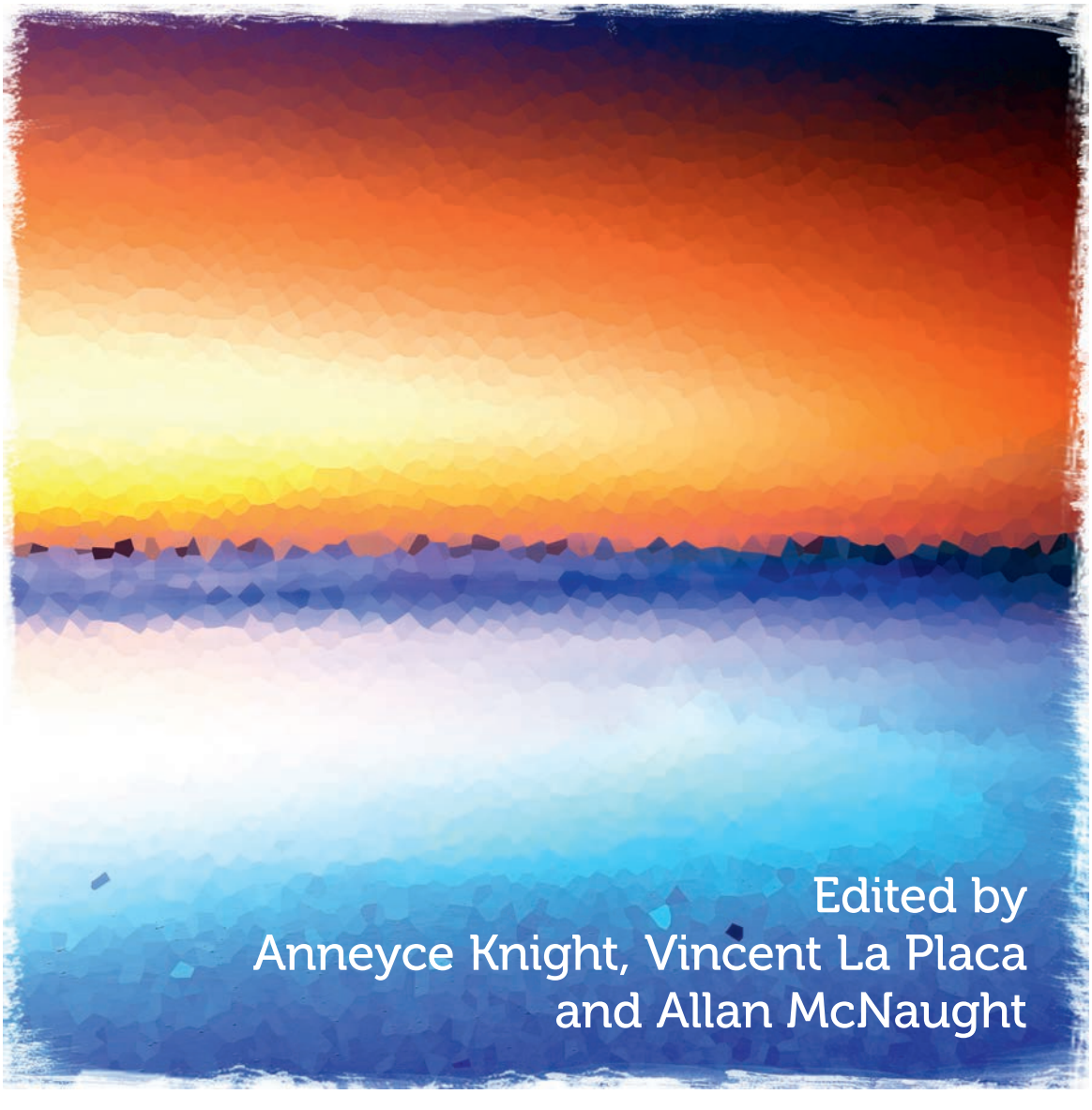
Wellbeing

Policy and Practice



Edited by
Anneyce Knight, Vincent La Placa
and Allan McNaught

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Policy and Practice

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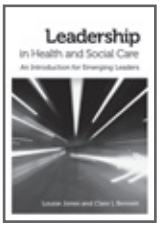

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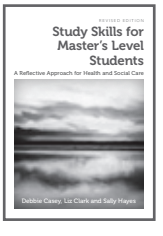

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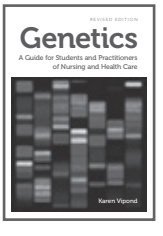

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This book is dedicated to our children, friends and colleagues.

Anneyce Knight would especially like to dedicate this book to Bonnie Shirley Knight and the late Shirley Landels.

CONTENTS

05

THE LIVING ENVIRONMENT AND WELLBEING: WICKED PROBLEMS, WICKED SOLUTIONS?

Jill Stewart and Jim Gritton

AIMS OF CHAPTER:

- To review opportunities to promote housing and wellbeing based on evidence;
- To consider two complex challenges for housing and wellbeing: those living in poor privately rented housing, and those ageing in place;
- To explore some of these complex interrelationships of housing, health and wellbeing in the light of theories around 'wicked' or 'messy' issues.

INTRODUCTION

Housing is an integral part of the wellbeing agenda, and links between housing, health and, more recently, wellbeing are firmly established. Wellbeing emphasises mental and emotional health, as well as enhancing quality of life, where possible, through supportive relationships and active citizenship. Questions about what constitutes wellbeing are considered elsewhere in this book (see *Chapters 2* and *3*). In this chapter we are concerned with some of the pertinent relationships, and complexities around how wellbeing needs can differ according to choices (or lack thereof) and how housing, health and social care needs change across the lifespan.

Evidence indicates that in order to maintain, promote and improve wellbeing, housing needs to be of decent quality, set in neighbourhoods offering community facilities and amenities, with places for children to play and adults to meet in the development of positive social relationships (see, for example, Marmot *et al.*, 2010; WHO and Commission on the Social Determinants of Health, 2008). Our knowledge is moving forward from the relationships between housing and wellbeing, to what we can do about it in practice to support and enhance often complex, multifaceted and sometimes changing housing and social care needs, in ways that are evidence-based and effective (Stewart, 2013).

However, a person's or community's housing is frequently indicative of their socio-economic position in society: is it a person's poverty or their housing environment that causes ill health? Many low income households suffer multiple stressors, which can place additional pressure on their families and communities and over which they may have little, if any, control or even influence (see, for example, Stewart *et al.*, 2005).

We are in a major phase of transition in public health and wellbeing and rethinking how we can best address the social determinants of health. Health and Wellbeing Boards (HWBs) will look to Joint Strategic Needs Assessments (JSNAs) with demonstrable health and wellbeing impacts and outcomes (see *Chapter 4*). As part of the policy context and location in local authorities, those charged with delivering public health and wellbeing will need to develop skills in using datasets to support evidence-based strategies and interventions that are evaluated for effectiveness.

A focus on partnership and evidence-based practice is further consolidating strategies and interventions as Public Health England reiterates the importance of delivering increasingly effective and proactive services, focusing on the social determinants of health to protect, improve and promote health. In housing, health and social care, this requires continued attention to demographic change, stock availability and condition, regard to changing housing need across the life-course, and consolidation of existing service provision to maximise both health impact and health outcomes of interventions and strategies.

As wellbeing becomes embedded as a key part of the public health agenda, with its new organisational and cultural changes, those charged with delivering housing services will need to look to more effective means of engagement in addressing our housing stock, but also in meeting wider wellbeing need. We need to find new ways of intervening in addressing housing stock and the complex lives of those who live there, particularly where alternative housing is frequently neither an option nor a choice in the short or longer term.

This chapter explores two very different manifestations of wellbeing in the housing sector. Firstly it looks at the bottom end of the privately rented sector, where housing conditions and insecure tenure can have a negative effect on wellbeing, and asks how the impact of some of these effects might be mitigated by effective partnership arrangements, particularly where children are involved. It then looks at a very different housing area – that of owner occupiers 'ageing in place' and how housing, health and social care partnerships can work in greater collaboration to provide more effective services in maintaining wellbeing. We then consider so-called 'wicked problems' in housing and wellbeing, using systems thinking and soft systems methodology to get 'under the skin' of some significant wicked issues and the need for effective, evidence-based collaborative solutions.

CAN WELLBEING BE ENHANCED FOR THOSE WITH FEW HOUSING OPTIONS?

As access to housing for many people closely correlates with income, rather than need, those on limited budgets have little choice in their housing. Whilst the privately rented sector caters well for some, at the bottom end it can be expensive, insecure and of poor condition. Many individuals and families can feel trapped in the sector, with little chance of their situation changing, and may or may not be able to access other housing tenures, either social housing (excluded due to ineligibility) or owner occupation (exclusion due to finance or previous inability to fund a mortgage, even though the rental level may be broadly equivalent to mortgage repayment). The focus of this section of the chapter is the lower end of the privately rented sector and it illustrates the challenge of improving wellbeing in the face of so many confounding factors.

The privately rented sector is complex and has disproportionate numbers of mobile and newly formed households, and its tenants tend to have less security than those in the social housing sector (see, for example, Kemp and Keoghan, 2001; Kemp, 2011). It has a high proportion of non-decent homes (Parliamentary Office of Science and Technology, 2011). Since 1988, private sector housing tenancies are 'Assured Shorthold', generally meaning a fixed-term tenancy (often fixed at six months) at a market-based rental level. For tenants, this can be stressful because long-term security is not guaranteed. In addition, there is evidence to suggest that many tenants seeking necessary repair work, etc. may find themselves in a worse position, facing rental increase, harassment or retaliatory eviction (Crew, 2007; Emanuel, 1993).

Houses in multiple occupation (HMOs) which are unsuitable house or hotel conversions can be particularly problematic and of poorest condition. This type of living accommodation includes hostels, houses divided into bedsits, and hotels used as permanent residences. Issues facing residents of this form of shared accommodation are not just related to poor housing conditions and inadequate amenities (bathroom, toilet, kitchen) but they may also be social, and/or emotional, particularly in the case of numerous families with complex needs and chaotic lives (including frequent movers) living in close quarters.

Whilst bedsits can provide low cost accommodation, they may also pose significant risks to the mental health of residents, and contribute to elevated levels of stress, anxiety and depression. Living in bedsits can make it difficult for residents to overcome drug and alcohol problems, often due to the behaviour of other residents (Barratt *et al.*, 2012a). Local authorities vested with improving conditions need to look more widely than just the physical housing conditions to mitigate wider health and wellbeing risks (Barratt *et al.*, 2012b). A further pressure for residents living in what were once hotels, now used for more permanent residence, can be food poverty, as kitchen facilities can be inadequate. Some authorities, such as Thanet District Council in Kent, are seeking to plug the gaps and help support more balanced diets where this applies (Hopkins, 2011).

Physical housing conditions aside, concerns have also been expressed about the Universal Credit and how existing and potential tenants might be able to access and maintain a private sector tenancy, further aggravating some of the health inequalities identified by Marmot *et al*. (2010). The Pro-Housing Alliance Report (2012) found that feelings of insecurity, stress and anxiety, and moving home added to existing problems such as isolation, loss of confidence and debt. Sometimes this meant making stark choices between 'heating or eating'. This report also identified a need to help tenants manage the changes in their lives without further detriment to their health and wellbeing.

Individuals and families with already complex needs may find themselves in this sector, or the sector may aggravate and create additional wellbeing needs. Questions relating to housing and wellbeing seem clear cut: people need somewhere secure, safe and affordable to live. What can services hope to offer those for whom wellbeing seems so out of reach?

Local authorities and their partners charged with enforcing, advising on and advocating for better living conditions in the private housing sector are faced with major challenges. Insecure tenancies and high rents are, to a great extent, out of their remit, but helping to support tenants though streamlined services that include advice and prompt benefit payments can make a real difference, alongside access to more suitable accommodation where this is possible. There are a range of options to help address fuel poverty, providing for warmer homes and potential for additional family income to spend elsewhere. Access into and assistance to remain in housing aside, there are many agencies able to help mitigate some of the negative wellbeing effect of the private housing sector, including Children's Centres which can offer a range of family support. Together with some of the innovative approaches many agencies are offering individually such as subsidised meals, more widely socio-economic regeneration can help provide and support access to education, training and employment opportunities for a more sustainable approach in addressing both individual and community wellbeing.

HOW CAN WELLBEING BE ENHANCED FOR THOSE WHO 'AGE IN PLACE'?

As a population we are living longer, and as we 'age in place', new challenges are presented for policy makers in supporting people to stay in their own homes for as long as possible. Successive governments have encouraged owner occupation as a cornerstone of personal responsibility, and the Government is increasingly looking to owner occupiers to use their own finance, including releasing equity from their property, to maintain, repair and improve their own homes.

As people grow older, the housing conditions may deteriorate around them, particularly if living alone; they are likely to be at home for longer, meaning that it would be more

expensive to heat adequately. Added to this, the ageing process may affect their physical and mental health in other ways, with an increasing risk of suffering home accidents and increased likelihood of dementia, each of which has an impact on their housing, health and social care needs.

With the demographics of an ageing population come more degenerative illnesses, and disease, notably dementia, which has become a priority policy area. This is now raising significant questions about the extent to which the State should support people living in their own homes and there are fundamental housing, health and social care implications to be considered. The numbers of people with dementia are increasing and most live in their own homes, more than half of these on their own (see evidence cited in Andrews and Molyneux, 2013).

Helping provide appropriate support to those with dementia in the owner occupied sector, and where applicable their carer (who will also be ageing and have their own developing needs), closely correlates with housing conditions. A healthy living environment remains important, and additional considerations and adaptations will become necessary as the condition deteriorates. With more time being spent at home, the cost of heating and lighting will be greater and there is an increased likelihood of home accidents, as well as a potential increase in isolation and loneliness.

Awareness, early diagnosis, appropriate treatment and signposting to alternative options can greatly enhance quality of life for both the person with dementia and their carer. Home-based solutions can help prevent crises arising and focus more on quality of life, relieving the pressure on number and duration of hospital stays, reducing costs elsewhere in the system (see, for example, evidence and good practice cited in Andrews and Molyneux, 2013). For some years, Home Improvement Agencies have been working to deliver more focused services based on individual need by drawing in appropriate expertise to help minimise disruption and maximise health and wellbeing outcomes for their clients, a role which can continue to be developed into other client areas.

Care and Repair England's 2012 brochure recognises that most people wish, and are able, to stay in their own homes for as long as possible, where the right housing and care support is combined with design and layout changes that take account of dementia symptoms, including memory loss, mood changes and problems in communicating and reasoning. In summary, the brochure suggests that certain features are particularly taken into consideration in supporting someone remaining in their own home (see *Table 5.1*).

With this renewed emphasis on effective partnerships, floating support within dementia-friendly communities will help ensure inclusion, independence and quality of life (Andrews and Molyneux, 2013), and continued research will pave the way for new methods of intervention.

Table 5.1 *Making it easier to keep living at home.*

Feature	Suggestions to make things easier at home
General design and layout	Strong colour coding to enable recognition and recall function; clear spaces to enable safety and mobility as well as ease of finding things; seating near windows for sensory and memory stimulation; glass fronted doors for recognition, with clear containers.
Lighting and heating	Promote strong daylight but reduce glare; good artificial light but avoid shadows; use timers and motion sensitive lights; fit fireguards and easy to use controls with timers and thermostats for water and heating.
Safety and security	Fit smoke and carbon monoxide detectors; install a key safe so trusted people can enter; fit hand and grab rails as necessary; investigate appropriate specialist equipment and adaptations, including telecare such as personal sensors to monitor movement and behaviour and trigger call for help when required.
Retro decorating	Identify items which trigger positive memories across senses of taste, smell, colour, shape and size; use older styles.
Going out and about	External door sensors and reminders; use familiar routes and use tracking devices (or mobile phone with location finder), carry a form of identity.
Gadgets and equipment	Get expert help and advice.

Source: Adapted from Care and Repair England (2013).

HOUSING, HEALTH AND WELLBEING: WICKED ISSUES, WICKED INTERVENTIONS?

In this chapter thus far, we have drawn attention to the complex interplay of housing, health and wellbeing. Many individuals, families and communities have complex, intractable needs that are difficult to address because the causes are deep-rooted and intertwined. Part of the difficulty in tackling such problems is that we often apply solutions that are really only useful for solving simple problems. What can we do about this? Perhaps the first step is to conceptualise the problems differently. Some problems are so persistent, stubborn and difficult to resolve, that they are often described as 'wicked' – not in a pejorative sense but in terms of their resistance to treatment or resolution. Wicked problems have many interlinking causes; they are difficult to categorise or define, and they tend to be immune to 'right' answers or simple solutions. They include many health and wellbeing problems; for example, poverty, mental health, substance misuse, antisocial behaviour or poor housing.

The origin of the concept of a wicked problem is usually attributed to Horst Rittel and Melvin Webber (1973), Professors of the Science of Design and Urban Planning, respectively, at the University of California at Berkeley. Unlike difficult but relatively straightforward

problems, which can usually be solved over time using tried or tested methods (these are referred to as tame problems), wicked problems have many interdependent causes, and attempts to find a solution sometimes result in unforeseen or undesirable consequences. Worse still, they may even aggravate the problem. According to Rittel and Webber (ibid.), there are at least ten distinguishing properties of wicked problems and these can be used as a handy checklist for determining whether a problem is in fact wicked:

1. There is no definitive formulation of a wicked problem.
2. The search for solutions never stops with wicked problems.
3. Solutions to wicked problems are neither right nor wrong, but better or worse.
4. There is no immediate or ultimate test of a solution to a wicked problem.
5. Every solution to a wicked problem is a 'one-shot' operation – because there is no opportunity to learn by trial and error, every attempt counts significantly.
6. Wicked problems do not have a calculable or exhaustively describable set of potential solutions.
7. Every wicked problem is essentially unique.
8. Every wicked problem can be considered to be a symptom of another problem.
9. A wicked problem involves many stakeholders, all of whom will have different ideas about what the problem really is and what its causes are.
10. Problem-solvers are liable for the consequences of the actions they generate.

Wicked problems have captured the attention of a number of other theorists, among them Russell Ackoff (1974), erstwhile Professor of Management Science at the University of Pennsylvania, who used the term 'mess' to describe complex problems. Although similar in idea to wicked problems, the main difference is one of nuance: the word mess is used to describe a complex network of interrelated problems that interact with each other. In contrast, Ronald Heifetz at the John F. Kennedy School of Government at Harvard University prefers the term 'adaptive challenge' to describe 'systemic problems with no ready answers' (Heifetz and Laurie, 1997: 124). The challenges are adaptive because solutions require new thinking, experimentation and a preparedness to think outside the box. In this chapter, we treat the three terms as de facto synonyms.

In order to be able to tackle wicked problems, we need to consider them in an all-round context. One way of approaching this is to use systems thinking, which is a holistic approach to analysis that seeks to understand how a system's parts interrelate and influence one another within a larger whole. In order to make sense of a wicked problem, we need to view it as a whole and understand the relationship of the many parts that contribute to the problem's complexity (see *Figure 5.1*).

Tempting as it may be, splitting the problem into parts and analysing each in isolation will not address the whole problem. To misquote Aristotle, a wicked problem is more complex and stubborn than the sum of its parts! In systems thinking, 'a problem is not solved by

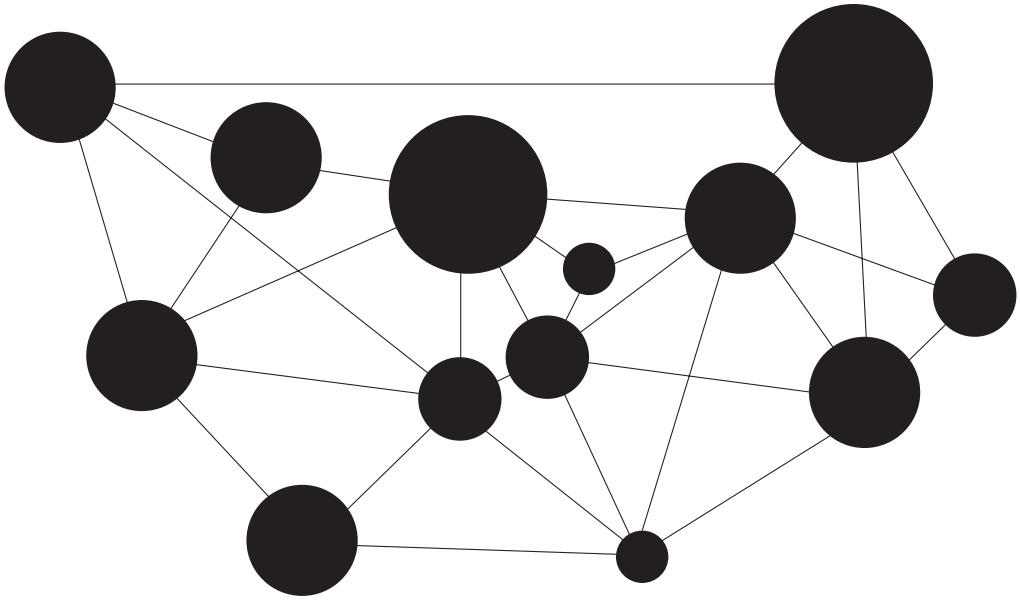

Figure 5.1 *A system has many interrelated parts.*

taking it apart but by viewing it as a part of a larger problem' (Ackoff, 1974: 14). If we use the idiom 'can't see the wood for the trees' as a metaphor, systems thinking is about diverting the focus of our attention away from the trees to the wood that they obscure.

Space precludes a detailed discussion of the origins of systems thinking in this chapter, but it has a long, interesting history which draws from cybernetics, engineering, biology, anthropology, management and many other disciplines too. (For readers who want to know more, *Systems Thinkers* by Ramage and Shipp (2009) is well worth a read.) The important thing to note about the development of systems thinking over the last 100 years is that it is both multidisciplinary and interdisciplinary. This not only highlights the need to view wicked problems from multiple perspectives but also suggests that only collaborative, multi-agency solutions will break down the kind of wicked problems seen in health and social care.

One specific branch of systems thinking that is particularly relevant to the kinds of wicked or messy problems discussed in this chapter is soft systems methodology (SSM), although it was originally developed as a learning system for tackling the wicked problems that managers face in organisational life. As an approach, SSM is most commonly associated with the work of Peter Checkland, Emeritus Professor of Systems, and his colleagues at Lancaster University. Deriving from his work on action research, SSM emerged as an approach for tackling real-world problems, and provides a methodology for dealing with wicked or messy problem situations – "soft systems methodology (SSM) is an organised way of tackling perceived problematical (social) situations. It is action-oriented. It organises thinking about such situations so that action to bring about improvement can be taken" (Checkland and Poulter, 2006: xv).

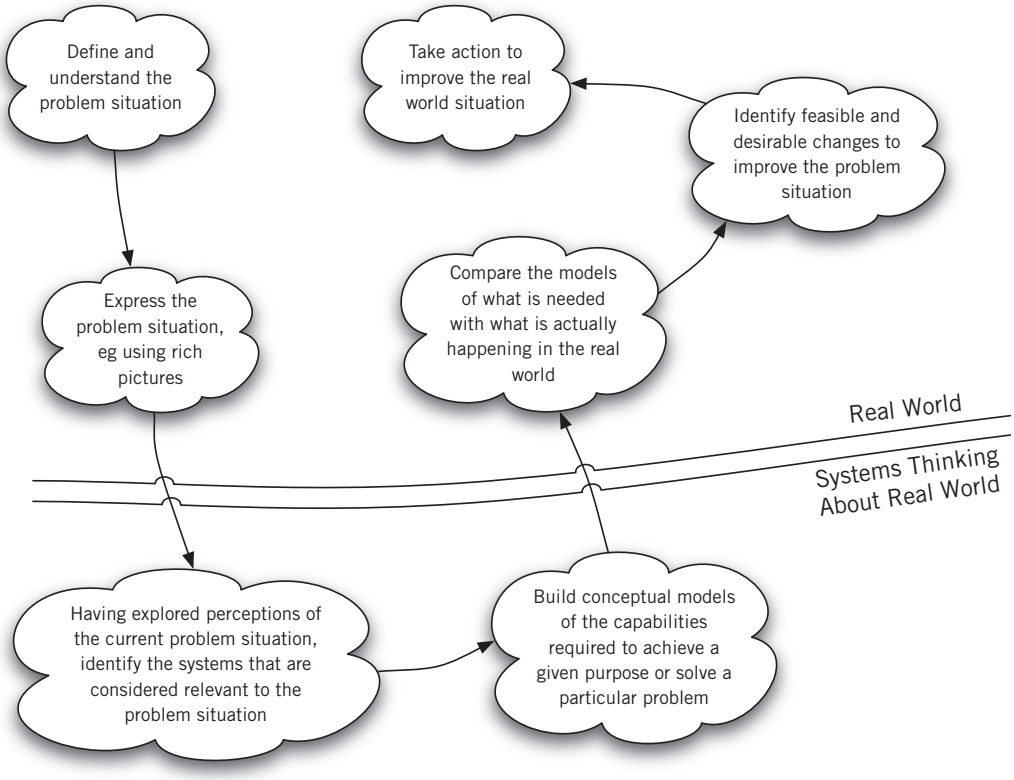

Figure 5.2 *Soft Systems Methodology (adapted from Checkland and Scholes,1990).*

SSM involves seven stages (see *Figure 5.2*). Although the stages are often represented in linear, sequential fashion, Checkland was keen to stress that they should not be viewed as a constraining straitjacket. Rather, users should feel free to start at any point and complete as many iterations as necessary to gain benefit from the model's use.

One of the most useful techniques drawn from SSM is rich pictures. Sometimes referred to as a situation summary, a rich picture is a flexible, creative and graphical technique, used to depict a complicated or problematic situation. Indeed, a well-crafted rich picture will contain everything that is relevant to a complex situation (see Monk and Howard, 1998, for some useful examples of rich pictures). Although rich pictures may sometimes look like a child's drawings because they contain cartoons or stick figures, the technique is deceptively powerful, as the very act of drawing the picture can reveal important insights about a problem.

One of the things that make wicked problems particularly challenging to deal with is the fact they are socially complex: they involve multiple stakeholders and seldom sit within the jurisdiction of one single organisation or agency. Moreover, stakeholders are seldom a homogeneous group and may have competing needs and/or vested interests. To quote Rittel

and Webber (op. cit.: 169), "what satisfies one may be abhorrent to another … [and] what comprises problem solution … is problem-generation for another".

Perhaps not surprisingly, the need for collaboration among stakeholders is a popular refrain in the literature on wicked problems. However, collaboration requires trust, knowledge sharing and structures that facilitate rather than impede the search for collaborative, multi-agency solutions. Sadly, hierarchical structures, bureaucratic cultures, professional 'preciousness' and inward-looking policy making act as a powerful but often invisible deterrent to knowledge sharing and cross-boundary collaboration, a viewpoint shared by Dawes *et al.* (2009: 395): "The boundaries of organisations, jurisdictions, and sectors present the most obvious challenges, but more subtle boundaries related to ideology, professional norms, and institutional divisions can be equally problematic". They go on to argue that success in tackling wicked problems means overcoming a 'need to know' culture in organisations and fostering a 'need to share' culture instead, but how can we achieve this?

David Hunter (2009), Professor of Health Policy and Management at Durham University, calls for a new leadership paradigm, arguing that we need leaders who are more politically astute and who are prepared to confront power and exert influence – "only through such means, and through seeing public health problems as examples of complex adaptive systems, can successful inroads be made into wicked problems" (ibid.: 203). They also need to think and act pro-socially and behave in a way that fosters collaboration and trust. This means building relationships with stakeholders and empowering others within the organisation to do the same, especially those who share clients with partner agencies, because solutions "reside not in the executive suite but in the collective intelligence of employees at all levels, who need to use one another as resources, often across boundaries" (Heifetz and Laurie, 1997: 124). It goes without saying that leaders at all levels of the organisation must be able to distinguish a wicked problem from a tame one. This means developing skills in systems thinking and building a toolkit of methodologies for successfully tackling wicked problems.

CONCLUSION

Many of the most intractable problems in housing, health and social care are certainly wicked or messy in the sense intended by Rittel and Webber (1973) or Ackoff (1974) above. For reasons we have explained, such problems need to be considered in the round using systems thinking, to make sense of their complexity and to facilitate a better understanding of the dynamic relationship between the problem's constituent parts and those whom it affects. This calls for a different way of thinking about and tackling wicked problems predicated on system-wide approaches that involve joined-up working and collaborative, multi-agency solutions (see, for example, *Chapter 8*).

We have seen that housing, health and wellbeing share a complex relationship, and to position housing more centrally, we need to maximise the potential of the new public health and wellbeing apparatus, in particular in demonstrating housing need in JSNAs. Whilst seeing the bigger picture of housing, by learning from and sharing evidence and good practice, and ensuring that the information reaches the right people in influencing policy and strategic direction, we also need to make every intervention count a little bit more.

RESEARCH POINTER 5.1

Read the Joint Strategic Needs Assessment (JSNA) for the area in which you live or work and consider the following questions:

- To what extent is housing considered a social determinant of health?
- How have housing needs been assessed, and why? Are there any gaps?
- What housing issues does the JSNA cover (e.g. overcrowding, availability of open spaces, age of residents, tenure, stock condition, poverty, crime, home accidents, etc.)?
- How will local partnerships deliver wellbeing through housing strategies and interventions?

RESEARCH POINTER 5.2

- What are the housing and wellbeing needs in your neighbourhood?
- How do you know? What evidence do you have to support this?
- Are you aware of where you might access further evidence and examples of good practice to help inform what you are doing, or what your organisation is doing?

RESEARCH POINTER 5.3

- What housing, health or wellbeing problems can you think of that are wicked?
- What makes them wicked?
- What solutions have been tried before, and why haven't they worked?

RESEARCH POINTER 5.4

- Earlier we asked you to identify a wicked housing, health or wellbeing problem. Now create your own rich picture that depicts the problem you identified.
- Rather than attempt this on a computer, we recommend you sketch it freehand using symbols, cartoons, keywords, stick figures, arrows and other diagrammatic tools.
- What did you learn about the problem?

FURTHER READING

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