in items and attending appointments. The same loss of freedom and impact on liberty was experienced by other residents in different care homes. Jean was 95 years old and lived in a Local Authority care home, she had lived in the care home for 18 months. In the data extract Jean talks about how things have changed since she had moved to a care home, the main change being her loss of freedom. Since moving to the care home, she is now reliant on others and says she is not '*allowed*' to go out on her own. A big change many residents found as they aged and moved to a care home is how reliant they became on others.

INT: So how have things changed since you've moved to the care home?

RES: Well, I've lost my freedom, I am not allowed to go out now on my own, it's quite true, I got this, but I couldn't go without anyone. *Jean, 95 years old.*

An implication of deteriorating mobility and is not only loss of individual freedom but also the loss of independence. In the extract below Bill talks about how he loves walking but is no longer able to go for a walk on his own. As his mobility has deteriorated, he had gone from walking independently, with a stick, to having to rely on someone to take him outside in a wheelchair.

INT Are there any activities you'd like to do?

> RES Oh yes walking, but it's finished now. I love to, when it was only the walking stick at that particular time I walked on my own. When I'd been going out on my own now it was around the area here, you know. I used to enjoy it of course, when they did the lake it was a big thing, they done the BLANK, that was a bigger thing altogether, but I've got to have somebody to pull and push me in the wheelchair now. *Bill, 89 years old.*

In the extract above Bill illustrates how he is now even reliant on others to go out and enjoy the grounds of the care home. Having to ask for help and wait to fit in with someone else has had a negative impact on Bill's liberty. He is no longer in control of his day having to rely on others to help him get around. Residents also rely on staff for activities and outings, which means if a care home is short staffed the residents have fewer outings and activities, which are both important components of mental well-being.

Residents not only reply on others for meaningful activities and to bring items into the care home but also for helping to keep them in touch with the world outside the care home. In the extract below Shirley, who was 90 years old and had lived in a Local Authority care home for two years illustrates how care home residents also rely on others, and people outside the home to keep them in touch with the world outside the care home.

> INT: Do they help you keep in touch with what's going on outside the care home?
>
> RES: Yes, erm, yes. To a certain extent. You can't expect to be part and parcel when you're not there any longer, can you?
>
> INT: No.
>
> RES: But, erm, yes, when I…when they come I say, right, tell me what's going on and, erm, yes, they do keep you in touch with…with what's going on, you know. And, erm, what else do I really like? It's amazing. You get used to your own company. And…and if there's something, for instance, that you would like to see, you're quite happy…as soon as anyone comes in, I turn that off, you know, for them to see, you're more important than television. But, on the other hand, it's a good second best when…when you are glad of… *Shirley, 90 years old.*

In the extract Shirley states that you cannot expect '*to be part and parcel'* with the outside world when you are no longer there, suggesting that Shirley no longer lives in the same world as those living outside the care home. Relying on visitors to keep them in touch with what's going on in the outside world can lead to residents feeling very disconnected with what is going on in the world. The importance of belonging and feeling part of the community and outside world has been found to be important to older adult quality of life and well-being (Forsman et al., 2011; Moore, 2013) and an important component in models of quality of life (Bowers et al., 2009).

5.5.4 Sub-theme: The trade-off

Making a choice to enter and live in a care home involves a weighing up of personal liberty costs versus care benefits, and it is striking the balance between these that appears to occupy the thoughts of participants in this study. Many residents talked about the 'complete take over' or trade off they experienced when moving into a care home. They often felt that this trade-off had positives as it meant that they were able to let go of some of the responsibilities they had been worrying about, and they felt secure and safe in a care home compared to living at home alone. Residents felt reassured that there was always someone around to help if they needed it. For this sense of security and fewer worries residents felt they had to accept a loss of independence and liberty. In the extract below, Nancy talks about the positives of having someone else do everything for you, but on the other hand, the trade-off for this is that she finds it *'boring'*. Nancy was 71 years old and had lived in a private care home for three years, she talked about how she sometimes forgets that she is not able to do what she wants when she wants to.

RES: Yes, and those boxes, I started doing that, but of course I can't stand for long and that's the problem. And sometimes I really want to go down town you know, to get stuff and I can't go down town, they haven't got the staff to take me. So, I've got to do, not this last year, but the year before that I couldn't get Christmas presents because there was nobody to take me down town. So, that's side of its very depressing and you know.

INT: Yes, how has the change affected you from being at home and then being in a care home?

RES: It's difficult, it has made a big change, but it's not a nice change. You know, it's all to do with independence, losing that independence it's hard. Yes, it's great that I've got, I haven't got to do any washing or ironing, my food is made for me, you know, my bathroom is cleaned.

I haven't got to do anything like that, it really is a life of luxury, but at the same time it's boring.

INT: And you do still miss things?

RES: Yes.

INT: That's understandable. So, what have been the main things you've noticed that have changed?

RES: As I say it's all down to independence, that is the big thing, you know when you're independent, like some of them who are in here, they can't do anything, you know, or where they've lost their independence because you don't want to do it. But it's funny really, quite often I'm sitting here, and I might be watching something on telly and perhaps they're making Mexican food, you know Mexican food looks gorgeous. I think I'll have to make, oh no I can't, you know suddenly comes to me. Oh, I'll have to make some of that, oh crikey no I can't. You know, that's where it gets you, yes that's where it gets you. *Nancy, 71 years old.*

In this section of her interview Nancy is giving examples of what she has given up for this '*life of luxury',* the examples Nancy gives in her interview are relatively simple pleasures that she is denied because she lives in a care home. Another implication of losing independence, sense of purpose, roles, occupation is that it is '*boring*'. This is part of the compromise older adults often make when moving to a care home, in order to feel more secure and safe. Having fewer things to do means residents are less occupied and there are no substitutes to fill the leisure time they suddenly have. In the extract above Nancy also talks about being reliant on staff to go shopping and buy Christmas presents, there are benefits she enjoys but that the trade-off is that her choices are limited and a simple thing like going shopping and cooking a meal she likes are denied her because of resource issues in the care home. She is in many senses, captive.

Nancy's extract above also highlights the changes in independence, and of habit and norms. It also shows how Nancy misses being spontaneous and simple pleasures such as being able to cook and eat something that she wants. Many of these issues could be addressed by increasing the number of staff available to support residents, and many of the residents were aware of the low numbers of staff and commented on how this had an impact on them.

Residents also spoke about how they were lucky to have somewhere to go, suggesting that they should be grateful for having a place in a care home, this also led to feelings of ambivalence and accepting that this was just the way things were. An example of this is seen in Bill's extract below. Bill was 89 years old and had lived in a different private care home to Nancy for six years and also discussed that giving up things was just something you had to accept in later life.

> INT Do you miss being at home, or did you miss being at home?
>
> RES At the beginning I did bach, at the beginning I did, but I sat down one night here and I had a good think, and I came to the conclusion I'm blooming lucky that I've got somewhere to go to, and BLANK told me the same thing. I think she said, if you would have stayed in BLANK that would have been the end of you, because you would have been there all day on your own, you're seeing the odd Carer, BLANK and BLANK would call in, and I would call on you, but at night she said you'd be on your own, whereas here you're not on your own, all you've got to do is buzz, and the Carer is here. It's the best thing I ever did bach.
>
> INT Oh that's good.
>
> RES There is no doubt about it. A lot of people here they can't stand it, they've given up their homes. The point is there comes a point in life when you've got to give way, you've got to give way bach. The circumstances of events tells you that. *Bill, 89 years old.*

Bill talks about how you have to *'give way'* to these changes in later life, however, that some people are resistant to this change. During the qualitative interviews many of the residents talked about having to accept that this was how things were now, that this was a part of ageing and living in a care home. A trade-off for feeling safe and cared for is to *'give way'* to the rules and restrictions, to give up some of your agency in order to feel safe and secure. Some residents seemed more aware of this or discussed it more freely than others. Residents also discussed that accepting the situation or giving way to it was the best way to adapt and feel happy about their new circumstances. Being able to adapt to the challenges faced in later life has been found to be important to maintaining mental health (Robinson, Clare & Evans, 2005).

A similar example is seen in Frances' extract below, Frances was 94 years old had lived in a Local Authority care home for two and a half years. In the extract below Frances discusses how she was not pleased about being in a care home and that she would rather be living at home, however, she has accepted what she feels is a different life to the one she had before moving to the care home.

INT: So can you give me some examples of when you've felt happy here?
RES: When I've felt happy?
INT: Yes
RES: Well I can't say I'm over the moon but I've accepted, put it like that, you, I've accepted I've got to be here. It wasn't what I wanted, I wanted to be in my own home.
INT: Yes
RES: And have the life that I had. I realised that I can't do it so I've got to accept a different life. *Frances, 94 years old.*

A further example of residents describing the trade-off they've experienced is seen in Jean's extract below.

INT: So, has anything been better since you've moved here?
RES: Oh yes, let me think, I haven't got to do any washing, I haven't got to make a bed, I haven't washed sheets, I haven't got to iron, I think all that's done for you, all you do in the morning is top and tail, because I bath once a week. I call it top and tail and then put clean clothes on and then if I've got clothes I think needs a wash, put them in the basket and they take them down the laundry and they wash them, and they come back then ready to put on.
INT: Oh.
RES: It's like being on holiday isn't it. If I was more free like, but you can't have everything, and I wouldn't be so solid on my feet now. I go out to my daughter, she comes to pick me up my granddaughter takes me out, my grandson takes me out. We go to, what do you call the place now down on the bridge, that water park, we go there for lunch. *Jean, 95 years old.*

In the extract above Jean refers to moving to a care home like *'being on holiday'*, suggesting she sees the positive side of moving to a care home. However, in the next sentence she adds *'if I was more free, but you can't have everything'*. This shows that she is not unaware the cost to her liberty moving to a care home has had. She lists all the positives of moving to a care home, and refers to it like being on holiday, except that she is less free. This suggests that Jean is aware of the compromise that's made when moving to a care home, that it is obvious to give up some of your freedom in order to receive the benefits of living in a care home.

In the extract below Shirley, who was 90 years old lived in a different Local Authority care home to Jean for two years. In contrast to other residents Shirley talks about the *'complete takeover'* that happened when she moved to a care home. In the data extract from her research interview below she explains how she came to enjoy having everything done for her. Shirley discusses the worries that she had about living on her own again and how she felt safer living in the care home.

> INT: So, since moving to the care home, how has the lifestyle change affected you? What have you found to be the differences between coming from home to moving into a care home?
>
> RES: Well, it's absolutely different. Of course it is. Because I had a nice…my house was a nice little house. I was proud of it. And, erm, I was capable of looking after myself, cooking for myself, doing…so when I came in, it is a complete takeover. Your food is done and everything. And, er…but, of course, you are very glad of that. And you come to enjoy having it done for you. And I think to myself sometimes, you know, "I'm not doing much." But, on the other hand, I suppose when…if you've been ill, ill enough say to come in, cos I came in the same day that I was ill, erm, I think that I was only ill for a little while.
>
> But I've been here ever since. And then when it was…after I'd been here a certain time, and you wonder sort of thinking, "Am I staying here or going home?", I suddenly thought if I go home, I'll be putting myself to bed. If I heard somebody trying the key in the door, I would be petrified. Why put myself through that? The privacy of your own home…there's so much.
>
> But, on the other hand, if you were gonna be worked up or worried, my thoughts about it and I told my…my two daughters down here, "I'm going to stay here." I didn't think it was fair for them to say, "What do you want to do?" in case they thought it would be better if she went in. And I…they wouldn't think like that. And I wouldn't want them to think that I thought that. So, I said, "I'm making my own mind up and I'm going to come in." *Shirley, 90 years old*

In this extract Shirley is taking us through her thinking and decision-making process, she illustrates that she sees the positives of both living in her own home and living in the care home, she also shows that she has weighed up the effect of any decision on her family. This demonstrates that a decision to leave your own home and live in a care home can be a complex set of judgements about, liberty, safety, and care, in addition to concerns about burden and anxieties. Shirley is content with her decision and indicates that she has made the right decision after considering her options and the impact her decisions would have on herself as well as others. Research has found that when the resident makes the decision and takes an active part in the decision-making process then the move to the care home is more positive than when than when the decision is made on behalf of the residents, without consultation or the residents is told what to do (Boyle et al., 2005; Cooney et al., 2009; Wilkinson et al., 2012; Knight et al., 2020). Comparable to Shirley, several residents found this *'take over'* to be a positive aspect of moving to a care home. Others felt that it was a relief that they no longer had to deal with a lot of the worries they had while living, quite often, alone at home or caring for a partner alone. They no longer had to worry about living alone, or the responsibilities of running a house with worsening health issues and getting older. Another issue residents talked about was that they felt vulnerable living alone at home, by moving to the care home they felt much more secure and were relieved of the reassurance that came from living in a care home with staff always available. An example of this is seen in Joseph's extract below. Joseph was 85 years old and lived in a different care home to Shirley, Joseph had lived in a care home run by the religious order he belonged to for four years. In contrast to Shirley, Joseph had not had an opportunity to consider his options before he moved to the care home, as he explains in the extract below, Joseph's decision was taken out of his hands.

> INT: So you mentioned you've been here 4 years and when did you decide to move to the Care Home?
>
> RES: I was kidnapped. I had an appointment with the Doctor in the Surgery and I found that I couldn't do it, I couldn't get there on my own so I rang up and BLANK, you don't know BLANK BLANK, she is up the road. I asked her to take me to the Doctors and she did to the surgery by the old hospital, what's it called? Is it BLANK Surgery?
>
> INT: I think so.
>
> RES: Yeah, anyway she took me there and I saw the Doctor and then when we came out she turned up and I said where are you going? You're coming to us she said so she brought me here to this room and I've been here ever since.

INT: So it wasn't your decision to…?
RES: Not really no.
INT: How do you feel about that?
RES: Oh I loved it.
INT: You were quite happy though?
RES: Oh yes, quite happy. It solved all my worries and problems because I have always lived alone and I loved shopping and I loved cooking but gradually bit by bit that disappeared and instead of being a pleasure and something I enjoyed it because a burden and a worry and so I came here and they informed my brother and he sorted…I lived in BLANK, you can see it from here. Do you know BLANK?
INT: Yes I do.
RES: I lived there and it sorted the flat and my car and all that sort of thing but I've been here ever since. I love it yeah. All those worries are taken away from you. I used to love cooking and shopping and all that kind of thing but you don't really notice how it is gradually bit by bit becoming incapable or indifferent or whatever the word is yeah. Anyway, she brought me here and I've been here ever since yeah. *Joseph, 85 years old.*

Looking back Joseph felt that moving to the care home was the right decision and, in his extract, he does not look back at the event negatively, even though he was not involved in the decision making process Joseph found that the move to the care home addressed a lot of the worries he had had from living at home struggling to manage and was therefore happy with the compromise of moving to a care home. This was one of the positives of moving to a care home that many residents discussed, and also addressed some of the worries they had while living at home such as loneliness, managing practical tasks, and their safety and security. A sense of security and not having to worry about the practical task of living along was termed 'enhanced comfort' by Cho et al. (2017).

Not all residents viewed the move in the same positive light, conversely, in the extract below, Nancy can be seen to argue that her agency had been removed and her liberty affected from the move to the care home.

INT: Was it your decision to move here or did something happen and then the decision was sort of made for you?
RES: Oh, I had a couple of black outs, laid on the floor for about 4 hours.
INT: Oh gosh.
RES: They said that I'd need 24-hour care and the council wouldn't give me 24-hour care, so my Social Worker advised me to come here. Advised

me to go into a nursing home and my sons as well, because they were worried sick about me, being on my own and so I thought well yes, it's the best thing for me really. So, I said yes find me a nursing home, but I said what I want you to do is when you go in through the door, take a sniff, breathe in and if you can smell urine, forget it. So, they came to this one I think, this was the third on the list and the Social Worker had said I don't know if you'll get her in there, they're very good, they'll full up. But indeed, there was a vacancy, so BLANK and BLANK had a word with the Social Worker, with the Boss here and she said well bring your mum down, so I came down and I chatted to her and they showed me the room, it wasn't this one, it was upstairs, and I liked it, so I decided to come here. But now when I think of all the stuff I've lost you know if they told me tomorrow I could go back to my bungalow, you know but a different bungalow I haven't got any furniture, I lost everything.

INT: Yes.

RES: I had to give everything away and there was some things that had to stay in my bungalow. You know, they couldn't get the settee out, so that had to stay, I put wooden flooring down and I spent thousands on the house and the back, the garden, so here I am now. And because I occasionally have a fall, I am staying here for the rest of my life. So, if I live to be 100, I've got another 30 years here.

INT: How does that make you feel?

RES: How does that make me feel? Well sometimes, some days I get up and I'm feeling good, but you see I'm finding it difficult to walk and so a little job to me is a big, I mean if I want to go out and water my plants I've got to get one of the nurses, a carer to come with me. So, it's you know, I get very cross. *Nancy, 71 years old.*

In the extract above Nancy gives examples of the things she has had to '*give up*' when she moved into the care home. For her it has not been a fair compromise, and she still mourns the loss of her bungalow, belongings and her liberty. Nancy argues that her agency has been impacted by using phrases such as '*I'm staying here for the rest of my life'*, on the other hand she uses her agency to protest, to show her resistance during the research interview. When referring to how long she will have to stay in the care home, she frames it as if it is a sentence, she is being held against her will and preference. This is in contrast to experiences such as Joseph's and Shirley's who state they are content with the move, and the trade-off. For Nancy she feels that she has had to compromise too much to feel safe and supported. Nancy feels frustrated that she is not able to do things independently. Having to rely on staff to help her do activities she enjoys or needs to do makes her feel *'very cross'*. The tasks she wishes to do are '*little jobs'* but because she is struggling with her mobility Nancy now finds them to be a big task that she needs assistance with. This change in her ability to function independently and enjoy meaningful activities has an impact on her mental well-being, and again shows the importance of simple pleasures to maintaining residents' mental well-being in care homes.

With people living longer, it is possible that residents spend many years living in a care home. It is important that they feel comfortable and at home and that every effort is made to maintain and promote their mental well-being while they live in the care home to ensure they can lead happy fulfilling lives.

As can be seen in the interview extracts above, choosing to move to a care home is a complex decision. Residents do not necessarily actively choose to move to a care home, it may be the only option available to them due to a variety of reasons such financial or health reasons. They may decide that moving to a care home is their only option or they may 'give in' to pressure from family, social workers, or health professionals. The 'trade off' may be used to justify or rationalise a decision or choice that they did not want to make or was forced upon them, or they may be happy and reassured by the move to a care home. We can assume that individuals have already weighed up their situation and decided that while things may not meet their ideal type, it may still be better than alternatives. The freedom they currently have may not be as complete as previously, however, it is a modest freedom nonetheless and affords some comforts and opportunities.

5.6 THEME 2: CHANGES IN IDENTITY

The second theme was developed from codes that related to residents' experiences of identity being important to their mental well-being. Extracts and analysis presented in this section and sub-sections have a shared meaning and are underpinned by the central organising concept that changes in identity contribute to the mental well-being of older adults in care homes. Residents discussed how these experiences contributed to their loss of identity, residents also mourned their previous selves as well as building new identities and purpose while living in a care home. The sub-themes within the theme of identity were 'sense of purpose', 'possessions and self-identity', and 'ageing assumptions and frailty'. A sense of purpose and occupation contributes to self-identity, without an opportunity for meaningful activities and occupation residents' sense of self and personal identity is negatively impacted (Gleibs et al., 2011) and having a role and meaningful activities that give an individual a sense of purpose is important to a person's identity and mental well-being (Godfrey & Denby, 2004). Residents' possessions and belongings are also important to their sense of self, and the way ageing assumptions impact older adults' own perceptions of themselves and has a negative impact on their self-identity (Levy, 1996; Herzberg, 1997). In their interviews residents can be seen reflecting these background expectancies and assumptions.

5.6.1 Sub-theme: Sense of purpose and occupation

Many of the residents I interviewed talked about how their sense of purpose had changed, and that they found it difficult to occupy their time since moving to the care home. Many residents spoke about needing to keep occupied and mentally active, about the importance of reading, using their laptop, and having something to do, these activities helped give them a sense of purpose and occupation which was important to their mental well-being. Some residents even went as far as to say that they found living in a care home 'boring'. Having a sense of purpose also contributes to our sense of self and our self-identity (Murphy et al., 2007). Boredom affects our social identity and those who experience boredom often feel a lack of meaning (van Tilberg & Igou, 2011). Having a sense of purpose and feeling one's life is meaningful impacts mental health and well-being (Thoits, 2012) and has been shown to decrease with age (Ryff, 1995).

An example of how a lack of meaningful activities can impact care homer residents can be seen in Barbara's extract below. Barbara was 98 years old and had lived in a Local Authority care home for one year and 10 months. The main reason Barbara had moved to the care home was because of her deteriorating vision, but Barbara was also hard of hearing which made engaging in certain activities and communicating with others difficult. She had been living alone in her own home before moving to the care home but as her eyesight had deteriorated, she found it difficult to manage living alone and her family decided that moving to a care home would be the best option for her. Barbara found life in the care home difficult because of her loss of vision and found that there were many things she missed out on because of this. During the interview Barbara talked about how she missed being able to sit and read or write, how she missed knitting and watching TV and films. In this extract Barbara encapsulates what it is like for her now that her vision had deteriorated, how lost she felt and how her life has changed since this loss.

> INT: So, did you feel you had more of a sense of purpose when you were at home?
> RES: Well, yeah. And the thing is, you see, nobody understands, if you can see, you don't need anybody to keep you company. You can keep your own company. You can read books. You can write. You can draw. You can….well, you can do everything. You don't think about it.
> INT: No, no, you don't.
> RES: And you've got, you're writing now and you're looking at me. You just think about it.
> INT: No, you take it for granted.
> RES: If suddenly your eyes went, then you'd be lost. Cos all the things you used to do you can't. And it's a job to know what to do in its place, you see. *Barbara, 98 years old.*

As Barbara illustrates in the extract above, she missed her independence and felt a sense of loss over the things that she was unable to do now. For Barbara, a deterioration in her eyesight had an impact on her sense of purpose and occupation which had an impact on her self-identity. Barbara emphasises how important her eyesight is, and what losing her eyesight has meant for her. She felt that she had more of a sense of purpose when she lived at home, and when her eyesight was better. Barbara felt that it is often taken for granted by people who have it, and that she felt lost now.

During the interview Barbara talked about the lack of activities that were available to her because she was visually impaired. She felt that the care home did not cater to her needs and found it frustrating that she was unable to do the activities she used to enjoy or the activities the care home offered her. Barbara also talked about the difficulties she had in attending activities outside the care home that were for visually impaired older adults, for example, knitting for the blind. Later in the interview Barbara illustrates her boredom and lack of meaningful activity by explaining how she does not have anything to do all day and that it is important to her to keep occupied and do something that interests her.

> RES: But, I mean, I don't…I must be honest. I…I haven't got a lot to do all day. And that's the worst part.
> INT: So, do you feel that's what's important to your mental well-being? Being able to do things?
> RES: It is. It's very important to me. Very. I don't like sitting doing nothing.
> INT: So, do you have any opportunities where you're able to contribute ideas to the activities that you do here?
> RES: [whispers] There's no activities
> INT: There's not enough?
> RES: What activities.
> INT: So, what sort of things would you like?
> RES: Well, something interesting. I mean, something…oh, I can't explain. Well, all I can say is I'm not doing anything and that's it. That's it.
> INT: And that's…that's the main issue?
> RES: It is the main issue. It means everything.
> INT: Do you like it when people come in and perform? Or do you prefer to do something rather than watch something?
> RES: Well, yes, it is, really. I mean, you can always sit there and…you're still not doing anything. And others are always doing it. So, I mean, you want to be able to…something you can join in with, you know. But, to be quite honest, I get bored stiff. And that's the answer. *Barbara, 98 years old.*

There were also social implications to Barbara's vision and hearing loss, she felt isolated and socially excluded because of her impairments. Having an impairment had an impact on Barbara's identity, autonomy, relationships, independence, hobbies, sense of purpose and interests. This would have a significant impact on any individual's mood and mental well-being. There is a need to have activities that cater for people with impairments, and to be more inclusive of individuals with impairments that prevent them from accessing activities.

During the interview Barbara was quite angry and abrupt when we discussed the topic of activities. Later in the interview, in the extract below, Barbara compares herself to the other residents, she refers to them as 'mostly sitting'.

> INT: So, do you feel that there's a sense of community here?
> RES: Oh, yes. They're a nice…they're a nice crowd, mind, but, er, mostly sitting.
> INT: Is that important to you to feel part of the community?
> RES: Well, it's important to do something, not just sit. They're quite happy to sit all day and stare at the wall.
> INT: But you're not content with that?
> RES: Of course not.
> INT: No, that's understandable.
> RES: And, I mean, they have a big television on all day. They sit blaring out and nobody's taking any notice. Now that sort of thing would drive me up the crazy. They've got it downstairs, the big one, you know and it just plays all day. Nobody's…nobody's looking at it. *Barbara, 98 years old.*

By referring to the other residents as 'mostly sitting' Barbara is separating herself from the other residents, she is not like the other residents, she has a different identity as she feels that she needs more meaningful activities than sitting in front of the television all day. These three extracts from Barbara illustrate how important meaningful activity and a sense of purpose are to her identity and mental well-being.

In the extract below Nancy also gives an example of how a lack of meaningful activity leads to boredom.

> INT: So, the first question is what's your daily routine like?
> RES: Boring, boring, you want a run down of it?
> INT: Yes, a typical day and what you find boring as well?

RES: Well it's the repetition, it's you know, it's very, I do look forward to the weekends for no reason, just look forward to them. But whereas you would say you look forward to the weekend because you have a lie in on a Saturday or Sunday. Nurse comes in at half past seven with your tablets and that's it you're up, you know. You've got to get up, they've got their routine to keep to, they've got to get everybody up and fed and washed and what have you. And so, it's nothing different, the tablets and you know.

INT: What happens after, do you get up and dressed and…

RES: Get up, you get dressed and I mean I sat here, I've been here now since I was dressed about 10 o'clock and I've been here sitting, doing a bit of work, that's why I'm trying to do a bit of work, to do something you know. I couldn't sit here looking out of the window, I started that little garden outside. *Nancy, 71 years old.*

In Nancy's example she demonstrates that she needs to comply with the care home routine, even when she looks forward to the weekend to have a 'lie in' as she used to when she was at home. Nancy is comparing herself now to her past self when she lived at home and how things have changed. Due to the care home routine Nancy is up early, even on the weekend. She is then left to fill her time and try and occupy herself. Occupation has been found to be important to well-being and has been found to improve the well-being of older adults (Atwal, Owen & Davies, 2003).

5.6.2 Sub-theme: Possessions and self-identity

One of the consequences of moving into a care home is that residents lose and give up their homes and their belongings. Our belongings and possessions are valuable to us as they carry meaning and are considered to be an extension of ourselves (Belk, 1988). Our belongings therefore contribute to our self-identity and losing these possessions would impact residents' self-identity and mental well-being. One aspect of moving to a care home is having to fit, often, a lifetime of belongings into one room, and residents must make the difficult decision of what to do with their belongings and homes. The residents I interviewed spoke about the possessions and homes they had left behind before moving to a care home, and how much they missed their belongings and homes. In the extract below Doris talks about how difficult it was to move to the care home and not bring her belongings with her.

INT: There we go. So what is your daily routine like?

RES: I've lived here in a fashion that I've never lived before because I had a big…well there's my house.

INT: Oh wow

RES: Yes it's lovely.

INT: That's a big house.

RES: It was.

INT: Was that a big change then?

RES: Ooh it was horrendous. I didn't settle for ages because it's one room and I've got too many tiddly bits as you can see and all along there but I couldn't bring furniture really. The only things I've kept are the two big armchairs, that table and these two armchairs. They are not big are they?

INT: No.

RES: And three stools and one oh very sparse room for keeping stuff compared with a house.

INT: Yes. Was it difficult to sort of downsize from that house to just one room?

RES: It was. And I was always in a muddle, always. It's comparatively tidy today. I didn't settle easily at all. *Doris, 94 years old.*

In her interview extract Doris talks about not being able to settle easily when she moved to the care home. Downsizing possessions can cause a huge amount of stress for residents as many residents find downsizing difficult to deal with, along with losing their home and any memories that are tied to their home and possessions that they have collected over the years and may have sentimental value to them. Our belongings and our possessions reflect important identity elements and have been found to provide residents moving to care homes with a sense of identity continuity during the move from home into a care home (Kroger & Adair, 2008). Nancy also discussed the belongings that she lost when she moved into the care home. Similarly, to Doris, Nancy also found it difficult to downsize from a house to a room in a care home. In the extract below Nancy illustrates this by discussing the way she is trying to decorate her room and make it her own.

INT: Did you sew that here?

RES: Yes, and I put it up, I turned the hem up on it and that's been done the wrong way around look, I asked her to put it up for me and she's done it the wrong way around. I just wanted to cover the thing, so I did it and I've had it hung up with nails, little pins you know. But I think it's going to have to come to be done again, so I did that then I thought what I might do is cover my bookcase.

INT: Oh yes.

RES: But somebody said oh I'd be far more interesting.

INT: That's true with the books on display.

RES: Oh, you should see the books that I've given away, oh, you know all the books I collected in College, the books I'd bought on Archaeology, it's amazing what I've given away. *Nancy, 71 years old.*

Nancy had studied many courses and took an interest in a variety of topics from interior design to Archaeology which meant she had collected many books over the years. Studying, reading, and teaching were a big part of her identity as someone who had trained and worked as a teacher and who took an active interest in other areas. Reading her books and talking to others about her interests was a significant part of Nancy's identity and she had to give these books away. Joseph also echoed Doris and Nancy's experiences of having to give up his home and leave behind some of his possessions. Joseph was also an avid reader and tried to keep up to date with his reading on religion. In the extract below Joseph is expressing that he left many of his books behind when he had to leave his flat. The ones that he keeps in his room are all that have been rescued from his flat when he moved to the care home. Having to leave his home and belongings that are important to him would have a significant impact on Joseph's mental well-being and his ability to maintain his mental well-being while living in a care home.

INT: Ah you have a lot of books.
RES: Yes.
INT: And ones behind you as well.
RES: This was only what was salvaged from my flat when I gave up my flat, yeah. *Joseph, 85 years old*

Belongings, especially in old age, can hold meaning for care home residents. Research has found that care home residents linked important relationships, personal and historical events, and their former selves during past life phases to their possessions (Cram & Paton, 1993). These possessions are even more important when our sense of self is threatened as a result of institutionalisation. In care home residents, possessions are important and have been linked to memories of people, memories from gifted possessions, memories of creator, memories of time or place, and possessions as part of self, which are all related to self-identity (Cram & Paton, 1993).

5.6.3 Sub-theme: Ageing identity and frailty

In later life assumptions are often made about how older adults behave and what they are able to achieve (Levy, 1996). These assumptions not only have an impact on how older adults are treated but also how older adults view themselves, and their self-identity (Levy, 1996; Herzberg, 1997). Helen illustrates how the impact of views on ageing effects how she views herself in the interview extract below.

INT: Do you get much of a chance to cook?
RES: Oh, you wouldn't get…no.
INT: No?
RES: There'd be…there'd be, erm, health hazard, wouldn't it now?
INT: So, no activities involving…?
RES: You can't allow somebody of 94 to start cooking. We'd come up here, put on a nice grill and put a steak and mushrooms and onions and…
INT: How does that make you feel, sort of thinking that you're not able to do something that you want to do?
RES: Well, I…I know…I feel… that I know I can't do it.
INT: Would you…?
RES: I wouldn't be…I mean, to stand for say even quarter of an hour.
INT: Yeah, it's a long time.
RES: A long time. I wouldn't. Er, although you could have a high stool.
INT: That's true. Or if you had support as well.
RES: I don't know. No. Yeah, yeah. *Helen, 93 years old.*

In her interview extract Helen talks about how she is unable to do activities such as cooking, which she used to enjoy, not only because of her health but because *'you can't allow'* someone of her age to cook. Using language such as this reflects the wider social view that older adults are not capable of doing things, and Helen has integrated this assumption into her own world view. It is important that residents can participate in activities that are meaningful to them, even when their abilities and health mean they are unable to do things unsupported at home. The negative assumption that older adults cannot cook has a negative impact on their identity, being in a care home should empower residents and provide them with the accommodations and support to participate in activities, that we often take for granted, that they enjoy and find meaningful. At the end of the data extract Helen suggests that she could possibly use a high stool to sit on while she cooked, with this she challenges the previous statement and the view that she is too old and not allowed to do the activity, she is thinking of ways it could be achieved. By suggesting solutions to this assumption that she is not allowed to cook, Helen is showing her resistance and asserting her agency, she is directly challenging her previous view and the identity of an older adult being unable to cook due to their age. Helen has thought about this situation and can see a way where it could be achieved. It is important that staff engage with her as a knower in order for them to have the full range of epistemological resources at their disposal when making decisions. Therefore, it is important to engage with residents as people with contributions to make in order for decisions to be co-produced and person-centred and not only assessing them on an individual basis.

Residents were seen to view themselves differently because they were older and living in a care home, they no longer viewed themselves as independent individuals with the same freedom, autonomy and agency as younger adults. During the qualitative interviews there were many instances where residents demonstrated that they had taken on and internalised assumptions about older adults being incapable of being independent or participating in activities. In the extract below Anna who lived in a private care home gives an example of residents reflecting the background expectancy of older people not being capable.

> INT: So, was it your decision to move to the care home?
>
> RES: Oh definitely, definitely. I mean if I stayed with my daughter, we were quite close, but she would have been stuck you know, you can't leave an old person like me alone in a home. And it's worked out very well, but she pops in all the time and the relatives all come to see me at the same time, so that's good too. We don't do a lot of things, but I am just lucky to be able to read and I get the newspaper that I read and there are other things that I can do. I am lucky, I know I'm lucky at my age to still be able to do these things. *Anna, 96 years old*

In her interview extract Anna says *'you can't leave an old person like me alone in a home',* she has internalised the view and taken on the identity of an older person who is incapable of being left on their own in a house. Having a negative view of growing older and ageing and internalised the view that older adults are dependence and incapable is not conducive with mental well-being (Herzberg, 1997).

Assumptions about people's abilities based on their age or whether they live in an institution such as a care home or hospital can be damaging to their identity and mental well-being. In a study with older adults in hospital Ballinger and Payne (2002) found that staff assumed incapacity and controlled risk for all patients. Capacity was not assessed on an individual basis and staff rigidly controlled risk for all patients and assumed incapacity because they were in a hospital setting. It is important to assess residents on an individual basis and also individual situation, residents should always be involved in decisions made about their care if at all possible. If they come to the conclusion themselves that it is not safe, or too much of a risk for them to do it will have less of a negative impact on their well-being than having the decision made on their behalf (Furness, 2011).

Mobility issues and impairments are difficulties that many care home residents face as they grow older, and are often a common reason for older adults to move to a care home. During the interviews residents talked about their mobility issues and impairments being part of growing older and their identity as an older person. In the interview extract Helen talked about the how her freedom has been restricted since she has grown older.

INT: So, since moving to the care home, is there anything in particular that comes to mind that you feel is…is worse than before you moved here?
RES: No, nothing except, as I said, the freedom of…
INT: The freedom. That's understandable.
RES: And, I mean, that…that would happen wherever I'd be because I wasn't able. The…the legs were so…no matter where I was, I…I wouldn't have the freedom that I had before. And travel. The freedom to travel. That was another thing.
INT: So, you think that that's a big part of growing older, that your freedom becomes restricted?
RES: Oh, yeah, definitely. The freedom. Yes, I miss freedom.

INT: That’s a really interesting point.
RES: And choice…and choice of what you can see or what you can do. I mean, I would love…as I say, flowers, I’d love to go to gardens now. You know, poppy gardens.
INT: Yes.
RES: And enjoy a day in a garden, yes. And see the different… *Helen, 93 years old.*

Interestingly, Helen felt that the lack of freedom was not only because of the move to the care but also due to growing older. Helen associated ageing with a lack of freedom, and now this was part of her identity as an older person living in a care home. This suggests that Helen has internalised the world view that as you grow older you will have less freedom. She is reflecting the background expectancy that with age your freedom and choices are impacted negatively, her identity is that of an older adult who is restricted. She also felt that a lack of choice and having less control of her life was a part of growing older. Older adults have been found to have more negative attitudes to ageing than professional caregivers (Janecková, Dragomirecká, Holmerová & Vanková, 2013). Helen missed having the freedom to travel, and to visit gardens.

Many residents spoke about giving up driving in relation to loss of independence and identity. Residents were often told by family members that they needed to stop driving. In the extract below from Beverley who was 92 years old and had lived in a religious care home for a year and three months, she illustrates how important driving is to identity as an independent person but also for socialising and maintaining relationships with family and friends outside the care home.

RES: I’ve lost touch with other friends.
INT: Has that been since moving to the Care Home?
RES: Yes.
INT: Oh that must be difficult.
RES: Well they live at a distance, my husband and I used to visit them, I can’t do that anymore.
INT: No, no, it makes it more difficult.
RES: I lost my car too, I couldn’t drive anyway now with the amount of traffic, she packed up on me, my children said, I had a Clio. My family said no, it’s better for you not to drive, and they were right. That was

> my independence, when I lived in, do you know BLANK Gardens? *Beverley, 92 years old.*

Beverley's interview extract above demonstrates an example of older adults being told not to drive and the impact that this has on their identity as an independent person. It is as much about loss as it is about freedom and independence, but it also again shows the Beverley presenting this as a combination of weighing up decisions and interaction with family members expressing concerns.

Dorothy who was 91 years old and had been living in a Local Authority care home for 18 months shared a similar experience to Beverley. She also noticed the loss of her independence since moving to the care home. Dorothy spoke about the difference between herself now and how just two years ago she was driving her car. In the interview extract below Dorothy is comparing her past identity as an independent person to her identity now that she has moved to a care home.

> INT: What have you found to be the main differences from living at home and living in a care home.
> RES: Oh yes, a big difference. I mean, two years ago I was driving a car.
> INT: So, it's a big change then?
> RES: Oh yes, a big change.
> INT: Anything else you've found different?
> RES: Your independence is gone, isn't it? I've got a good family.
> INT: Well that's good. Has that helped with the move?
> RES: Oh, yes.
> INT: So, has anything stayed the same since you've moved to a care home? You've found that hasn't changed much in your life?
> RES: Well, it's a big change from being able to get in the car and go and be in the home. I'm lucky that I can walk about. *Dorothy, 91 years old.*

Dorothy's extract illustrates how quickly things can change and independence can be lost. In the extract Dorothy also illustrates the contrast between her life now and how much more independent she was then when she could drive, she is mourning the loss of her identity as an independent person that driving afforded her.

Residents also discussed examples of when care home staff made assumptions about their likes and dislikes and commented on the appropriateness of some of the activities in the care home. Their examples illustrate that assumption were made based on their identity of an older adult living in a care home that they would enjoy these activities. In the extract below Patricia gives an example of this. Patricia was 88 years old and had been living in a Local Authority care home for two years.

> INT: Do you do any activities in between the meals?
>
> RES: We've done a few. I'm afraid I was anti, because oh, it was just around Christmas and they wanted us to be drawing and making things. I don't want to do that because I'd be teaching that. That was, you know … I don't know what they thought of me, but anyway I just didn't. They do have … I suggested why didn't we have exercises? Because I rely on this and it does make you a little …
>
> INT: Well you lean over it, don't you?
>
> RES: Yes, and I do try standing at the wall and getting straight and so on. I said it would be better for us because I felt that they were doing the pictures and so on for them, and for the building. We needed exercising. *Patricia, 88 years old.*

Patricia explains that the activity is not for her and gives the reason that she was once a teacher, and it would be one of the activities she did with the children she taught and therefore not of interest to her or part of her identity. Patricia also describes some of the activities that would be of interest and use to her, suggesting she has thought about this issue and thought of an activity that would be more appropriate for her. Later in the interview Patricia described another instance where an assumption was made about what she liked.

> INT: That's good. So, you definitely like reading.
>
> RES: Large print, that's right. It'd always be that she'd bring me another one, you know? Here's another one for you to read. I don't like to say, well I don't like Mills and Boon much. I don't. I've read them, but I don't want to sit here reading Mills and Boon, thank you. I can't say that to her, you know. *Patricia, 88 years old.*

In the extract above Patricia illustrates another example where an assumption has been made about what a care home resident’s interests are. It is also another example where a resident does not want to ‘bother’ a member of staff and illustrates the reality that many care home residents do not have their voices heard or many opportunities for choice.

5.7 THEME 3: IMPORTANCE OF RELATEDNESS

A third, and important, theme that was related to the mental well-being of older adults in care homes was developed through coding and reflecting on the qualitative interview transcripts. I defined this third theme the ‘importance of relatedness’. The extracts and analysis presented in this section and sub-sections have a shared meaning and are underpinned by the central organising concept that relatedness is important to the mental well-being of older adults in care homes. The sub-themes within this theme are ‘interdependence’ and ‘maintaining relationships’. Residents discussed how their experiences of relatedness and connectedness were important to their mental well-being and gave examples of when interactions with others had an impact on them. Residents also spoke about the challenges they faced to maintain relationships, in addition to developing new friendships and relationships within the care home. Social relationships and social participation have been found to be important to well-being (Smith, Borchelt & Maier, 2002), this was also found in the qualitative interviews with the care home residents and is presented in the extracts and analysis below.

5.7.1 Sub-theme: Interdependence

Interdependence refers to the process of individuals interacting with each other and the impact and influence an individual can have on another’s experiences, thoughts, emotions, and behaviour (Van Lange & Balliet, 2015). Kitwood (1997) also suggested that interdependence, the way in which others treat and interact with an individual impacts their personhood which has a significant effect on resident’s experiences in care homes and contributes to their mental well-being. Within social psychology personhood is associated with an individual’s sense of self, self-esteem, their social interactions and relationships with others and their impact. Several residents spoke about the pressure they felt from family members and professionals to move to a care home. This pressure usually accompanied a time of loss and distress. Loss of loved ones was a common topic that residents spoke about in the interviews. Many residents had experienced the loss of a spouse before moving to the care home. In the extract below Doris looks back and reflects on the time when her husband was ill and the pressure she felt to move into the care home.

RES: the Doctor said if you don't get him out of BLANK which was where we were living before we moved here and I thought of this place because it's run by BLANK and both of us were so we came here to the flat and then they were after me to come in here because my husband was ill and he was in hospital most of the time and he died and that was a big thing and then I got more and more and more pressure, not nasty but persistent and in the end had thought maybe they were right and I came here. But I had a big sitting room, quite a nice hall with a recess for keeping clothes in and a lovely bathroom which we bought with a new bath and a new shower, new toilet everything was new in there because I didn't like the way it was set up, and we lived there for 20 years me and him.

INT: Gosh.

RES: Perhaps not quite 20 years but I can't remember the dates when we came. Sarah will tell you if you…would you ask her?

INT: Yes, I can ask.

RES: Not now but ask her when we came here when we left the little flat over there and it was lovely and we bought new sanitary stuff like bath and a shower and toilet, wash basin which cost an awful lot of money.

INT: 20 years is a long time.

RES: I loved it too.

INT: It's home isn't it?

RES: And then they said you must come in here because it's too much for me looking after him but I didn't like it and he died and I've survived.

INT: Did you move here after he died then?

RES: I was under a lot of pressure from people and it was true up to a point because they clean my room and do all my laundry, ironing, and they are very nice, the helpers. *Doris, 94 years old.*

Doris describes her husband's death as *'a big thing'*. This was a huge loss for her, and she still felt persistent pressure from others to move to a care home. The pressure she felt from others to move to a care home at a time where she was grieving and needed understanding and support from others was very difficult for Doris. She describes the pressure as '*not nasty but persistent*', however, any persistent pressure to do something an individual is not happy with could be considered coercion. Doris' interaction with the people around her had impacted her negatively and caused her distress. Doris did not particularly want to move to a care home especially at such a difficult time. If this had happened at any other time of life, there would be more support and understanding, and consideration for the loss of a significant relationship in her life and the home where she and her husband had lived together.

Virginia who lived in a different care home to Doris also experienced similar pressure when deciding whether to move to a care home. In the extract below Virginia gives an account of how others put pressure on her to move to a care home.

> INT: How long have you lived here?
> RES: I came last May. No. I didn't think I'd end up in here, mind, but they told me I wouldn't manage on my own.
> INT: What made you decide to move here?
> RES: Well, my family told me, 'You won't cope on your own now,' and the social worker said, 'You'll never manage on your own.' So I thought oh well, so I gave in. It's the best thing I've done. *Virginia, 86 years old*.

In the data extract Virginia mentions that she did not think she would end up in a care home, but that pressure from family and social services meant that she *'gave in'* in the end. Using words such as *'gave in'* suggests Virginia felt pressured to moving to the care home, much like Doris. Virginia also says, '*I didn't think I'd end up here'*, demonstrating that she did not view the move to the care as a positive one and felt ambivalence towards the decision to move to the care home and that she had been worn down by others saying that she would never manage on her own. Fortunately, Virginia felt that it was the best thing she had done, some residents felt the same, that the move to the care home had turned out to be positive. However, many residents did not feel the same, they felt pressured to give up their home and move to the care home, which can lead to a feeling of complete takeover and have a negative impact on residents. Many residents viewed this negatively, they felt they had lost their independence, freedom, and autonomy.

The importance of positive interactions with staff and developing a good relationship has been found to have a positive effect on resident mental well-being (Gleibs et al., 2014). Often staff do not have the opportunity to get to know residents or to stop and talk due to low staffing levels and a task-oriented approach to care. As seen in resident interviews residents notice the lack of time staff have to speak with them and spend time with them and it has an impact on their mental well-being. In the extract below, Nancy illustrates how busy staff are how important it is for her to have positive interactions with them.

> INT: So, what's the environment like here?
> RES: What do you mean darling?
> INT: Like the sort of atmosphere, the environment within the care home?
> RES: It's good, it's good. It's better when some of the staff are on duty, you can tell the ones that are a lot of fun you know, but you see one of the girls told me they've got so much work to do they haven't got time to sit and talk to us.
> INT: No.
> RES: You know, and they feel it as well.
> INT: Would you like that someone to sit and have a chat with you now and then.
> RES: Oh yes, very often they come in and I'd say have you come for a history lesson. Because when they're doing me they'd say something, and I'd say oh yes but look at this and I'd show them, oh I didn't know that Nancy you know.
> INT: You're a teacher as well.
> RES: I'm a teacher as well, yes. They did ask me if I wanted to set up a little lecture thing for, but there's only three of us on this side who are compos mentis, the rest are you know they're away with the fairies.
> INT: Oh, I'm sure the staff would enjoy as well.
> RES: Yes, but they haven't got time, see. Because believe it or not when they, on the night shift for example when they've put everybody to bed, they've got to clean the vegetables, do the washing, do some ironing, you know they've got to do all that.
> INT: It's a busy day for them isn't it.
> RES: They have a busy day and a busy night. *Nancy, 71 years old*

As Nancy mentions above, residents often rely on staff for socialisation, however, staff are often too busy to spend time getting to know and talking to residents. She illustrates her point by listing the tasks that staff must do while they are working, indicating that the staff's lack of time has not gone unnoticed. Interactions with staff are incredibly important to the mental well-being of residents, often staff and other residents are the main sources of social interaction residents have. Staff are often focused on meeting the physical needs of residents but there is less focus on meeting the psychosocial needs of care home residents (Hancock et al., 2006).

Residents are aware that their care home is short staffed and the implications of staffing levels on their ability to do activities or go on outings outside the care home. During the interviews residents also discussed how having busy staff made them feel. In the extract below Joseph describes how it feels when staff are rushing trying to complete tasks as quickly as possible, after a member of staff has quickly entered his room to offer him a cup of tea.

> RES: Do you want a cup of tea?
> INT: No, I'm okay thank you.
> RES: She's very flash you know, she does it too quick. The various helpers have various personalities. She's in and out, in and out, in and out, you know and sometimes it makes you feel you're a nuisance but there we are. And some of them are very chatty you know and more sympathetic to your situation but what was the question you asked? *Joseph, 85 years old.*

This type of task orientated environment can lead residents to feel that they are a burden, or a nuisance and they do not want to '*bother*' the staff. Joseph's extracts explains this well, the member of staff is more the likely trying to work as quickly and efficiently as possible, making sure all residents have teas and coffees before moving on to their next task. However, to a resident this can make them feel that they are not important, that they are just a task to be completed quickly. Joseph also refers to staff that take the time to talk to him as being '*sympathetic to his situation'*, Joseph values the time some staff take to interact and talk to him.

Person-centred care encompasses different principles of placing the individual at the centre of their care and caring for individuals as individuals and tailoring their care to meet their needs and preferences (Health Foundation, 2016). Meaningful interactions are therefore important to good quality person-centred care. Care home staff are often busy and over stretched which leads to less time available to communicate and respond to residents. Their time is restricted and therefore the care they deliver is less likely to be person-centred and more likely to be task-orientated which has an impact on residents. Kitwood argues that a consequence of not engaging or facilitating communication and residents' voices going unheard was dependency (Kitwood, 1997). Kitwood (1997) also discusses the microstructure of therapeutic communication and applies counselling methods to dementia care. These methods such as holding, and validation could also be applied to the care of residents without a diagnosis of dementia. Many of the residents interviewed commented on how busy the staff were, and how they did not have enough time to talk with them or to facilitate trips out or activities. The residents were understanding of the time constraints put on staff, but it still had an impact on how residents felt. Care homes need to consider that even small interactions are meaningful, and the negative impact being rushed or dismissed has on older adult mental well-being.

Care staff being too busy to support residents and interact with residents also has an adverse effect on resident mental health. Research suggests that nursing home nurses and staff should be given more time to interact with their residents as nurse-patient interactions have been found to impact resident mental health (Haugan et al., 2013). The behaviour of staff and their interactions with residents also have a significant impact on the mental well-being of residents. The impact staff have on residents can be positive, from positive interactions that help to maintain and promote residents' mental well-being or a negative interaction that are detrimental to residents' mental well-being. Kitwood also discussed the impact of care home staff's behaviours and interactions on mental well-being and personhood in his work with care home residents living with dementia. Kitwood developed the term Malignant Social Psychology (Kitwood, 1990) to describe behaviours that have a negative impact on an individual's personhood. Although Kitwood developed his work with residents living with dementia, his Malignant Social Psychology could be applied to any care home resident whose experience of a social environment would have a negative impact on their mental well-being and personhood.

5.7.2 Sub-theme: Maintaining relationships

Residents spoke about maintaining relationships while living in a care home and the obstacles they faced when maintaining contact with the outside world. During the qualitative interviews residents often talked about the different barriers they encountered in trying to maintain relationships with people outside the care home. A number of residents had moved from other parts of the UK whilst others had grown up or lived in neighbouring counties. Not only was the care home new to them but also the area that they now lived in. Mary who lived in a religious care home, had moved from London to South Wales to live in the care home. In the extract below Mary mentions that she had never been to the area until she moved to the care home, and this had an impact on the social aspect of her life.

> INT: So, is that one way your lifestyle has changed since moving to a care home?
> RES: Oh, yes. From teaching, yes.
> INT: So, you're busy…busy…
> RES: Oh, no, I wouldn't say my life…it's the social aspect that has changed. You know, coming the first time to South Wales, er, never been here in my life. - *Mary, 87 years old*

Mary talks the social aspect of her life had changed since moving, and the people she once saw on a regular basis were no longer able to visit her. This had happened to several residents that were interviewed. Residents had moved to care homes in different parts of the country because they had family members in the area, or it was the only care home in the UK run by the religious organisation they belonged to. Others were living in care homes in areas where they had moved to work earlier in life but had no family living nearby. Living away from friends and family has significant implications on residents' contact with the world outside the care home, their visitors, and their ability to buy supplies. Older adults are often reliant on others, and even in a care home when other needs are met by staff, residents still rely on visitors, family, and friends for many things, including companionship, providing a link to the outside world, and practical tasks such as bringing them toiletries and clothes and taking them out or to appointments. Therefore, maintaining relationships with those outside the care home is vital to older adults' mental well-being.

During the interviews residents often talked about not seeing many people day to day and missing the connections and social side of living in the community and seeing and meeting different people regularly. Many residents also spoke about enjoying meeting young people and seeing new faces. In the extract below Anna illustrates this.

> INT: What brings meaning to your life?
> RES: What gives me meaning?

INT: Yes.
RES: Just everything that I’ve got is meaning, that fact that I can see, I can hear, I can speak, I have got a lovely daughter, I’ve got lovely children, I’ve got lovely grandchildren, I’m just very, very lucky. I know that and I’m very aware of it. *Anna, 96 years old.*

Several of the residents talked about the importance of their families and visitors. Even residents who did not have their own visitors often enjoyed other people’s visitors as it was an opportunity to talk to someone new and to be included in the conversation. Residents relied on visitors for many things, they relied on them for companionship, practical tasks, and saw their visitors as a connection to the community and to the outside world. In the extract above Anna talks about what brings meaning to her life and contributes to her mental well-being. Anna felt being able to communicate and maintain her relationships with her family were important to her mental well-being and that these are abilities many take for granted. For some residents, visual and hearing impairments made communication and maintaining relationships difficult. During the qualitative interviews several residents referred to the social implications of not being able to hear, or see, and how that has an impact on their ability to build relationships, combat loneliness and communicate effectively with others, which all have an impact on their mental well-being. Anna’s extract emphasises the importance of family and visitors.

Living with impairments can also have an impact on residents’ ability to socialise and maintain relationships within the care home and outside the care home. Like Barbara and Patricia, many older adults and care home residents live with vision or hearing impairments. In the extract below Patricia, who lived in the same Local Authority care home as Barbara talks about how her hearing has had an impact on her relationships within the home, and also keeping in touch with others over the phone.

INT: Yes. Do you find it difficult to maintain relationships while you're here?
RES: Yes. I'm wary of getting too friendly, I'm afraid. It's nice to be friendly and then come in and shut the door, you know?
INT: What makes you wary?
RES: I can't hear, and I … 'What did you say?' and so on. It's very boring for people to have to repeat for me, and I'm wary of being a bore. *Patricia, 88 years old.*

Patricia explains that she is reluctant to hold conversations and get to know people because she is self-conscious of not being able to hear people and worries what others will think if she asks them to repeat themselves. This must be very lonely for Patricia, not having any companionship or someone to talk to while she lives in the care home. Making friends within a care home has been found to have a greater positive impact than visits from friends and family on nursing home residents' levels of life satisfaction and depression (Wolff, 2013).

A number of residents experienced feelings of loneliness and had noticed that they did not have people visiting as much compared to when they lived at home. This could be for several reasons, residents talked about how their friendship circles were much smaller now because as they got older their friends had died. Their friends were also older and found it difficult to travel to visit them or were also living in care homes and unable to go visiting. In the extract below Shirley describes the change in the number of visitors she has noticed since moving to the care home.

> INT: So, you mentioned things that are better. Is there anything that's worse? There might be things-
>
> RES: Well, there…I mean, there's got to be some things…I won't use the word "worse". Different. Erm, when I was home, I always had somebody calling in cos I had a lot of friends. Now I do get visitors but nothing like the people who'd be calling in when I was at home. Cos I was up and about and they'd come in and have a cup of tea, cup of coffee. Well, the visits are a bit different in that way. But I mustn't grumble. And I've got two daughters living in South Wales and grandchildren and they're all very good. They're very good visitors. But at the moment, I've got a grandson and a granddaughter in America. *Shirley, 90 years old.*

In the interview extract Shirley states that she must not 'grumble' about the lack of visitors now that she is living in a care home, suggesting that it is a topic that bothers her, and she wished it were different. However, she is resigned to the fact that she no longer has as many visitors now that she is older and living in a care home.

Another issue some of the residents spoke about was the difficulty they had in maintaining relationships while living in a care home was visiting spouses that had more complex needs and were being cared for in a different care home. The extract below is from an interview with George, a 92-year-old man who had been living in a religious care home for 18 months to two years. George's wife had dementia and was living in a different care home approximately a 30-minute drive away from the care home he lived in.

> INT: What activities do you find meaningful?
> RES: Visiting my wife, not as often as I would like. But she has Alzheimer's, which is terrible and it's difficult. Sometimes there's flashes of the old, and you think she's back! Her memory is okay! But then it's gone [pause] My life ended when my wife became ill. Gave up everything, house, cars, all the things I used to do. *George, 92 years old.*

In the extract George talks about how he would like to visit his wife more often, but he is unable to as he no longer drives due to his health. George must rely on family members to take him to visit his wife, and unfortunately this is not as often as he would like. George discusses the difficulty of coping with a spouse who has dementia and the impact it has had on his mental well-being and feelings of loss. After being together for many years it is difficult for couples to deal with the changes that result from illness or dementia. George felt that his life ended when his wife became ill. This represented a significant change in George's life, he gave up the things that he used to do to care for his wife and saw his wife's illness as also meaning the end of his life. George is dealing with a significant amount of loss, his wife's health and his own health, and the life that they would have planned for their retirement. He has also lost the ability to see his wife on a regular basis since he became ill himself which makes maintaining a relationship with his wife even more challenging.

George's experiences were echoed in Joan's extract below. Joan was 78 years old and had lived in a Local Authority care home for eight months. Joan also lived in a different care home to her husband and had cared for her husband at home, but as his dementia progressed and her health deteriorated, she found it more and more difficult to cope at home. In the extract below Joan gives an example of how living in different care homes has made it difficult to maintain a relationship with her husband.

INT: It's really interesting to hear how, you know, things change for people.
RES: Yeah. Well, my husband has dementia. He has it bad, didn't he?
INT: But you tried to take care of him. That was...
RES: I tried but I couldn't.
INT: No.
RES: And he'd gone nasty and things, punching me and things like that, yeah.
INT: That must have been really difficult.
RES: Oh terrible, yeah it is. See him as a young man. Tall and you know [unclear 00:11:05] and now. Well there we are.
INT: It's sad, isn't it?
RES: It is sad.
INT: It sounds like you did the right thing.
RES: Yes. Well, they advised me to do it [unclear 00:11:22] I haven't been ungrateful for it because I could never do it.
INT: No, no.
RES: And he's alright. My son and daughter-in-law, they're down every week. But I can't because…it would be expensive for me to go down because I've got to book a certain taxi to put the wheelchair in. So, they go down for me. But he doesn't talk to them. But he's alright. That's the main thing. *Joan, 78 years old.*

As Joan explains in the extract above her mobility and use of a wheelchair means that she relies on specialist taxis if she wants to go anywhere. These taxis are expensive and therefore Joan's mobility restricts her from visiting her husband. She relies on and is reassured that her son and daughter-in-law visit him every week. Being unable to visit her husband has an impact on Joan's mental well-being as her mobility issues restrict her ability to maintain relationships and feel connected to her family.

Care homes can be lonely places for many residents (Weyener et al., 1995 & Scocco et al., 2006), and the significance of maintaining relationships outside of the care home and developing relationships within the care home is often underestimated (Bradshaw et al., 2012; Bergland & Kirkevold, 2006; Robichaud et al., 2006; Hall et al., 2011; Cooney et al., 2014). In the extract below Mary wholeheartedly illustrates the significance of relationships and interactions with others.

INT: So, what makes it the perfect environment for a care home?
RES: I think it's the people. And it's one's relationship, you know…it's your attitude to life. If you've got the right attitude, you'll adapt to any

situation. And I feel I have a positive attitude. That's…that, you know, gives me life and energy. And you…you get energy from other people.

INT: Well, that's good.

RES: When you're around other people, chatting to other people and sitting with them, listening to their stories. Well, they energise me.

INT: That's good. So, do you feel there's a nice sense of community here? Do you feel there's a nice sense of community here?

RES: Yeah, I do, yes, very much.

INT: And that's important?

RES: That's absolutely…that's true, yeah.

INT: Important to you. Oh, that's good.

RES: Oh, yes. That's important. And people are very important. *Mary, 87 years old.*

Mary lived in a religious care home and felt a sense of community living with others that shared the same religion and beliefs as her. Mary summarises what interactions with others mean to her, and the importance of community and social interaction, and relationships to mental well-being.

When discussing relationships in care homes a number of residents discussed losing friends as they grew older. In the extract below Joseph describes friendships in later life and the difficulty he found in losing friends and making new friends later in life.

INT: So you've been here four years. Have you found it difficult to maintain relationships since coming to the care home? You know keeping in touch with people or going to see people?

RES: Well I don't go to see people now like I used to because I've got to depend on other people to take me. As I was saying, a lot of people are dying and so your friendships become fewer and fewer in that sense. Your memories…you see if I make a friend with somebody now we don't have the same memories. *Joseph, 85 years old.*

Research has found similar findings to what Joseph describes in his extract above, Lang and Carstensen (1994) found that residents often preferred established close friendships to making new friends. Similarly, to Joseph, Bill also discussed friendships in later life, and the impact it has had on him when friends within the care home have died. After losing his friend Bill preferred to stay in his room and had not been to the communal dining room for his meals for some time, preferring to keep himself to himself.

> RES: I like my own company too bach, not a lot of people like that, but I like my own company. It isn't the case that I'm standoffish or anything like that. I had a heck of a shock not so very long ago, there was a fella, a gentlemen a bit further down on the right hand side there, BLANK BLANK, and he used to come in here and he was a very big Rugby man and he played cricket for BLANK. He used to come in here, and we used to chat about rugby, and this that and the other, and then I'd go for a walk up that way, and then I'd call into his room and we'd have a chat for a half hour. The poor blighter died, and my life went (makes noise). *Bill, 89 years old.*

The loss of his friend had been a shock to Bill and had affected his mood and his desire to socialise with other residents in the care home. Bill describes his life as going downhill since his friend died. Older adults who live in care homes are often surrounded by a loss of co-residents, either through hospital admissions, moving to a different care home or through death, and these losses will have a significant impact on residents' mental well-being.

5.8 SUMMARY

In this chapter I presented the analysis of the qualitative interviews. From the analysis I developed three themes with the overarching theme of loss. The three themes were 'challenges to liberty', 'changes in identity' and 'the importance of relatedness'. The extracts supporting the analysis were organised into sub-themes. The sub-themes identified for the 'challenges to liberty' theme were 'rules vs agency', 'privacy', 'relying on others', and 'the trade-off'. The sub-themes identified for the 'changes in identity' theme were 'sense of purpose and occupation', 'possessions and self-identity', and 'ageing identity and frailty'. The sub-themes identified for the third theme of 'importance of relatedness' were 'interdependence' and 'maintaining relationships'.

The qualitative analysis indicated that care home residents experience greater loss in old age, and the loss of freedom is one of the losses experienced in care homes. From the data gathered in the qualitative interviews contributing factors to older adults' losses were found to be restrictions, lack of privacy, reliance on others, choice, and control. The analysis also demonstrated that older people's personhood, autonomy, self-identity, relationships, and liberty need to be respected and maintained in order to promote and maintain older people's mental well-being in care homes.

In the next chapter I will discuss the key findings from both stages of data collection and present and integration of the findings from both quantitative and qualitative findings. I also explore how the findings from this PhD research study fit within the current research landscape and discuss the limitations of the study, the practical issues of care home research, my reflections on the research and the COVID-19 context. In the conclusion I discuss this research study's original contribution to knowledge, offer recommendations for policy and practice and discuss areas for further research.

6 CHAPTER 6: DISCUSSION AND CONCLUSION

6.1 INTRODUCTION

This PhD research set out to examine the experiences of older adults in care homes relating to their mental well-being with the aims of developing a better understanding of what is important to their mental well-being and offer recommendations on how their mental well-being could be maintained and promoted. The first quantitative stage used the standardised measure, the Mental Health Continuum Short Form (MHC-SF) to assess the well-being of care home residents. A significant finding of the MHC-SF analysis was that younger residents were more likely to be categorised as ‘languishing’ by the MHC-SF categorising criteria. The findings of the first stage were then used to aid the development of the qualitative interview schedule for the second stage of data collection where older adult mental well-being was explored further. Using Reflexive Thematic Analysis (RTA) I generated three themes from the coding and analysis of the qualitative interviews. These were ‘challenges to liberty’, ‘changes in identity’, and ‘importance of relatedness’. Loss was a common thread running through each theme that was developed from the analysis of the qualitative interviews, therefore loss was the overarching theme.

In this discussion chapter I will elaborate on the key findings from the data collection and discuss the integration of the mixed methods data and how the quantitative and qualitative methods and data have been integrated. I will then discuss how these fit in the current research landscape before discussing the limitations, practical issues, reflections on the research and the findings within the context of COVID 19. To close the chapter, I will discuss the research’s original contribution to knowledge, the recommendations for policy and practice and suggest areas for further research in the conclusion of this chapter.

6.2 MIXED METHODS INTEGRATION

For the final stage of integration of the mixed methods design I present an integration of the quantitative and qualitative data collected in this research study. The quantitative and qualitative analysis of each stage have been discussed separately in

Chapter five and six. There was complementarity between the quantitative data and qualitative data and social aspects of well-being. The quantitative data showed that residents experienced social aspects of well-being less frequently than emotional or psychological components of well-being. This finding was reflected in the qualitative interviews where residents discussed the many social losses they had experienced since moving to a care home and the impact these losses had on their mental well-being.

In contrast to the quantitative data, analysis of the qualitative interviews showed the importance of freedom, agency, and autonomy to residents' mental well-being, which correspond with psychological components of mental well-being. However, the MHC-SF does not contain items on these topics other than the items on being able to express their opinion and manage their responsibilities. These findings indicate that a scale that includes these topics would be more appropriate for use with older adults in care homes as they value these aspects as important to their mental well-being.

In the quantitative findings older adults on average scored higher on social aspects of well-being, and therefore experienced feelings of belonging and community often. This is where the data diverged as during the interviews residents spoke about how they were no longer '*part and parcel*' with the outside world and how they missed their community, and how important feeling included, and a sense of belonging were to them. Care home residents also discussed several topic areas that were not included in the MHC-SF that were important to their mental well-being and were therefore silent in the quantitative data. Shared meaning around autonomy, liberty, choice, and identity were found to be important to mental well-being in the qualitative data, however, these topics were not covered in the quantitative data. Therefore, to understand the experience of older adults in care homes it is important that these areas are covered in any assessments or measurements of their mental well-being.

The findings from the integration of the qualitative and quantitative data also reflects the theoretical underpinnings of this PhD research study, that mental well-being is measurable but complex and based on important experiential and contextual factors.

By combining both quantitative and qualitative methods it has been possible to build a fuller picture of what is important to the mental well-being of care home residents. This can be seen where the two different types of data complement each other and also where they diverge. If only one method had been used, then certain important components of mental well-being related to residents' experiences would not have been included in the findings. The findings also support the two-continua model of mental well-being, that positive mental health and well-being needs a proactive approach to help maintain and promote it. Residents spoke about their experiences of living in a care home and how these impacted their mental well-being. By taking a proactive approach and addressing the issues raised we can begin to help maintain and promote resident mental well-being.

6.3 HOW THIS STUDY FITS IN WITH THE CURRENT RESEARCH LANDSCAPE

6.3.1 Findings from the Mental Health Continuum Short Form

The Mental Health Continuum Short Form (MHC-SF) has not been used in the Welsh care home population before. Early indications of using this tool in Welsh care homes suggested it worked well. The scale was useful to use as it produced a set of findings that were used to develop the interview topic guide for the second stage of data collection and allowed me to speak to 141 care home residents from 23 different care homes across South Wales. Residents were able to complete the tool without issue and it offered findings that represented differing mental well-being. It is beyond the scope of this research to ascertain its validity and reliability in this context, but future research might do this, for example looking at contextual factors of Welsh care homes, cultural factors in Wales and language and culture in the potential necessity of a Welsh Language version of the tool.

There have been conflicting findings using the MHC-SF in research. For example, following a natural disaster in Azerbaijan older people over 60 scored significantly higher than younger people on the MHC-SF (Rafiey, Momtaz, Alipour, Khankeh, Ahmadi, Khoshnamni, & Heron, 2016). Compared to a MIDUS survey in the United States, which included the long version of the MHC-SF (MHC-LF), that found that older participants experienced a small decline in their mental well-being compared to younger adults (Snowden et al., 2010). Being in the oldest age cohort (65-74 years old) significantly predicted a decrease in mental well-being and lower levels of emotional and psychological well-being (Snowden et al., 2010). In research using the MHC-SF it has been found that women usually score higher in the emotional well-being domain compared to men (Joshanloo & Lamers 2016; Graham and Chattopadhyay, 2013). Conversely, Petrillo et al. (2015) who found significant differences between men and women in their study population using the MHC-SF, found that men had higher scores on emotional well-being, and social well-being but lower scores than women on psychological well-being. However, in this PhD research study, there was no significant difference between men and women in emotional, social, and psychological well-being scores.

Petrillo et al.’s (2015) study of Italians between 18 and 89 years old also found that younger people scored higher on emotional well-being than older people, whereas there was no significant difference between age and subscale score found in the current study. In Westerhof and Keyes’ (2010) study of 18- to 87-year-olds, older Dutch adults experienced higher levels of emotional well-being, similar levels of social well-being and slightly lower levels of psychological well-being than younger adults in the study. They also found there was no association between age and social well-being, a positive correlation between age and emotional well-being and a negative relationship between psychological well-being. However, in this current study age did not significantly predict lower levels of emotional or psychological well-being. There was, however, a significant relationship between age and being categorised as ‘languishing’ suggesting that contrary to earlier findings (Snowden et al., 2010; Petrillo et al., 2015) younger participants were more likely to be categorised as ‘languishing’ compared to older participants and therefore have lower levels of mental well-being.

The majority of studies that used the MHC-SF did not publish the categorisations of their participants (Salama-Younes, 2011; Westerhof & Keyes, 2010; Snowden et al., 2010) but focused on the analysis of the subscale scores and factor structure of the measure which makes comparisons between previous research populations and this research population difficult. However, populations from South African, US, and Italian studies have found higher levels of ‘languishing’ and ‘moderately mentally healthy' participants, and lower levels of 'flourishing' participants compared to the current study's participants. (Keyes et al., 2008; Keyes, 2005; Petrillo et al., 2015).

6.3.2 Findings from the qualitative analysis

The findings from this research study suggest that the restrictions older adults face while living in care homes due to the rules imposed by the care home impact negatively on their liberty, agency, and autonomy which leads to poor mental well-being. This finding has also been found in earlier research, Boyle (2008) found that any restrictions on autonomy has a negative impact on mental health, and choice and independence have been found to be key dimensions of QoL (Walker & Hannessey, 2004). One of the reasons for these rules and restrictions in care homes is to attempt to manage or eliminate risk. Furness (2011) argues that it is essential that risk is managed instead of eliminated in order to protect autonomy in care home residents. When care homes create risk averse environments and cultures through procedures that are designed to limit risk there is a danger that everyday activities such as drinking tea from a plastic beaker instead of a teacup to avoid spillages become a 'care activity' (Furness, 2011). Procedures such as this perpetuate the assumption that the resident is no longer capable of drinking from a teacup, residents internalise this assumption of being incapable and lacking autonomy which leads to a feeling of institutionalisation (Furness, 2011). Risk averse environments have also been found to have a negative impact on QoL (Parker, Barnes, McKee, Morgan, Torrington, & Tregenza, 2004). Restrictive structures and processes are often brought in as a way to cope with low staffing levels and to still ensure the physical safety of residents which is a priority. However, this is often at the sacrifice of activities and freedoms that are corner stones of mental well-being.

Low staffing levels and high staff turnover in care homes have been an issue for a number of years. There are various reasons for low staffing levels in care homes, these range from the impact of Brexit making recruiting staff more difficult as many care home staff are EU workers (Skills for Care, 2021), to increasing workloads, low pay, poor recognition of care work, lack of career progression and development (Kaya & Fotaki, 2022). With fewer members of staff available to work and a high staff turnover this type of practice is more congruent with a task-oriented approach to care where efficiency is key, than a relationship or person-centred approach to care where staff have the time and are encouraged to spend time developing a rapport with residents. Unfortunately, as earlier research has found and is reflected in the qualitative findings of this study, this type of approach to care has a detrimental effect on resident mental well-being.

Even though it is care homes who often implement practices to eliminate risk, it is a much more complex decision with input from many stakeholders. For example, the discourse around risk reduction resides in policy, societal infra-humanisation of older people and in health and safety regulations. Care homes have guidelines and regulations to follow in order to operate, they also have concerned family members wanting to keep their relatives as safe as possible while they are being cared for somewhere else. An accumulation of these pressures, guidance, regulations, and culture result in care homes being more likely to steer towards eliminating risk rather than managing risk on an individual case by case basis. Managing risk on an individual basis also puts more strain on a care sector already strapped by very limited resources. These issues mentioned above all contribute to a task-oriented, risk averse approach to care which is not conducive with resident autonomy, agency, and choice or promoting and maintaining their mental well-being. Through moving away from a structured routine of care and risk elimination care home residents' independence, individuality, and autonomy would be maintained which have been found to contribute to older adults' QoL and avoid the risk of institutionalisation (Lee et al., 2009). Similarly to the findings from the qualitative analysis of this research study earlier literature has also found issues with rules vs. agency and striking the balance between choice and freedom for residents and the institutional constraints of the care home (Lundin et al., 2016). To avoid feelings of institutionalisation and lower levels of QoL there is a need to assess the potential benefits and risk on an individual basis and what is normal to the resident in order to maintain their independence and self-identity. Consideration should also be given to the likelihood of harm and does it infringe on the residents right to independence, autonomy, well-being and choice. Furness (2011) posited that the decision needs to be collaborative with the involvement of older adults and those working for the care home. Through codecision and positive risk management the resident is kept involved which promotes independence and well-being (Furness, 2011).

Within the qualitative data residents showed examples of resistance to the rules and regulations of the care home. These acts of resistance and asserting their autonomy is also seen in research on institutions (Rubin, 2017). In Rubin's (2017) study acts of resistance were seen from prisoners who were exercising their agency and autonomy against the restrictive prison setting. Autonomy is also important to older adult mental well-being and should be a human right for older people living in long-term care, as social rights are needed to empower older adults and facilitate autonomy (Boyle, 2008).

Privacy was an issue that residents raised during the interviews, they described two types of privacy, the privacy of their room, and also the privacy of their information. During the interviews residents expressed that the privacy of their room was not always respected when staff would enter without knocking. A similar issue was found with residents' private information. Residents expressed that they did not always tell the care home staff things because they knew that this information would not be kept private and would be passed on to other staff. This finding is also reflected in the research literature. Forbes-Thompson and Gessert (2006) research with older nursing home residents found that residents also experienced a loss or privacy since moving to a nursing home which contributed to feelings of institutionalisation. Privacy has also been identified in the literature as being an important contributor to resident QoL in nursing and care homes (Mickinley & Adler, 2006; Kane, 2001; Edwards et al., 2003; Cooney et al., 2003). Findings from this research study and previous research indicates that resident privacy is an important issue in care homes and needs to be respected and maintained in order to promote mental well-being.

The findings that older adults rely on others for many things which impacts their independence and liberty was not reflected in the literature included in the literature review. The qualitative analysis found that residents having to rely on others for simple things such as toiletries and clothes and also companionship, keeping in touch with others and the outside world had an impact on their liberty and mental well-being. Taking steps to help residents feel less dependent on others, such as being able to purchase toiletries in the care home, may have a positive effect on their liberty and subsequently their mental well-being. The compromises or 'trade-off' that residents felt they had to make in order to feel secure and supported were also not reflected in the literature included in the literature review. In the qualitative analysis of this research study many of the residents felt that they had to give up some of their freedom in order to move to the care home and be supported and cared for. This was an interesting and novel finding, residents often described feeling safer and secure and having fewer worries, but also that this came at a cost. During the interviews residents described living in a care home like being on holiday but with less freedom, they spoke of being grateful that they were safe in a care home but missed the autonomy and freedom of living in their homes. Supporting residents to feel freer and more independent while living in a care home would therefore have a significant impact on maintaining and promoting their mental well-being.

Residents expressing that they felt since moving to the care home was also seen at other points during the interviews. A finding from the qualitative analysis was that residents felt more safe and secure since moving to the care home and they felt relieved and reassured that there were staff on hand should they need anything. Feeling safe and secure has been found to contribute to well-being, for example, Nolan's (2006) Senses Framework highlights the importance of security to well-being and Bradshaw et al. (2012) found that security was an important contributing factor for older adult QoL. Interestingly, Cho et al. (2012) describes the concept of not having to worry about practical task and safety as 'enhanced comfort', which older adults often experience once they move to a care home. An example of this was found in Minney and Ranzij's (2016) study, they found that residents no longer worried about their safety since moving to a care home.

A significant finding from the qualitative analysis was the importance of meaningful activities and sense of purpose and the impact these had on older adults' identity and mental well-being. In the literature a lack of meaningful activity has been found to be a contributing factor for depression (Davison et al., 2012), therefore ensuring residents are able to engage in activities which are meaningful to them is important. Comparable to the findings in the qualitative analysis earlier research has also found that residents were often bored due to the long days with little activity in the care home and therefore they valued meaningful activities which contributed to their QoL and kept them occupied (Cooney et al., 2009). While in Bergland and Kirkevold's (2006) study they found that participating in meaningful activities contributed to 'thriving' in nursing home residents. In addition to having a positive impact on QoL, identity, and mental well-being meaningful activities have been found to help with social interactions which are also important to the mental well-being of care home residents (Gleibs et al., 2011; Gleibs et al., 2014). The findings from this study therefore support the outcomes of earlier research that ensuring older adults are able to participate in activities that are meaningful to them is important to their sense of purpose, social interactions, and mental well-being.

An interesting sub-theme that was generated from the analysis was the importance of possessions to identity. Residents talked about how they had to give up many of their possessions when they moved to the care home and how this negatively impacted them. The possessions they described were often parts of their former selves, such as academic books, furniture, and art they had collected with their spouses and therefore were a part of their former lives before moving to the care and also held memories from the past. This finding echoes earlier research which has found that residents experience a loss of personal possessions when they move to a care home or nursing home (Forbes-Thompson & Gessert, 2006) and that being able to express their identity through their possessions was important to QoL (Cooney et al., 2009). Therefore, the importance of residents' belongings should not be underestimated, and in order to promote and maintain their mental well-being efforts should be made to ensure important possessions can be moved to the home with them, in addition to understanding the importance of losing their possessions.

Assumptions made about older adults can be damaging to their self-identity and mental well-being, examples of this were seen in the findings of the qualitative analysis where residents demonstrated that they had internalised some of the negative assumptions about older adults not being independent or capable. The research literature has also found this, Levy (1996) found that the way older adults are treated had an impact on how they behaved and viewed themselves. In the study, older adults who participated in an intervention which activated positive stereotypes of aging improved memory performance compared to older adults who were exposed to an intervention that activated negative stereotypes of ageing, which worsened memory performance (Levy, 1996). Another example of how damaging assumptions are is seen in Hezberg’s (1997) study, where it was found that labelling caused staff to make assumptions about residents and made them treat and behave differently towards them depending on the label they were given. Remarkably, in the qualitative analysis of this study many residents could be seen to challenge some of these ageing assumptions and assumptions about care home residents. Residents expressed that they wanted to learn new skills, attend online courses, cook and be more active. These are all activities and hobbies that are enjoyable and keep individuals occupied and contribute to mental well-being. Younger adults under the age of 65 would be expected to have hobbies and participate in activities that they found interesting; this should be the same for older adults living in a care home. Therefore, ensuring staff are aware of these ageing assumptions and the negative impact these have on older adults is a priority. Assumptions need to be challenged and older adults need to be supported to participate in activities that they find enjoyable, no matter their age.

In the qualitative analysis residents also demonstrated the importance of relatedness, interdependence and the importance and impact others’ behaviours can have on individuals. Research has also found that the way older adults are treated also has an impact on their mental well-being (Ward, 2012). For example, Mikelyte and Milne’s (2016) work on micro-cultures in care homes – the way residents interact with each other and with staff has been found to have an impact on mental health and well-being. Kitwood (1997) also recognised that other people’s behaviours have an impact on an individual’s personhood whether they realise it or not. The importance of being recognised, respected by others and feelings of trust are essential to personhood and mental well-being (Kitwood, 1997). Residents also discussed the impact of staffing levels and how busy staff had an impact on how they felt, this highlights that residents are aware of staff shortages and the impact this has on them. Research has found that a good relationship with staff can have a positive effect on resident mental well-being (Gleibs et al, 2014; Haugan et al., 2013), therefore it is important to consider how staff interact with residents, and how this makes them feel. Designating staff more time to get to know residents and interact with them has been shown to have a positive impact on resident's QoL and mental well-being (Edwards et al., 2003). Bradshaw et al. (2012) also found connectedness to be an important component, adding further evidence that more time is needed to develop relationships and for residents not to feel like a nuisance or a burden and the impact this has on their mental well-being. Further support for the development of meaningful relationships and the impact or interdependence is seen in McLaren et al. (2013). Their research found that a sense of belonging and feeling included is important to older adults in care homes, which was also reflected in the qualitative data of this research study and is further support that higher social engagement correlates with higher levels of well-being in institutional settings (Gilbart & Hirdes, 2000). Fisher (1995) asserted that successful ageing includes interactions with others, a sense of purpose, self-acceptance, personal growth, and autonomy, which is also reflected in the findings from the qualitative analysis of this study.

The research finding on the importance of relatedness and interdependence and the impact interactions and relationships with care home residents have on mental well-being resonates with ethics of care. Ethics of care emphasises the importance of the response to the individual and highlights attentiveness and responsiveness in delivering care (Tronto, 2020), and conceptualises the individual as dependent on others in order to achieve independence and autonomy (Lloyd, 2012). The development of 'care-full relationships' between older adults and care practitioners have been found to be important to older adult well-being (Ward & Barnes, 2016). This is in contrast to the often procedurally driven care sector, these 'care-full relationships' aim to enable transformative dialogue about care while involving older adults which is in keeping with a more holistic approach that considers the circumstances and concerns of the older adult (Ward & Barnes, 2016).

Many older adults who need support with activities of daily living (ADL) are 'necessarily dependent', this dependency is only seen as an issue when a culture views independence as the norm (Lloyd, 2012). Lloyd (2012) asserts that care should be seen as inherent as we all will need care across the life course. If the value of care is to be appreciated and understood as more than simply meeting the needs of individuals who are dependent on others, it needs to be evaluated and understood at the micro and macro level. Services have been developed under patriarchal and paternalistic conditions and feminists posit that this is the explanation for the low status given to those who do care work and those who receive care (Lloyd, 2012). Unfortunately, being 'necessarily dependent' or needing care and support is not congruent with the active or successful ageing narrative. If you are dependent on others for care this does not mean that you have failed to age successfully. This was seen in many of the qualitative interviews where residents had taken on these negative assumptions about not being capable and viewed themselves negatively because they needed care and support. Being 'necessarily dependent' should not be viewed negatively. Society views needing help with everyday activities as a burden which is damaging to older adults' self-identity as they experience a loss of self-reliance and growing dependency (Lloyd, 2010). In the qualitative interviews many residents showed that they had internalised ageing assumptions and believed that they were also incapable of doing tasks or caring for themselves because they were now old.

In the qualitative analysis it was clear that residents struggled to maintain relationships while living in the care home, this finding is also found in the literature where residents have spoken about the difficulties in maintaining relationships outside of the care home (Thomas et al., 2013). Maintaining relationships outside of the care home has also been found to be important to QoL (Cooney et al., 2014). In addition to maintaining relationships outside of the care home, several of the residents in the qualitative interviews spoke about the difficulty they had in forming relationships within the care home, this has also been found in the literature and is a concern for many residents which has a negative impact on their QoL and mental well-being (Bradshaw et al., 2012). Being able to stay connected and spend time with family and friends also has a positive impact on older adults in care homes' levels of loneliness (Prieto-Flores et al., 2011). Bowers et al. (2009) also found that care home residents valued the importance of belonging, being able to choose how they spend their time, maintaining and developing their sense of self and personal identity, and the importance of relationships. These findings from this study are also congruent with key elements from the Strategy for Older People in Wales 2013-2023 of maintaining good relationships and social support and having a sense of purpose. This suggests there is a need to prioritise developing new relationships and maintaining existing ones when an older adult lives in a care home.

The themes identified in this research study were also found in reviews of the literature around QoL and the mental well-being of older adults in care homes. Berland and Kirkevold's (2006) similar themes identified that participation in meaningful activities, relationships with family, and also resident's accepting their move to the care home were important to their QoL and mental well-being. The residents in the qualitative interviews in this study also discussed the importance of accepting the move to the care home and how this had helped them feel more positive about the move. Being able to cope and adapt and create meaning in life has been found to be important to resident QoL and mental well-being in earlier research also (Oleson et al., 1994; Robinson et al., 2005).

Bradshaw et al. (2012) and Murphy et al. (2014) both found in their systematic reviews looking at improving the QoL of care home residents that autonomy, connectedness, sense of self, independence, and meaningful activity were all important to residents. These components were also identified in this research and were discussed as being important to the mental well-being of older adults in care homes. Further support of the importance of these components is seen in research by Murphy et al. (2007), who also identified themes of personal identity, connectedness to family and community in their study on QoL in long-term care facilities in Ireland. Cooney et al. (2009) also identified similar themes such as sense of self and identity, connectedness, and activities in addition to therapy as being important to older adult QoL and mental well-being in care homes. Their research also emphasised the importance of residents participating and having a voice in decisions about their care.

Topics residents also discussed as being important to them were the importance of green space to mental well-being which has also been found in other studies (Bhatti, 2006; Burton & Sheehan, 2010; Patomella et al., 2016; Lord & Coffey, 2021). Examples of epistemic injustice (Fricker, 2007) were also demonstrated throughout the qualitative interviews where residents' voices were often not heard or ignored. Residents demonstrated this when they discussed instances where they had not been asked about their preference of an activity or book, or when decisions about their care or driving had been made for them. The research literature has also emphasised the importance of supporting resident choice (Furness, 2011), and the impact this has on mental well-being.

6.4 LIMITATIONS

The research design of this research study was cross-sectional which has its limitations as it only provides a 'snapshot' of the mental well-being of older adults in care homes. Using a quantitative measure that asked residents to think about how they had felt in the past two week and qualitative interview questions where residents were asked to talk about different time points to try and mitigate this limitation to some extent.

Another limitation of the study was the sample and recruitment method used. Only care homes who agreed to participate took part in the research and managers and owners acted as gatekeepers and approached residents to participate in the research. Even though this method is recommended as helping to facilitate care home research (Luff et al, 2011), it does introduce bias and means that some residents may be excluded from participating in research. It is also a limitation that only those who had capacity to consent or those who did not have severe impairments such as severe hearing impairments were able to participate in the study. There may also be potential for bias in certain types of care homes who may have more actively engaged residents participating in the research. However, health varies from week to week and the population is not static, and the engagement of the care home does not always reflect the engagement of the residents.

During the quantitative stage of data collection several residents commented on the difficulty in understanding and following some of the items on the MHC-SF. Concepts such as 'growing to be a better person' seemed strange to them and they often asked for clarification. Due to visual impairments or residents asking for the MHC-SF questions to be read aloud, I noticed there was a lot of information to take in with the question and then each of the possible answers on the Likert scale. Some residents may have found this onerous or confusing which may have affected their responses. Unfortunately, due to time constraints I failed to reach the target sample of 149 for the data collection of the MHC-SF. However, due to the exploratory nature of the research and the majority of the data was collected during the second stage of data collection this was less of a limitation.

During the interview and listening to the interview transcripts I noticed that there were instances where interview question could have been worded better or more precisely. There were also opportunities I had missed to ask follow up questions that would have given residents an opportunity to elaborate and expand on their answer and this may have affected the data that I collected.

The current generation of older care home residents are likely to respond differently to future generations due to cohort effects which impact the transferability of the findings of this study for future generations of care home residents. Younger generations are likely to be more assertive and possibly less tolerant with having restrictions placed on their freedom as acceptingly as the current generations of older adults (Bowling et al., 2002). This research only provides a ‘snapshot’ of what the current generations in the particular care homes I visited and the residents I spoke to. Nonetheless, their voices and experiences are still important and is echoed in much of the research already. Their thoughts and feelings of what contributes to their mental well-being are likely to still be relevant for future generations of older adults living in care homes.

6.5 PRACTICAL ISSUES OF CARE HOME RESEARCH

Throughout the PhD I encountered several practical issues of doing research in care homes. One issue that I found was that it was sometimes difficult to get staff on board with the research. This is difficult as even though many residents are able to choose whether they want to speak to you or participate in research, if the care home management or staff refuse or are reluctant for you to come in and speak to residents there is not much you can do. During the recruitment process for the first stage of data collection I came across this several times, either when speaking to care home managers over the phone or on one occasion when I met with one care home manager who seemed keen to participate in the research, however, the clinical lead who was also at the meeting, was against any residents participating in the research. They felt that there was no way the residents living in the care home would be able to participate in my research and was adamant it was a bad idea. Unfortunately, this meant that the care home and its residents did not participate in the research. It's unfortunate that the residents were not even given the opportunity to participate. Overall, most of the care home managers I met with were keen to participate, even the two managers that I met with but then never heard from.

Another practical challenge was that care homes are busy places, on a few occasions I had arranged to go to a care home to collect data but after arriving there I was told that the care home manager was not there or was too busy, or that residents had other plans. Although it was frustrating, there was not much I could do apart from rearrange the visit. This was a practical issue that impacted the progress I made with the data collection, and it was frustrating when I had driven a considerable distance to the care home.

During the time between data collection stages some of the privately owned care homes had changed management which meant I needed to start again with developing a relationship and explaining the research. Another problem was that some of the residents I wished to contact and invite to interview had either moved to a different home or had died.

During the interviews and completion of the MHC-SF it was sometimes difficult maintaining confidentiality and anonymity with staff members or other residents walking into rooms. When this happened, I stopped the interview and waited until the other person had left the room before restarting. It was challenging to retain complete anonymity within the care home around who participated in the research since staff were asked to speak to residents about the research and would introduce me to the resident. The staff would often see who I was speaking to and, therefore which residents were participating. From the data integration between the quantitative and qualitative data it was possible to establish where there were areas that the MHC-SF did not cover but were important to older adults. For example, a scale that covers more of the psychological components of well-being may be more appropriate.

An issue with conducting any research is that those that participate are also likely to be participating in other research. For example, the care homes that agreed to take part in my research are also more likely to be the care homes that have agreed to take part in other research, which leads to participants being over-researched (Nature, 2017). This means the same population being used in research over and over again. This is an issue with response bias, the same type of care homes agree to participate, and the same residents are approached and agree to participate each time.

6.6 REFLECTIONS ON THE RESEARCH

Reflecting on the data collection, I found conducting the qualitative interviews quite difficult and emotionally draining at times when residents spoke about something upsetting. During the qualitative analysis, while reading each transcript and then recalling and thinking about the resident who spoke those words can be very emotive.

Due to how emotive some of the topics residents discussed in the qualitative interviews I wanted to make sure that I did the data, and the residents' voices justice. Each resident is important, what they experience and discuss is important, and having their voices heard is important. I also found piecing together the narrative difficult at times, sometimes I was painting quite an unhappy story.

I have found that there is more distance when collecting and analysing the quantitative data, the 'richness', and emotion is often missing. Compared to qualitative analysis, in quantitative analysis everything is included. In reflexive thematic analysis (RTA) the researcher chooses which extracts to include in writing up the analysis. I found this difficult because I felt that each extract was valuable, and residents should have their voices heard. I spent a lot of time teasing out extracts and meaning, trying to choose extracts that also reflected what other residents had said.

The interviews varied in length, for example, one interview only lasted 22 minutes which meant that I was unable to cover each of the topics on the interview schedule. In this particular interview, the participant decided that they did not want to continue with the interview, and we ended the interview early. Even though I was not able to ask questions from each topic area, the resident had many interesting and poignant things to say about her experiences of living in the care home and how they had impacted her mental well-being.

6.7 COVID-19

The research preparation and data collection in this PhD study was conducted in a different context to the current COVID-19 pandemic and resident experiences may be different now. However, the themes generated from the qualitative interviews are still applicable in the context of COVID, as COVID restrictions have had a significant negative impact on care home residents and their families. Their liberty, identity and relatedness will have been severely impacted by COVID restrictions, and it is likely that these components that are important to their mental well-being have been impacted significantly by the restrictions, especially with little to no easing of restrictions for older adults in care homes for almost two years.

6.8 CONCLUSION

This PhD research study aimed to select an appropriate definition, model, and measurement of mental well-being for use with older adults in a care home context through reviewing the current literature and a review of prospective measures. Research has not used the MHC-SF in the care home context with older adults or used the findings from the MHC-SF to inform and develop a qualitative interview schedule to explore the experiences of older adult’s mental well-being in care homes in order to better understand and offer recommendations on how it can be promoted and maintained.

There is limited research into the experiences of older adults living in care homes (Dening & Milne, 2011). The findings from the research supports earlier findings on what contributes to older adult mental health and well-being and offers the additional findings that relying on others and the compromises residents make when they move to the care home impact their liberty and mental well-being.

The findings indicate that a more holistic, person-centred approach to care would have a positive impact on resident mental well-being. It is important to also promote and maintain components of mental well-being that are important to older adults in care homes such as liberty, identity, and relatedness instead of only treating mental ill health. These findings are therefore in keeping with the two-continua model of mental well-being that underpins this PhD research study, that positive mental health and well-being needs a proactive holistic approach to help maintain and promote it. Residents spoke about their experiences of living in a care home and how these impacted their mental well-being. By taking a proactive approach and addressing the issues raised we can begin to help maintain and promote resident mental well-being. The findings from the integration of the qualitative and quantitative data also reflects the theoretical underpinnings of this PhD research study, that mental well-being is measurable but complex and based on important experiential and contextual factors. By combining both quantitative and qualitative methods it has been possible to build a fuller picture of what is important to the mental well-being of care home residents. This can be seen where the two different types of data complement each other and also where they diverge. If only one method had been used, then certain important components of mental well-being related to residents' experiences would not have been discovered.

The qualitative analysis indicated that care home residents experience greater loss in old age, and the loss of freedom is one of the losses experienced in care homes. From the data gathered in the qualitative interviews contributing factors to older adults' losses were found to be restrictions, lack of privacy, reliance on others, choice, and control. The analysis also demonstrated that older people's personhood, autonomy, self-identity, relationships, and liberty need to be respected and maintained in order to promote and maintain older people's mental well-being in care homes.

One suggestion from the findings is that by increasing the number of staff and taking a less task-orientated approach to care, staff will have more time to develop relationships with care home residents which have been found in this research and in previous research to help maintain and promote mental well-being. A focus on the social side of care and staff having more time and a less task-oriented approach will also allow time for more positive interactions with residents. This in turn, will lead to residents being less likely to feel like a nuisance or a burden to staff and feeling more able to approach staff. More members of staff will also permit more opportunities for residents to enjoy meaningful activities which this research and earlier research has identified as being important to mental well-being.

Respecting older adults' privacy and their right to privacy and autonomy may also help develop more trusting relationships with staff and help to promote and maintain their mental well-being. While supporting older care home residents to remain independent or regain some independence through occupational therapy could help mitigate feelings of always having to rely on others and how this impacts their liberty. Being mindful of the compromises that older adults have had to make when moving to the care home and supporting them to maintain some of their freedom and independence and help maintain and promote their mental well-being.

Being more mindful and understanding of the losses that older adults have endured will also have a positive impact on older adult mental well-being. Care home residents face many challenges to their liberty and by focusing on managing risk rather than eliminating them and involving residents in decisions their agency is protected and mental well-being more likely to be maintained. These findings also support the SSWWA 2014 key elements of voice and choice, well-being, and the importance of co-production.

Changes in identity is another issue older adults faced when they moved to a care home. The changes in residents' ability to participate in meaningful activity and occupation impacted residents' sense of purpose and role. Supporting residents to participate in activities that are meaningful to them may help to preserve their self-identity and contribute to maintaining and promoting their mental well-being. An important finding from this research is the importance of possessions and belongings to care home residents. Residents will lose most of their belongings when they move to a care home, and this is a significant loss which has an impact on their mental well-being as their possessions often hold significance and memories. Their belongings are also a part of their self-identity and their identity before they moved to a care home. The significance of possessions and belongings to care home residents and their identity and mental well-being should not be underestimated and should be considered as essential when planning a move to a care home.

During the interviews residents demonstrated that they had internalised some negative assumptions about older adults and believed that they were not capable. Negative assumptions about ageing and frailty have a negative impact on residents' self-identity as they view themselves as no longer able to do things due to their age. Residents often referred to their past selves as being independent and saw themselves as being dependent and a burden now. These assumptions should be challenged by everyone. There were also examples of residents challenging these negative ageing assumptions in the qualitative data where residents strived to remain independent and to learn new skills.

The impact of relationships and interactions with others was important to residents' mental well-being. Residents were affected negatively by the way others treated them and when staff were busy trying to complete their work. Taking the time to interact with residents and to respect their wishes and ensure their voices and opinions are heard is important to maintaining their mental well-being. Residents struggled with maintaining relationships with those outside the care homes. The importance of meaningful relationships needs to be encouraged and residents should be supported to maintain those relationships either through phones, technology, or support in travelling to visit loved ones. The social implications of impairments should also be acknowledged, residents in the study spoke about how their hearing impairment meant that they did not like to interact with others and felt embarrassed having to ask people to repeat themselves. Ensuring that the sensory impairment needs of residents are met and are a priority is essential, as the social impact of sensory impairments may lead to loneliness and isolation, and subsequently contribute negatively to mental well-being.

It is important to keep in mind the person and the journey they have taken to reach this point in life and how their experiences have shaped them as a person and continue to shape them as they grow older. There is a need for more understanding of the impact of moving to a care home can have on an individual. Some residents welcome the change, but many struggle. A change in the culture around ageing and care is needed and it is important for the people who provide care and support and also policy makers to ensure that the individual is respected and cared for along with their history, thoughts, feelings, and opinions in order to maintain and promote their mental well-being.

Below in table 6.10 is a summary of the recommendations from the research. These recommendations need more co-development with residents, care homes, key stakeholders, and policy makers before becoming concrete recommendations. The responsibility for making changes within care homes does not solely lie with care homes. Any changes will need the cooperation and collaboration from commissioners, policy makers, Local Authorities, NHS Trusts, Senedd ministers in addition to care home owners, managers, and their staff.

Table 6.9 Summary of research recommendations for good practice

Importance of relationships	Through focusing on building relationships with care home residents and prioritising maintaining relationships within and outside the care home resident mental well-being can be promoted and maintained.
Respecting privacy	By respecting and striving to maintain residents' physical privacy, in addition to privacy of their information, resident mental well-being can be promoted and maintained.
Holistic, person-centred approach	Treating residents as individuals and consider the journey they have taken before moving to the care home and the impact this has had on the individual. Ensuring that their voice and choice is protected and heard, residents should be involved in all decisions made about their care. This is in

	keeping with the SSWWA 2014 and shared co-operative power empowers residents and maintains their liberty.
Cultural change	Challenge ageing assumptions that impact how older care home residents are treated and are often internalised by residents, which has a negative impact on their self-identity and mental well-being.

The findings of this study reflect the underpinning theoretical framework of this thesis, that mental well-being is a concept that is real and measurable, but also complex and based on important experiential and contextual factors. Each of the three well-being domains that Keyes' (2002) included in his model and well-being scale were reflected in the study findings, with emotional, psychological and social components of well-being also being discussed by residents in the qualitative interviews and how these domains relate to their mental well-being. The findings also support a holistic, person-centred approach to care that will help maintain and promote resident mental well-being. This is congruent with the two continua model of mental well-being, in addition to acknowledging the eudiamonic and hedonic perspectives that are essential to maintaining positive mental health and well-being.

The practice implications that older adults need to be involved in decisions that concern them and their experiences of mental well-being in care homes need to be included in research and policy. This will undoubtedly have resource implications for a care sector already strapped by very limited resources such as staffing. During the interviews residents were often sympathetic and understanding to the challenges of running a care home, this needs to be reciprocated. Co-produced and co-developed research and policy and procedures informed by research involving older adults is already taking place in Wales. This study highlights the importance of experiential knowledge in developing and understanding how mental well-being may be maintained and promoted in care homes.

6.8.1 Areas for further research

A possible area for further research would be to extend the research study to older adults living in the community to explore whether they have similar experiences to older adults living in care homes and whether they value the same experiences as contributing to their mental well-being. Further research also needs to be conducted into the development of a mental well-being measure for use in care homes. From the findings of the quantitative analysis of this research study a measure that included topics were more applicable to older adults living in a care home is needed. The measure could then be used to assess the mental well-being of care home residents when they first move to the care home and to monitor their mental well-being while living in a care home. Through including topic areas more applicable to older adults in care homes this would allow care homes and their staff to understand which areas of residents' mental well-being need to be better supported and maintained, which may help act as a preventative measure against mental ill health.

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APPENDICES

APPENDIX 1 : MENTAL WELL-BEING IN CARE HOMES SEARCH TERMS

Mental well-being in care homes Search Terms:

Field 1: “Old* people*” OR “Old* adult*” OR “Old* person*” OR Geriatric* OR Pensioner* OR Elderly

Field 2: “Mental well-being” OR “mental health” OR well-being OR wellbeing OR “mental wellbeing” OR “quality of life” OR “satisfaction with life” OR “emotional well-being” OR “emotional wellbeing” OR Happiness OR Depression OR “low mood” OR “psychological well-being” OR “psychological wellbeing”

Field 3: “Care home*” OR “Nursing home*” OR “Residential care home*” OR “Residential home*” OR “Nursing care*” OR “Nursing facilit*” OR “Residential care facilit*” OR “Elderly care facilit*” OR “Aged care” OR “long-term care” OR Institution*

APPENDIX 2: PROSPECTIVE WELL-BEING MEASURES TABLE

Instrument name	First version	Latest Version	Items		
1. Basic Psychological Needs Scale (BPNS)	2003	2003	21, 21 + 9 separate scales	Self-report	scale
2. BBC Subjective Well-Being Scale (BBC-SWB)	2011	2013	24	Self-report	scale
3. Biopsychosocial Spiritual Inventory (BioPSSI)	2007	2007	41	Self-report	Scale
4. Emotional Well-being Scale (EWBS)	2011	2011	13	Self-report	scale
5. EUROHIS-QOL (E-QOL)	1998	2003	8	Self-report	scale
6. General Health Questionnaire (GHQ12)	1978	1988	12	Self-report	scale
7. Goteborg Quality of Life Instrument (GQLI)	1967	1990	Well-being part has 18 items	Self-report	Well-being part is a scale includes three parts: the well-being part, the symptoms checklist, and an activity scale
8. ICOPEE (Interpersonal community, occupational, physical and economic well-being)	2015	2015	21	Self-report	Scale 1-10 on which number do you stand on… present, past and future.
9. Mental Health Continuum-Short Form (MHC-SF)	2002	2005	14	Self-report	Multiple choice or scale?
10. Mental Health Inventory-5 (MHI5)	1983	1988	5	Self-report	Multiple choice
11. Mental Physical Spiritual Well-Being Scale (MPS)	1995	1995	30	Self-report	scale

12. Older Adult Health and Mood Questionnaire (OAMHQ)	1995	1995	22	Self-report	True or false
13. Ontological Well-Being Scale (OWBS)	2013	2013	24	Self-report	scale
14. Personal Wellbeing Index-Adult (PWI-A)	1994	2013	7	Self-report	scale
15. Physical, Mental and Social Well-being Scale (PMSW-21)	2014	2014	21	Self-report	scale
16. Positive Functioning Inventory (PFI-12)	2014	2014	12	Self-report	categorical
17. Psychological General Well-Being Index (PGWB-S)	1970	2006	22, 6	Self-report	scale or multiple choice? categorical
18. Questionnaire for Eudaimonic Well-being (QEWB)	2010	2010	21	Self-report	scale
19. The Spiritual Well-Being Questionnaire (SWBQ)	2003	2003	25	Self-report	scale
20. Warwick-Edinburgh Mental Well-Being Scale-Short (WEMWBS)	1983	2009	7, 14	Self-report	scale
21. WHO-5 (WHO5)	1982	1998	5	Self-report	scale
22. WHO-Brief Spiritual, Religious and Personal Beliefs (WHO-QBF)	1995	2013	32	Self-report	scale
23. Anamnestic Comparative Self-Assessment (ACSA)	1983	2006	1	Self-report	n/a
24. Arizona Integrative Outcomes Scale	2004	2004	1	Self-report	scale
25. Cantril Self-Anchoring Striving Scale (CL)	1965	1965	1	Self-report	n/a
26. Life Satisfaction Questionnaire 9 (LISAT9)	1991	1991	9	Self-report	scale
27. Measure Yourself Concerns and Wellbeing (MYCAW)	1996	2007	3	Self-report	Question and scale

28. Public Health Surveillance Well-Being Scale (PHS-WB)	2012	2012	10	Self-report	scale
29. Questions on Life Satisfaction (QOLS)	1988	2000	16	Self-report	scale
30. Satisfaction with Life Scale (SWLS)	1985	1985	5	Self-report	scale
31. Self-Evaluated Quality of Life Questionnaire (SEQOL)	2003	2003	317	Self-report	scale
32. Temporal Satisfaction with Life Scale (TSWLS)	1985	1998	15	Self-report	scale
33. Well-Being Picture Scale (WPS)	1979	2005	10	Self-report	scale
34. Beck Depression Inventory (BDI)	1961		21,13,11	Self-report	Multiple choice
35. Depression in Old Age Scale (DIA-S)	2010	2010	10	Self-report	scale
36. Geriatric Depression Scale-12R (GDS-12R)/Geriatric Depression Scale-15 (GDS-15)	2000	2000	15 or 12 residential version	Self-report	True-false
37. Hamilton Depression Rating Scale	1960	1980	17	Trained observer	after 30 min clinical interview
38. Minimum Data Set Depression Rating Scale (MDSDR)	2000	2000	7	Observation based	Score out of 10
39. Montgomery-Aasberg depression rating scale	1979		10	Observer-rated	Clinical Interview
40. Older People's Quality of Life Scale (OPQoL)	2009	2010	35	Self-report	scale
41. Older People's Quality of Life Scale Brief (OPQOL-BRIEF)		2013	13	Self-report	scale
42. Patient Health Questionnaire (PHQ)	1990		9	Self-report	Multiple choice

43. Ryff's Scale of Psychological Well-being	1995		84,54,42,22, 3-12	Self-report	scale
44. Short Form 36 (SF-36v2)	1990	1998	36	Self-report	scale or multiple choice?
45. Short Form 12		1996	12	Self-report	scale or multiple choice
46. The Cornell Scale for Depression in Dementia	1988?		19	Observation based	
47. State Trait Anxiety Scale	1968		40	Self-report	scale
48. World Health Organisation Quality of Life Scale (WHOQoL-BREF)	1991		26	Self-report	scale
49. 15D swap out?	1981	1989	15	Self-report	scale
50. Affect Balance Scale (ABS)	1969	1969	10	Self-report	Yes/No
51. Affectometer 2 (A2)	1979	1983	20	Self-report	scale
52. Assessment of Quality of Life (AQOL)	1999	1999	15	Self-report	Multiple choice
53. Authentic Happiness Index	2005	2005	24	Self-report	Multiple choice
54. CASP-19 (Control, Autonomy, Self-realisation and Pleasure) (C19)	2003	2003	19	Self-report	scale
55. Chinese Happiness Inventory (CHI)	1997	1997	48	Self-report	scale
56. EUROQOL-5D-5L (EQ-5D-5L)???	1990	2011	5	Self-report	multiple choice
57. EURO-D	1999	1999	12	Self-report	scale
58. Flourishing Scale (FS)	2010	2010	8	Self-report	scale
59. Health and Well-Being Assessment (HWB)	2005	2005	20	Self-report	Multiple choice
60. Herth Hope Index (HHI)	1991	1992	12	Self-report	Multiple choice

61. Hospital Anxiety and Depression Scale (HADS)	1983	1983	14	Self-report	scale or multiple choice?
62. ICECAP-A	2012	2012	5	Self-report	Multiple choice
63. ICECAP-O	2008	2008	5	Self-report	Multiple choice
64. In Charge Financial Distress/Well-being scale (IFDWS)	2006	2006	8	Self-report	scale
65. Inventory of Positive Psychological Attitudes (IPPA)	1991	1991	32	Self-report	scale
66. Jarel Spiritual Well-being Scale (JSWBS)	1996	1996	21	Self-report	scale
67. Kellner's Symptom Questionnaire (KSQ)	1987	1987	92	Self-report	Yes/No
68. Life Orientation Test-Revisited (LOT-R)	1985	1994	10	Self-report	multiple choice
69. Life Satisfaction Index-A (LSI-A)	1961	1961	20	Self-report	scale
70. Meaning of Life Questionnaire (MLQ)	2006	2006	10	Self-report	scale
71. Memorial University of Newfoundland Scale of Happiness (MUNSH)	1980	1980	24	Self-report	scale
72. Multiple Affect Adjective Check List-Revisited (MAACL-R)	1965	1983	132	Self-report	scale
73. Nottingham Health Profile (NHP)	1975	1985	45	Self-report	Yes or no
74. Orientation to Happiness (OTH)	2005	2005	18	Self-report	Scale
75. Oxford Happiness Questionnaire (OHQ)	1989	2002	29	Self-report	scale
76. Personal Growth Initiative Scale (PGIS)	1998	1998	9	Self-report	scale
77. Philadelphia Geriatric Centre Morale Scale (PGCMS)	1972	1975	17	Self-report	Yes/No

78. Positive and Negative Affect Scale (PANAS)	1988	1988	20	Self-report	scale
79. Positive Mental Health Instrument (PMH)	2011	2011	47	Self-report	scale
80. Profile of Mood States Short (POMS2)	1971	1983	Short 35	Self-report	scale
81. Purpose in Life Test-Short Form (PIL-SF)	1964	2011	20	Self-report	Scale
82. Quality of Life Index-Generic (QOLI-G)	1985	1985	66	Self-report	scale
83. Quality of Life Inventory (QOLI)	1988	1994	32	Self-report	scale
84. Quality of Well-Being Self-Administered (QWB-SA)	1970	1997	10 or 80? Actual questions	Self-report	Scale, multiple choice
85. Rosenberg Self-Esteem Scale (RSES)	1965	1965	10	Self-report	scale
86. Salutogenic Health Indicator Scale (SHIS)	2009	2009	12	Self-report	scale
87. Scale of Positive and Negative Experience (SPANE)	2010	2010	12	Self-report	scale
88. Serenity Scale-Brief (SS-B)	1993	2009	22	Self-report	scale
89. Snaith-Hamilton Pleasure Scale (SHAPS)	1995	1995	14	Self-report	scale
90. Social Production Function-IL (SPF-IL)	2005	2005	58, 15 item available	Self-report	scale
91. Spirituality Index of Well-Being (SIWB)	2004	2004	12	Self-report	scale
92. State-Trait Cheerfulness Inventory (STCI)	1996	1996	30	Self-report	scale
93. Subjective Happiness Scale (SHS)	1999	1999	4	Self-report	scale
94. Subjective Vitality Scale (SVS)	1997	1997	7	Self-report	scale
95. The Spirituality Scale (SS)	2005	2005	23	Self-report	scale
96. COOP/WONCA COOP	1989	1992	6	Self-report	Scale

97. Functional Status Questionnaire (FSQ)			34	self-report	Scale
98. Sickness Impact Scale (SIP)	2012		68, 136	self-report	Yes/no
99. Comprehensive Assessment and Referral Evaluation (CARE)	1977		30	interview	Semi-structured
100.SHORT-CARE	1984?			interview	scales
101.IOWA Self-assessment Inventory (ISAI)	1989		120, 56	Self-report	scales
102.LEIPAD	1998?		39, 49	Self-report	Scale
103.Multidimensional Functional Assessment Questionnaire (OMFAQ)	1975	1988		interview	scales
104.Perceived Well-being Scale (PWBS)	1984		14	self-report	Scale
105.Quality of Life Cards (QLC)	1995?		80 cards	Self-report	Cards
106.Quality of Life Profile-Senior Version (QOLPSV)	1997?		111	self-report	Scale
107.Self-Evaluation of Life Scale (SELF)	1984		54 or 16 telephone version	self-report/telephone interview	Scale
108.The Wellness Index (WI)	1996		79	self-report	Scale
109.Older Americans Resources and Services (OARS) Activity of Daily Living Questionnaire	1981		14	Interview – self-report	scale
110.Mood Adjective Checklist	1990?		29	self-report	rate the adjective scale
111.Life satisfaction in the Elderly Scale	1984		200 or 40?	self-report	Multiple choice sentence completion
112.General Well-being Schedule (GWB)	1970		18	self-report	scale

113. Mental Health Continuum-Long Form (MHC-LF)	2008		40? 22?	Self-report	scale
114. The Life Satisfaction Index – Well-being (LSI-W)	1974		8	Self-report	3-point Likert scale

APPENDIX 3: INVITATION LETTERS FOR CARE HOME OWNERS AND MANAGERS

Centre for Innovative Ageing
College of Human and Health Sciences
[redacted]
Swansea University
Singleton Park
Swansea
SA2 8PP
E-mail: [redacted]
Phone: [redacted]
July 27th 2017

Dear,

<u>Understanding and Improving the Mental Well-being of Older Adults in Residential Care</u>

I'm a PhD student at Swansea University in the Centre for Innovative Ageing, conducting research on the well-being of older adults in residential care. I'm looking for residential care homes and their residents in the South Wales area who may be interested in taking part in the research this year.

The research – titled 'Understanding and Improving the Mental Well-being of Older Adults in Residential care' - is supervised by Associate Professors Dr Charles Musselwhite and Dr Michael Coffey. I'm aiming to measure the well-being of older adults in different residential care settings using a short standardised questionnaire for the first stage. The results from the first stage will inform the second stage of research; after further ethical approval I am hoping to conduct individual interviews with care home residents about what well-being means to them. I will be in touch in the future regarding the second stage of the research after further ethical approval. The aim of the research is to understand what contributes to the well-being of older adults in residential care, what it means to them and how it could be promoted and maintained.

If you feel that you would be interested in contributing to the research and would like further information, please get in touch. An expression of interest at this stage does not commit you to participating in either stage of the research. While the research focuses specifically on residents, we hope that the process of being involved in the project will support residential care homes' own efforts to safeguard and promote well-being.

I look forward to hearing from you.

Yours sincerely,

Caitlin Reid

Happy to communicate in Welsh or English

Canolfan Heneiddio Arloesol
Coleg y Gwyddorau Dynol ac Iechyd
[redacted]
Prifysgol Abertawe
Parc Singleton
Abertawe
SA2 8PP
Ebost: [redacted]
Ffôn: [redacted]
Gorffenaf 27ain 2017

Annwyl,

<u>Deall a Gwella Lles Meddyliol Oedolion Hŷn mewn Gofal Preswyl</u>

Rwy'n fyfyriwr PhD yn y Ganolfan Heneiddio Arloesol ym Mhrifysgol Abertawe, ac yn cynnal ymchwil ar les oedolion hŷn mewn gofal preswyl. Rwyf yn edrych am gartrefi gofal preswyl a'u preswylwyr yn Ne Cymru a fyddai gyda diddordeb mewn cymryd rhan yn yr ymchwil.

Goruchwylir yr ymchwil – 'Deall a Gwella Lles Meddyliol Oedolion Hŷn mewn Gofal Preswyl' – gan yr Athrawon Cysylltiol Dr Charles Musselwhite a Dr Michael Coffey. Ar gyfer y rhan cyntaf mae'r ymchwil yn anelu i fesur lles oedolion hŷn mewn lleoliadau gofal preswyl gwahanol yn Ne Cymru trwy ddefnyddio holidur byr. Bydd yr ail rhan or ymchwil yn adeiliadu ar canlyniadau y rhan cyntaf. Yn ystod yr ail rhan or ymchwil byddaf yn cyfweld ag unigolion yn eu cartrefi gofal ynglŷn a beth mae lles yn ei olygu iddyn nhw. Byddaf yn cysylltu eto yn y dyfodol am cymrud rhan yn yr ail rhan ar ôl sicrhau caniatâd moesegol. Nod yr ymchwil fydd deall beth sy'n cyfrannu at les oedolion hŷn mewn gofal preswyl, yr hyn y mae'n ei olygu iddyn nhw a sut y gellir ei wella.

Os oes gennych diddordeb mewn cymryd rhan yn y gwaith ymchwil byddwn yn ddiolchgar pe gallech gysylltu am mwy o wybodaeth. Dyw datganiad o ddidordeb nawr ddim yn eich ymrwymo I gymryd rhan. Er bod y gwaith ymchwil yn canolbwyntio'n benodol ar oedolion hŷn, rydym yn gobeithio bydd y broses o cymryd rhan yn y prosiect yn cefnogi ymdrechion cartrefi gofal preswyl eu hun i ddiogelu a hybu lles.

Edrychaf ymlaen at glywed gennych.

Yn gywir,

Caitlin Reid

Hapus i gyfarthrebu yn Gymraeg a Saesneg.

APPENDIX 4: CARE HOME MANAGER CONSENT FORM

Care Home Manager consent form

Centre for Innovative Ageing, College of Human and Health Sciences, Swansea University.

I understand that the care home's participation in this project will involve:

- Assisting the researcher to identify suitable residents to voluntarily take part in the study and distribute the study information sheets to those residents.
- Allowing the researcher, the use of a suitable location in which to conduct the research.
- Allowing the researcher to meet with individual residents in order to gain their consent to take part in the research.
- Consent to staff support being available in the unlikely event a resident becomes distressed or upset.

I understand that the care home's participation in this research is entirely voluntary and they are able to withdraw from the research at any time. I understand that the residents that take part in the study will also be free to withdraw themselves from the research at any time and without giving a reason. If the care home withdraws from the study, any data that has not been anonymised will be destroyed and no further data collection will take place.

I understand that the identity of all residents and the care home and their staff who participate is confidential.

I understand that the identity of residents and the care home will be treated confidentially by the researcher and that all information will be stored anonymously and securely. All information appearing in the final report will be anonymised. All residents who take part will have the option of withdrawing their data from the study, up until their questionnaire has been anonymised.

I understand that I am free to discuss any questions or comments I might have with either the researcher Caitlin Reid or the research supervisors Dr Charles Musselwhite and Dr Michael Coffey (contact details below).

I understand that I am free to contact the Swansea University Ethics Committee to discuss any complaints I might have.
I also understand that at the end of the study I and the residents who took part will be provided with additional information and feedback about the purpose of the study.

I, …………………………………………………… (NAME) consent to Caitlin Reid proceeding with this research with the supervision of Dr Charles Musselwhite and Dr Michael Coffey.

Signature of Care Home Manager………………………………………….

Date…………………………………………………….

PhD researcher: Caitlin Reid

Email: [redacted]
Phone: [redacted]
Research supervisors: Dr Charles Musselwhite Dr Michael Coffey
Email: [redacted]
[redacted]
Phone: [redacted] [redacted]

APPENDIX 5: PARTICIPANT INFORMATION SHEET

Invitation and information about the research

Title: Understanding and Improving the Mental Well-being of Older Adults in Residential Care

We would like to invite you to take part in research looking at the well-being of older adults in residential care. We would like you to understand why the research is being done and what it would involve for you. Please feel free to talk to others about the study if you wish before deciding whether to take part.

The aim of the research is to measure the mental well-being of older adults living in residential care. We will collect data through the use of a questionnaire called the Mental Health Continuum-Short Form. The questionnaires will be filled in anonymously and all data will be kept confidential. The data we collect from you will be handled and stored in accordance with the Data Protection Act 1998 and Freedom of Information Act 2000.

The questionnaire has 14 positively worded questions and will take 10 minutes to complete; I will be on hand to help or to answer any questions you might have. You are free to withdraw from the study at any time, up until the anonymous questionnaires have been collected. After they have been collected it will be impossible to identify your questionnaire. If you or your care home withdraws from the study, any data that has not been made anonymous will be destroyed and no further data collection will take place. You have the right to decline to offer any particular information requested. If you wish to withdraw from the study, please let myself or your care home manager know. This will not affect the care you receive.

It is not anticipated that the questionnaire will cause distress as it is positively worded but in the unlikely event that you feel upset or distressed a member of staff will be on hand for support, and you are free to withdraw at any time.

The data collected will be used to inform the next stage of research and the development of interview questions to ask older adults what well-being means to them. Care homes and residents that take part in the research will be provided with a summary of the research findings at the end of the research project.

If you have any questions about the research, please feel free to contact myself or one of the research supervisors.

PhD researcher: Caitlin Reid
Email: [redacted]
Phone: [redacted]
Research supervisor: Dr Charles Musselwhite
Email: [redacted]
Phone: [redacted]
Second research supervisor: Dr Michael Coffey
Email: [redacted]
Phone: [redacted]

APPENDIX 6: PARTICIPANT CONSENT FORM

Participant consent form

Title of Project: Understanding and Improving the Mental Well-being of Older adults in Residential Care.

If you would like to take part, read this and sign your name.

Any questions I had about the study have been answered and I understand that:

- I am agreeing to take part in this study, which asks questions about well-being.
- My answers on the questionnaire are anonymous, so no one, except me, knows what I wrote.
- My answers on the questionnaire will be kept strictly confidential.
- My participation in this study is completely voluntary. Therefore, I can stop doing the study at any time for any reason.
- My answers will be collected with other older adults' answers to gain a better understanding of what well-being means for older adults.

If you or your care home withdraws from the study, any data that has not been made anonymous will be destroyed and no further data will be collected. This will not affect the care you receive.

Participant's signature:……………………………………………

Date:…………………………………….

Participant's name (in CAPITALS)……………………………………………………………………………….

Researcher's signature:…………………………………………….

Date:……………………………….

If you have any questions, please don’t hesitate to contact the researcher or research supervisors.

APPENDIX 7: MENTAL HEALTH CONTINUUM SHORT FORM (MHC-SF)

Participant number…………………………….

Please answer the following questions are about how you have been feeling during the past two weeks. Place a check mark in the box that best represents how often you have experienced or felt the following:

During the past two weeks, how often did you feel …	NEVER	ONCE OR TWICE	ABOUT ONCE A WEEK	ABOUT 2 OR 3 TIMES A WEEK	ALMOST EVERY DAY	EVERY DAY
1. happy						
2. interested in life						
3. satisfied						
4. that you had something important to contribute to society						
5. that you belonged to a community (like a social group, or						

your neighbourhood)						
6. that our society is becoming a better place for people like you						
7. that people are basically good						
8. that the way our society works makes sense to you						
During the past two weeks, how often did you feel …	NEVER	ONCE OR TWICE	ABOUT ONCE A WEEK	ABOUT 2 OR 3 TIMES A WEEK	ALMOST EVERY DAY	EVERY DAY
9. that you liked most parts of your personality						

10. good at managing the responsibilities of your daily life						
11. that you had warm and trusting relationships with others						
12. that you had experiences that challenged you to grow and become a better person						
13. confident to think or express your own ideas and opinions						
14. that your life has a sense of direction						

or meaning to it						

APPENDIX 8: PARTICIPANT DEBRIEF SHEET

Participant debriefing letter

Thank you for taking part in my study. I feel that it is important to talk to older adults about their well-being and their experiences of living in residential care to make sure that their opinions are being heard.

The aim of this study is to gather information about the well-being of older adults living in care homes to help understand and improve their well-being.

The information you have given me will be held anonymously, this means that it will be impossible for people to know what your answers were.

If you have any questions, please do not hesitate to contact me or the study supervisor Dr Charles Musselwhite.

PhD researcher: Caitlin Reid

Email: [redacted]

Phone: [redacted]

Research supervisor: Dr Charles Musselwhite

Email: [redacted]

Phone: [redacted]

APPENDIX 9: CARE HOME MANAGER CONSENT FORM

Care Home Manager consent form

Centre for Innovative Ageing, College of Human and Health Sciences, Swansea University.

I understand that the care home's participation in this project will involve:

- Assisting the researcher to approach identified residents to voluntarily take part in the study and distribute the study information sheets to those residents.
- Allowing the researcher, the use of a suitable location in which to conduct the research interviews.
- Allowing the researcher to meet with individual residents in order to gain their consent to take part in the research.
- Consent to staff support being available in the unlikely event a resident becomes distressed or upset.

I understand that the care home's participation in this research is entirely voluntary and they are able to withdraw from the research at any time. I understand that the residents that take part in the study will also be free to withdraw themselves from the research at any time and without giving a reason. If the care home withdraws from the study, any data that has not been anonymised will be destroyed and no further data collection will take place.

I understand that the identity of all residents and the care home and their staff who participate is confidential.

I understand that the identity of residents and the care home will be treated confidentially by the researcher and that all information will be stored anonymously and securely. All information appearing in the final report will be anonymised. All residents who take part will have the option of withdrawing their data from the study, up until their interview has been anonymised.

I understand that I am free to discuss any questions or comments I might have with either the researcher Caitlin Reid or the research supervisors Dr Charles Musselwhite and Professor Michael Coffey (contact details below).

I also understand that at the end of the study I and the residents who took part will be provided with additional information and feedback about the purpose of the study.

I, ………………………………………………… (NAME) consent to Caitlin Reid proceeding with this research with the supervision of Dr Charles Musselwhite and Professor Michael Coffey.

Signature of Care Home Manager………………………………………….

Date…………………………………………………….

PhD researcher: Caitlin Reid
Email: [redacted]
Phone: [redacted]
Research supervisors: Dr Charles Musselwhite
Email: [redacted]
Phone: [redacted]

Professor Michael Coffey
[redacted]
[redacted]

APPENDIX 10: PARTICIPANT INFORMATION SHEET

Participant Information Sheet

Title: Understanding and Improving the Mental Well-being of Older Adults in Residential Care

We would like to invite you to take part in research looking at the well-being of older adults in residential care. We would like you to understand why the research is being done and what it would involve for you. Please feel free to talk to others about the study if you wish before deciding whether to take part.

What is the purpose of this study?

The researcher is Caitlin Reid, a PhD student studying at the Centre of Innovative Ageing, Swansea University. The aim of the study is to develop a better understanding of what contributes to the mental well-being of older adults living in residential care.

What do I have to do?

The researcher will be interviewing care home residents about what they think is important to their mental well-being. The interviews will be digitally recorded and kept anonymous and confidential. The researcher will ask questions about emotional, social and psychological well-being and will take up to an hour to complete.

Will me information be kept confidential?

Your name will not be recorded during the interview and any data collected will be kept confidential. The data will be handled and stored in accordance with the Data Protection Act 1998 and the Freedom of Information Act 2000.

Do I have to take part?

Participation in the research is completely voluntary. You do not have to take part if you do not want to.

What happens if I change my mind?

You are free to withdraw from the study at any time, up until the interviews have been made anonymous. After then it will not be possible to identify your interview from others that have been collected. If you or your care home withdraws from the study, any data that has not been made anonymous will be destroyed and no further data collection will take place. You have the right to decline to offer any particular information requested. If you wish to withdraw from the study, please let myself or your care home manager know. This will not affect the care you receive.

What are the risks of taking part?

It is not anticipated that the research interview will cause distress but in the unlikely event that you feel upset or distressed a member of staff will be on hand for support, and you are free to withdraw at any time.

What will happen to the results of the study?

The results of the study will form part of a higher degree thesis (PhD). The results may also be presented at conferences or published in a relevant journal in order to help improve the well-being of older adults in residential care. The names of residents will not be included. Care homes and residents that take part in the research will be provided with a summary of the research findings at the end research project.

Who is organising and funding the research?

The study is being organised by a PhD student at Swansea University and is funded by the Healthcare Management Trust. The research is carried out by PhD student Caitlin Reid and is supervised by Dr Charles Musselwhite and Professor Michael Coffey.

Who can I contact for further information?

If you would like any further information, or have any questions or concerns please contact either the researcher, Caitlin Reid or the research supervisors (see below).

PhD researcher: Caitlin Reid
Email: [redacted]
Phone: [redacted]
Research supervisor: Dr Charles Musselwhite
Email: [redacted]
Phone: [redacted]
Second research supervisor: Professor Michael Coffey
Email: [redacted]
Phone: [redacted]

APPENDIX 11: PARTICIPANT CONSENT FORM

Participant consent form

Title of Project: Understanding and Improving the Mental Well-being of Older adults in Residential Care.

If you would like to take part, read this and sign your name.

Any questions I had about the study have been answered and I understand that:

	Initial
I am agreeing to take part in this study, which asks questions about well-being	
My answers in the interview will be recorded and made anonymous.	
My answers in the interview will be kept strictly confidential.	
My participation in this study is completely voluntary. Therefore, I can stop doing the study at any time for any reason.	

If you or your care home withdraws from the study, any data that has not been made anonymous will be destroyed and no further data will be collected. This will not affect the care you receive.

Participant's signature:……………………………………………
Date:…………………………………….
Participant's name (in CAPITALS)…………………………………………………………………………….
Researcher's signature:…………………………………………….
Date:………………………………

If you have any questions, please don’t hesitate to contact the researcher or research supervisors.

APPENDIX 12: PARTICIPANT DEBRIEF SHEET

Participant debriefing letter

Thank you for taking part in the study. I feel that it is important to talk to older adults about their well-being and their experiences of living in residential care to make sure that their opinions are being heard.
The aim of this study is to gather information about the well-being of older adults living in care homes to help understand and improve their well-being.

The information you have given me will be held anonymously, this means that it will be impossible for people to know what your answers were.

If you feel you would like support with any distress you've felt during the research please contact your care home manager or access support from a member of staff you feel comfortable speaking with.

If you wish to speak to an outside agency Age Cymru offer information, advice, and advocacy you can contact them on 08000 223444. If you wish to contact your local branch you can reach the Swansea, Neath, Port Talbot, Bridgend Age Cymru branch on 01792 648866, and the Llanelli branch on 01554 784080.

Care and Social Services Inspectorate Wales: 0300 7900 126

If you have any questions, please do not hesitate to contact myself or the research supervisors Dr Charles Musselwhite or Professor Michael Coffey.

PhD researcher: Caitlin Reid
Email: [redacted]
Phone: [redacted]

Research supervisor: Dr Charles Musselwhite

Email: [redacted]

Second research supervisor: Professor Michael Coffey
Email:[redacted]
Phone: [redacted]

APPENDIX 13: INTERVIEW TOPIC GUIDE

Example questions e.g. life style issues

1. What's your daily routine like?
2. What's the environment here like?
3. **What would make things better for you?**
4. **Since moving to the care home, how has the lifestyle change affected you?** What have you found to be the differences?
5. What things have changed since you moved to a care home?
6. What things have stayed the same since moving to a care home?
7. What things are better since you moved and what are worse? And why?
8. **What do you feel is important to your mental well-being?**
9. **Are there opportunities for you to contribute ideas for activities?**
10. Can you change things you don't like here? Are there things you feel you should/need to change that are difficult to do so?
11. **Do you feel listened to?**

Emotional well-being

12. What makes you happy? What makes you take an interest in life? What interests you in life?
13. **What makes you feel satisfied with life?**
14. **Are there times when you feel happy here? Can you give me an example?**

Social well-being

15. **How do you feel about the way society is today/what's going on in the world at the moment?**
16. How do you think people contribute to society?
17. **How has your role/sense of purpose changed since you were younger/moving to a care home?**
18. **Can you tell me about a time you felt you were able to contribute to society? Do you feel that it's important?**
19. **Is a sense of community important?** Is there a sense of community here? Can you tell me about it? Is this important to you?

Psychological well-being

20. **Can you tell me how your responsibilities have changed since moving to a care home?**
21. **Do you feel that you have warm and trusting relationships with others?**
22. **Are you able to maintain relationships since moving to a care home?**
23. **What brings meaning to your life?**
24. What activities do you find meaningful? Can you engage with these here?
25. Do you believe people's experiences help them grow to become better people?
26. **Are you able to accomplish what you'd like to accomplish? Can you give me an example?**
27. Before we finish, is there anything else you'd like to add?

Prompts

Can you tell me more?

Can you tell me about a time….? What was that like for you?