

Interrelated understandings of supporting health in later life

It is increasingly acknowledged that understanding how we can maintain good health in older life means attending to many more aspects of our lives than specific and separate biological functions. The articles in this issue offer perspectives and evidence which bear on the complexities that follow from acknowledging the inter-relatedness of health processes and outcomes. Smith's conceptual paper points up the multiple links between musculoskeletal pain, psychological self-management and social isolation in older people. He goes on to argue that health and social care professionals must look well beyond the physical symptoms or physical circumstances when considering the recommendations for actions. He sees taking the time to do this as worthwhile for improving peoples' social participation and also as cost effective, urgently requiring research to focus. Such suggestions are echoed by Tinker *et al.* whose scoping review of evidence about the effects of exercise on the mental health problems of women in later life, of whom many experience significant anxiety and depression, but whose physical, social and resource constraints may limit their opportunities to follow official health guidance on exercising. They identify how this group is least likely in the population to meet current guidelines. Paradoxically, they also find there has been little research evidence about what types of exercise may benefit which specific mental health problems. Neither is there enough evidence on how far the symptoms and circumstances of women living with such problems may themselves limit their ability to engage in exercise-supportive practices and programmes.

Malnutrition in older adults is another health issue widely assumed to be both less widespread and also more straightforward to address than the more complex realities brought to light in examining the evidence more closely. While the systematic review by Douglas, Lawrence and Knowlden identifies that fortifying common food ingredients is reported as increasing calorie and protein intake, as with many studies of dietary intake and outcomes, the quality of the underpinning research is limited, so that the case for such interventions improving clinical outcomes remains unclear.

Assumptions are also challenged by research on peer support through befriending for older veterans, carried out by Burnell, Needs and Gordon. This identifies how the changing nature of war, and generational effects in and experiences for different veteran populations may condition both needs and expectations brought to such relationships. While younger individuals may seek support to transition to civilian life, both younger and older veterans may have overlooked the needs to have the effects on them of service experiences, shared through peer befriending. But rather than proliferating new support groups they argue that addressing this real gap in existing provision needs to build on organisations already trusted by the veteran community.

As elder care issues and preferences become more complex, forms of care provision are changing to reflect a shift from more institutional to more consumer-led, client-centred and policy-regulated. The focus group study by Hogden *et al.* with 66 care staff from 11 care homes in Australia explored how staff specifically, viewed these changes in relation to the influence of accreditation on quality in homes provision by standards assessed and accredited through site visits. This highlighted how changing circumstances have affected both the regulation and delivery of care. However, it also raised further questions about what possibly contradictory factors may, in turn, influence the regulatory framework and how these should appropriately reflect the changing dynamics between care providers and consumers.

Instructive international contrasts between quality judgements on care homes provision are provided by the study by Adra *et al.* of the views of residents, their family caregivers and staff in two nursing homes in the Lebanon. This was a pioneering exploration from a region where care

homes have been hardly researched. Their study nonetheless found considerable agreement across all the participant groups, that residents' quality of life could be enhanced if they were able to collaborate in co-constructing residents' sense of self, identity and continuity of meaningful self-care routines. This suggested the need for a model of purposeful, collaborative person-centred caring with the potential to further inform nursing care in nursing homes more widely.

The final article in this issue, by Beech *et al.* is also pioneering in offering a process and outcomes evaluation of an initiative using asset-based methods to deploy non-clinical members of primary health care or hospital teams, to support the wellbeing of community older people with long-term conditions and unmet social needs to continue to live in the community. In many respects, the findings of this mixed methods case study resonate with the types of argument advanced in most of this issue's articles, from Smith's opening article onwards. These have highlighted how attending to the social elements underpinning ill health appreciating individuals' own definitions of their priorities, seen in the wider social context of their lives, would be most important in sustaining their health holistically and also for pointing the way to a more integrated cross-sector approach to effective service provision for this challenging but growing group of older people.