PROJECT REPORT

European Welfare Models and Mental Wellbeing in Final Years of Life (EMMY)

The EMMY project is funded by the MYBL Joint Programing Initiative

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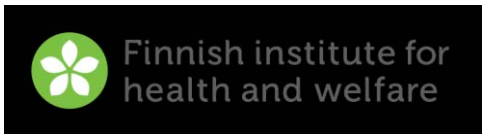

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EXECUTIVE SUMMARY

The main aim of the EMMY project was to contribute to the development of good welfare policies which support mental wellbeing (MWB) in oldest-old age.

Oldest old age is defined as 80 years and over, and is a growing age demographic globally today. This demographic transition may require new policy development which builds on mental wellbeing. Mental wellbeing is a multidimensional concept centring around three separate domains; *evaluative wellbeing* which relates to satisfaction with life, *hedonic wellbeing* which is linked to positive and negative emotions or affect, and *eudaimonic wellbeing* with a focus on meaning in life.

The mixed methods study used qualitative methods to explore what people aged 80 and over themselves define as important for their mental wellbeing, and quantitative methods to analyse components of mental wellbeing in oldest old age using existing data from the European Social Survey (ESS). Furthermore, a policy analysis mapped out how policy development tin the four partner countries (Finland, Italy, Norway and Spain) support mental wellbeing in oldest old age.

A total of 117 participants from all four countries were included in the focus group study. Participants were recruited from senior community centres, adult day care centres, and nursing homes. Data was assessed using qualitative content analysis. Participants' perspectives on MWB were collated along four dimensions: functional, social, personal and environmental. Staying healthy and maintaining independence, having close relationships with others, and insightful experiences with friends positively contributed to MWB. Additionally, engagement in fruitful or inspiring activities contributed to enhance personal development, which, in turn, had beneficial effects on MWB. Having a positive outlook was also found to be associated with MWB. The results reinforce the dynamic and multidimensional nature state of MWB. Supporting the social and physical environment as well as strengthening personal capabilities and self-esteem, can foster MWB among the oldest old population.

Quantitative analyses were based on data from Round 6 (2012) of the European Social Survey (ESS) which includes a broad range of items related to MWB. To increase comparability, data from the 24 countries belonging to either the European Union (EU) or the European Free Trade Association (EFTA) participating in ESS is used. To explore MWB dimensions in old age Exploratory Structural Equation Model (ESEM) was performed based on initial results of Exploratory Factor Analysis (EFA).

Results from the ESEM analyses were used to construct MWB measures providing the basis of analyses of welfare system impact on MWB. Results indicate that high level of formal support and gender equality are beneficial for both subjective and psychological aspects of MWB. Furthermore, social trust, reduced income inequalities and long duration of labour market participation increased life satisfaction and happiness in the oldest old population. The most important aspects of welfare state for MWB included ability to cope on own income, physical health and place in society, social trust and social interaction, learning new things and having an appreciation for ones surroundings.

Developing policies which support mental wellbeing also in the oldest old age group can harness existing resources such as MWB.

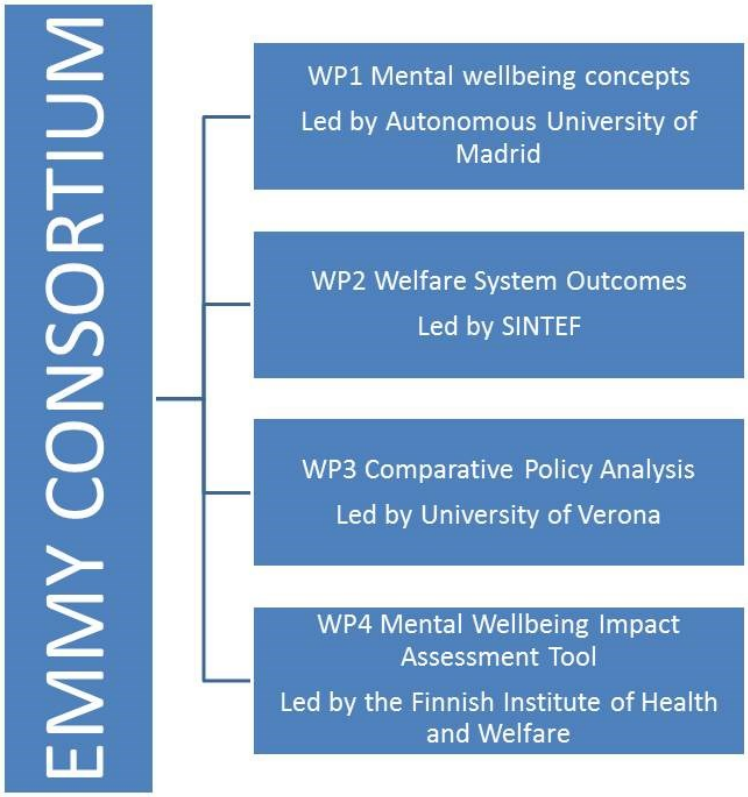
Project structure and management

The EMMY project was coordinated by the Finnish Institute for Health and Welfare (THL), led by Professor Kristian Wahlbeck and coordinated by Johanna Cresswell-Smith.

Project outcomes were determined by the research proposal and no major changes were made to the research plan. The project website (www.emmyproject.eu) and Decision Support Tool was linked into THL's existing infrastructure in order to ensure longevity after the project end.

Funding was provided by the MYBL Joint Programing Initiative, in collaboration with national funders in each country. Partners reported individually according to national requirements.

A considerable complication has been the severe delay in funding for the Italian partners. The EMMY final Report will be updated with final WP3 outputs when they are completed (more detail in section WP3-Comparative Policy p.25). The updated version of the Final report will be disseminated on the project website www.emmyproject.eu.



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Work Package 1: Mental Wellbeing Concepts

Overview

The aim of this work package was to strengthen the understanding of Mental Wellbeing (MWB) in oldest old age in relation to experiences and expectations, as well as underlying concepts and mechanisms.

This has been achieved via several focus groups (FG) including people aged 80 years and over. Focus groups were performed in all partner countries. This work package has also contributed to the development of a systematic review of instruments to evaluate MWB in the ageing population. A critical appraisal of the instruments using the COnsensus-based Standards for the selection of health Measurement Instruments (COSMIN) guidelines was performed, including quality indicators as well as psychometric properties.

Focus group study[1]

This was the first European qualitative study exploring MWB and its dimensions among the oldest old population. As opposed to quantitative methods, our study followed a reflexive approach, which allows for greater self-critical thinking and trustworthiness of the data collection and analysis.

Individuals aged 80+ were recruited in senior community centres, adult day care centres, and nursing homes in order to obtain a broad representation of older individuals with differing levels of functioning. All participants were informed about the purpose of the study and written informed consent was obtained from all participants, except for those individuals with moving difficulties who provided a recorded verbal consent.

The composition and number of the FG held were based on established guidelines (Krueger & Casey, 2000) with a minimum of six FG's per country (two per recruiting centre) and a maximum of nine. Theoretical saturation, i.e. when respondents' insights no longer added new significant information (Strauss & Corbin, 1990), was also taken into account. FG's were led by two researchers (moderator and assistant), both with previous experience of conducting FG's. Training for the task was provided in order to homogenize study procedures in all countries. FG's were guided by a structured interview protocol including a set of open-ended questions and when appropriate additional follow-up questions. FG sessions were carried out in the local language of each region. All FG were audiotaped, transcribed verbatim in the participating institutions and translated into English. All data was anonymised.

[1] This study has been published in Journal of Happiness Studies (doi: 10.1007/s10902-019-00090-1)

The transcripts were analysed using qualitative content analysis with an inductive approach where both manifest and latent content was considered (Graneheim et al, 2017). By the process of constant comparison (Glaser and Strauss 1967), similar units of meaning were assembled into categories and also either divided into smaller subcategories and grouped into broader themes (i.e. dimensions) though latent level interpretation. Qualitative analysis was performed assisted by the computer software NVivo.

Twenty-three FG were performed including 117 individuals. The size of the FG ranged from 3 to 8 individuals, aiming for gender-balanced groups including at least one male participant per group. Sessions lasted from 30 to 90 minutes.

Results

Definition of mental wellbeing

In general, respondents highlighted the complexity of the MWB concept, as well as its abstract, subjective and broad nature.

> *"[What does wellbeing mean to you?] … This question is so ambiguous that its precision is somewhat difficult"*

In this regard, nearly all participants were prone to conceptualising MWB by specifying the factors that would increase it. Furthermore MWB perceived in relation to a calm, being comfortable and fulfilled (with both the surroundings and oneself), as well as being described as state of serenity with inner and outer peace. Some respondents spoke about happiness distinguishing between tangible contentment and perceptions.

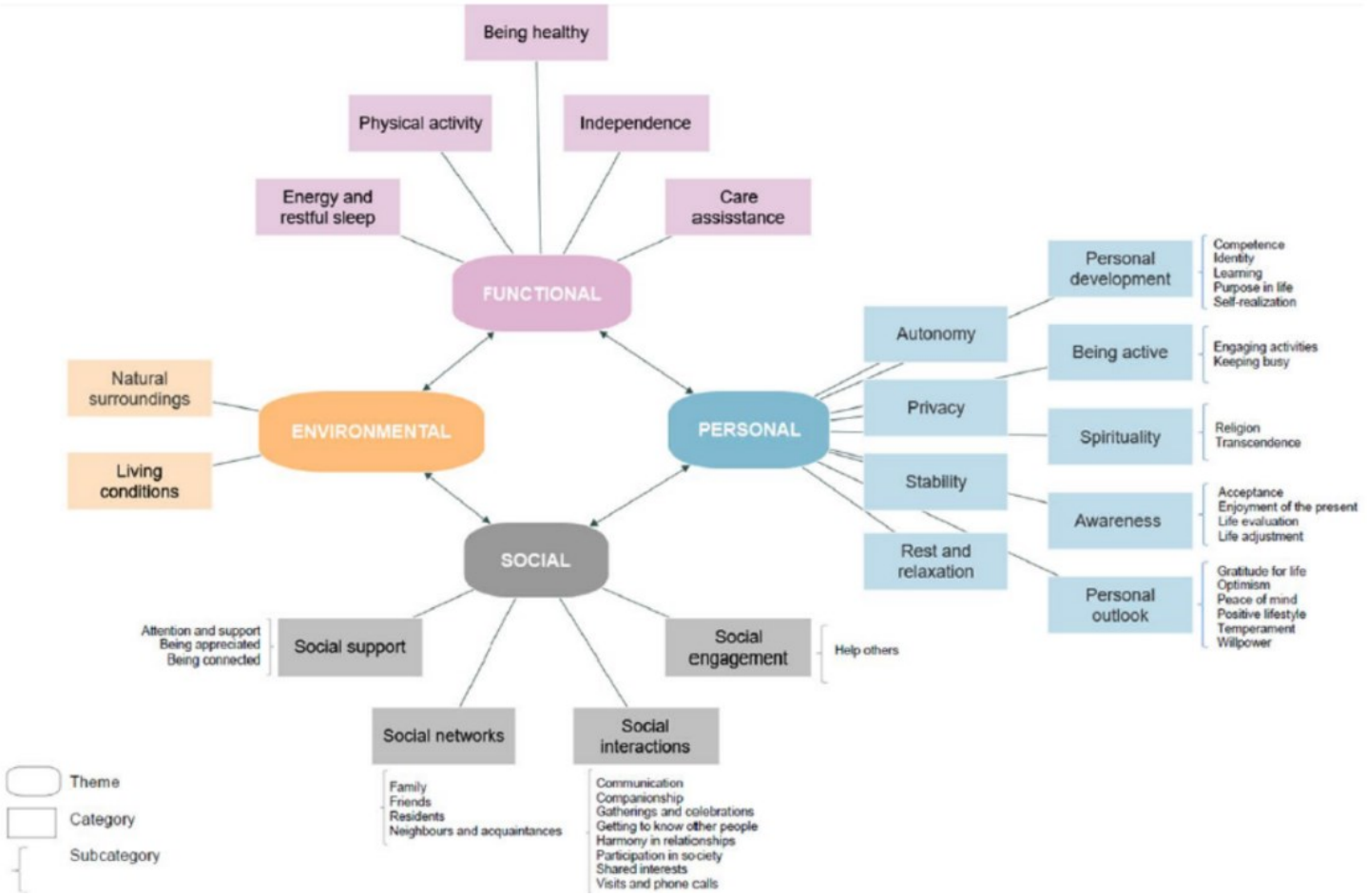
> *"There is a happiness... that can be taken into account from both a human and from a spiritual point of view. From a human point of view, it is very easy to find the answer to this question, right? Well, in so many ways, one feels well... And there is another transcendent [point of view], that can be found when providing charity to another person. This one is profound, it transpires, and you cannot count, weigh or measure it, but it is true that it exists..."*

Feeling 'alive' and feeling free was also pointed out as important for MWB.

Determinants of mental wellbeing in oldest old age

Results reinforced the dynamic state of the MWB concept and its multidimensional nature, highlighting the significance of the psychosocial factors. Indeed, all emerged dimensions (Figure 1) appeared to be closely linked to one another.

Figure 1. Conceptual model of dimensions of mental well-being according to the participants' experiences[2]



1.

[2] Permission to use Figure 1 has been provided by Journal of Happiness Studies (doi: 10.1007/s10902-019-00090-1)

1. *Functional dimension: Feeling healthy and being independent*

This theme was classified according to five categories: care assistance, energy and restful sleep, being healthy, independence and physical activity. Health was unanimously considered essential MWB. The sense of being free of illness and pain was important for feeling well.

> *"In particular a day is good or not according to my health. When you don´t feel good or you have pain is not a good day"*

Being healthy was related with the idea of keeping fit and in good shape. Participants who expressed higher levels of MWB usually reported some sort of exercise in their daily routine. In this regard, most participants agreed on the benefits of physical activity. Respondents also noted that getting a satisfactory result in a medical check-up and not having to take medication also enhanced their MWB. Nearly all participants mentioned the importance of staying independent, emphasising the importance of freedom of movement and performing daily activities.

> *"Also that I can look after myself, it can be one reason why I moved here [to the nursing home] too. I don't need someone to help me all the time. I can go to the shops by myself even if I go ten times, if I can't carry so much at one go. So, I manage it myself anyhow. And that is something that means a lot, that as long as you can, you manage on your own"*

Individuals with higher levels of physical limitations underlined the importance of practical aids and resources for maintaining independence. Restful sleep was also reported to link up with higher levels of MWB. Feeling rested resulted in adequate levels of energy to better cope with daily routines, responsibilities or serious issues.

2. *Social dimension: Structural networks and meaningful connections*

Overall, respondents highlighted the essential role of social factors for MWB. Several categories emerged under this theme: *social networks, social interactions, social support* and *social engagement*.

In terms of social networks, the nearest family (i.e. spouse, children and grandchildren) was, by far, the most repeated concept and key source for MWB. Participants discussed the importance of having a supportive and caring family including frequent interactions with family members, preferably through visits, but also including phone calls from family members not living nearby or those who were busy.

> *"It is nice if someone comes to visit because then I can follow what is happening with my nearest. They are out in the world, one grandchild lives in [country far away] and they were here yesterday. I feel well when they come and make contact with me, they have not forgotten me"*

These interactions significantly enhanced MWB allowing participants to feel connected to their nearest and dearest and creating a sense of belonging to relatives or community. Relationships with the grandchildren were also seen to add value for MWB in a major group of participants inducing feelings of love, usefulness and pleasure.

> *"It makes me feel good when I realize I'm able to talk to my great grandchildren and when I can sit with the little ones. That gives me a lot of joy."*

Also relatives were mentioned as important for MWB. Firstly, family gatherings (going out for lunch or celebrations, among others) gave them a lot of joy, especially when the whole family was together. Secondly, family wellbeing, seen as personal and professional achievements, stability, and health, contributed to participants' own MWB. Another fundamental source for MWB came from friends, participants stressing how important it was being surrounded by their trusted friends. Participants reported feeling better when socialising and sharing activities with individuals of the same age, in particular with those who shared common interests, concerns and experiences from the past. However, respondents also pointed out the difficulties encountered in maintaining friendships at old age, as many friends had passed away or had serious health problems.

Respondents living in nursing homes focused on relations to other residents and personnel. Being looked after, being accepted by other residents and participating in scheduled activities in order to strengthen social connections were strongly associated with higher levels of MWB.

> *"That one can get care and knows that one is safe if something should happen, and that you're looked after, not forgotten"*

Some, but not all, individuals felt that moving from their own home to a nursing home had limited their access to their usual surroundings and social contacts. Still, most of them remained in contact with their closest relationships (e.g. by phone) whereas others appeared to have adapted to their circumstances. Regardless, participants underscored the highly negative impact of loneliness, underlining the need to be active when building or maintaining a social network.

Nearly all respondents discussed the importance of remaining engaged in social activities in the community. Altruistic help or regular volunteering were among the most important contributors for MWB, not only in terms of it being a generous act, but also in terms of fulfilment and giving meaning of life.

3. Personal dimension: Life engagement and positive outlook

Various categories related to the personal dimension: *autonomy, awareness, being active, intimacy, personal development, positive outlook, rest and relaxation, spirituality and stability*. Engaging in different activities appeared as a recurrent theme.

Participants talked about cultural activities, intellectual games, gardening and handcrafts, among others. For the most part, these activities involved social interactions and were preferably practiced outdoors. Engagement related not only with entertainment and keeping busy, but also with seeking stimulation,

freedom and autonomy, and life enrichment. In line with this, participants reported that being active was a necessary condition for their personal growth.

Although some individuals identified later life as a time for rest without major responsibilities, many highlighted that getting older also implied giving to others, lifelong learning and feelings of usefulness. This approach was deeply related with the concepts of self-realisation, contribution and competence.

Of equal (if not more) interest was the concept of autonomy (ability to take own decisions) as an essential aspect of MWB. Respondents from Nordic countries repeatedly mentioned driving as an indicator of freedom and autonomy. Individuals also discussed about everyday activities providing a sense of accomplishment and purpose in life. Having goals and challenges was considered to maintain balance in life and enhance MWB. Furthermore, participants reported higher MWB when they could accomplish what had been planned on a regular day.

Awareness included the acceptance of growing old and related life adjustments. The majority of respondents expressed a realistic appraisal about their actual circumstances and showed confidence about the future. Likewise, MWB depended on the enjoyment of the present, on what really mattered according to various participants. A positive outlook was frequently referred to as a primary source for MWB. Some individuals talked about optimism and contentment with life as key indicators for the enhancement of MWB. In this regard, a few participants believed that having a positive outlook about the aging process and life in general was due to a genetic predisposition. Similarly, others focused on personal traits such as resilience, willpower, prudence or persistence as quality attributes that helped individuals to adapt to the aging challenges. A connection with something greater than themselves, either a religious faith or a spiritual belief also seemed to have a positive impact on MWB.

4. *Environmental dimension*

Environmental factors were grouped as natural surroundings and living conditions indicators. A peaceful and quiet environment was regarded as an important indicator for MWB. Respondents reported feeling well when they could enjoy inspiring sounds, natural landscapes or nice weather (particularly in the Nordic countries). Furthermore safety, privacy, freedom or memories about remarkable events were all positively associated with remaining or living in their own houses leading to higher levels of MWB. Participants residing in nursing homes generally considered the nursing home as their own home. Financial security was also mentioned by several participants in terms of the importance of having enough money to afford their own food and medicines as well as maintaining a financial cushion to cover unexpected expenses.

Country specific differences

Even though MWB dimensions were similar in all participating countries, small differences could be noted depending on the welfare systems and cultural norms. Strong interactions with the closest family seemed to be key for MWB in Spain and Italy, while their Nordic counterparts perceived, on a slightly lower level, that both informal relationships and formal social participation were important indicators for MWB. Additionally, Finish and Norwegian participants described the value of autonomy to a greater extent,

corresponding with their cultural principle of self-determination. Furthermore, the Nordic respondents most frequently emphasised the outdoor environment, offering great opportunities for active ageing.

Systematic Review of Instruments Measuring Mental Wellbeing in the Oldest Old age

Measures designed to tap MWB are often devised to evaluate the general population, and little is known about specific measurement tools that assess MWB in the oldest old. Due to the lack of instruments specifically designed to evaluate MWB in the oldest old, our search was broadened to include old age, and not focus specifically in the oldest old.[3]

The aim was therefore to systematically review and evaluate the measurement characteristics and the quality of existing instruments for measuring MWB in old age. It was timely both in terms of identifying which instruments may be most suited for the older population, but also in order to guide public policy development towards and increased focus on mental well-being in the older population.

Brief description

A literature search using a combination of various keywords for measurement and MWB in the ageing population was carried out using the following electronic databases: PubMed, PsycINFO, ProQuest Research Library, AgeLine, and CINAHL. Furthermore a 'snow-balling' technique was combined with a manual search to locate primary instruments that had not been identified in the bibliographic database searches.

The psychometric properties and quality of each instrument were then critically appraised following an adapted version of the COnsensus-based Standards for the selection of health Measurement INstruments (COSMIN) guidelines (Mokkink et al., 2018; Terwee et al., 2007). The COSMIN instrument covers nine different domains: internal consistency, test-retest reliability, measurement error, content validity, structural validity, criterion validity, hypothesis testing, cross-cultural validity, and responsiveness. Articles were classified by the type of MWB assessed: evaluative, hedonic or eudaimonic well-being.

Principal results

A total of 3684 articles were found based on the initial search strategy. After excluding duplicates, 2250 articles were screened. Of these, 229 articles were retrieved for more detailed evaluation according to the information provided in their title and abstract. Finally, 20 original measurement tools designed for older population were found. Eight instruments originally created for older adults were identified in the manual search.

[3] Martín-Maríaa N, Lara E, Cresswell-Smith J, Forsman AK, Kalseth J, Donisi V, Amaddeo F, Wahlbeck K, Miret M. Instruments to evaluate mental well-being in old age: a systematic review. Submitted to Journal of Positive Psychology 2019

Table WP1.1 Mental well-being instruments and their principal characteristics (Martín-María et al., submitted to the *Journal of Positive Psychology*).

Instrument (acronym) (author/s, year)	**Age of participants** (mean)	**Sample size, gender (Nation)**	**Subscales/factors. Type of MWB**	**Original language**	**Available translations**
*Revised Philadelphia Geriatric Center Morale Scale (RPGCMS) (Lawton, 1975)	Not reported (mean = 72.6)	828 mw (United States)	Agitation; Attitude toward aging; Lonely dissatisfaction. Md	English	Chinese, Czech, Dutch, French, Japanese, Spanish, Swedish, Turkish
Scale of Happiness of the Memorial University of Newfounland (MUNSH) (Kozma & Stones, 1980)	65-95 y (not reported)	297 mw (United States)	Positive affect; Negative affect; General positive experience; General negative experience. Md	English	French, Spanish
Salamon-Conte Life Satisfaction in the Elderly Scale (SCLSES) (Salamon, 1988)	55-90 y (not reported)	650 mw (United States)	Pleasure in daily activities; Meaningfulness of life; Fit between desired & achieved goals; Mood tone; Self-concept; Perceived health; Financial security; Social contacts. Md	English	Chinese, French, Italian, Persian
*Perceived Well-Being Scale (PWB) (Reker & Wong, 1984)	61-93 y (not reported)	238 mw (United States)	Psychological well-being; Physical well-being. Md	English	Arabic, Chinese, French, Turkish
Satisfaction With Life Scale (SWLS) (Diener et al., 1985)	Not reported (mean = 75.0)	53 mw (United States)	5 items. Ev	English	Arabic, Bosnian, Chinese, Czech, Danish, Dutch, Flemish, French, Georgian, German, Greek, Hebrew, Hindi, Hungarian, Icelandic, Italian, Japanese, Khmer, Korean, Malay, Norwegian, Persian, Portuguese, Polish, Romanian, Russian, Serbian, Setswana, Spanish, Thai, Turkish, Urdu, Vietnamese
Life-satisfaction construct (Closs & Kempe, 1986)	54-95 y (mean = 80.0)	457 w (Germany)	Social integration/ loneliness; Satisfaction with life in old age; Subjective somatic symptoms; Tranquillity/ insecurity; concern; Retrospective; congruence. Ev	German	Not available
Life Satisfaction Scale (LSS-A) (Salokangas, Joukamaa, & Mattila, 1988)	63+ y (not reported)	325 mw (Finland)	Psychic balance; Assessment of past life; Present happiness. Md	English	Not available
*Six Scales of Psychological Well-Being (PWBS) (Ryff, 1989)	Not reported (mean = 75.0)	80 mw (United States)	Self-acceptance; Positive relation with others; Autonomy; Environmental mastery; Purpose in life; Personal growth. Eu	English	Arabic, Chinese, Dutch, Filipino, French, Italian, Japanese, Persian, Romanian, Russian, Serbian, Setswana, Spanish, Swedish, Turkish, Urdu
*Herth Hope Scale (HHS) (Herth, 1991)	Study one: 62-92 y (mean =72.2) Study two: 63-94	Study one: 40 mw ; Study two: 75 mw (United	Temporality and future; Positive readiness and expectancy; Interconnectedness. Eu	English	Chinese, Dutch, German, Italian, Japanese, Korean, Norwegian, Persian, Portuguese, Spanish, Swedish, Thai

	y (mean =79.0)	States)			
Integration Inventory (II) (Ruffing-Rahal, 1991)	60-98 y (mean = 77.0)	156 mw (United States)	Activity; Affirmation; Synthesis. Md	English	Not available
Congruity Life Satisfaction Scale (Meadow, Mentzer, Rahtz, & Sirgy, 1992)	Study one: 60+ y (mean = 70.5 y) Study two: 55+ y (mean =72.9 y)	Study one: 752 mw; Study two: 529 mw (United States)	10 items. Ev	English	Not available
Wellness Index (Slivinske, Fitch, & Morawski, 1996)	62+ y (mean =73.4)	463 mw (United States)	Physical health; Morale; Economic resources; ADL-IADL; Religiosity; Social resources. Md	English	Not available
Subjective Happiness Scale (SHS) (Lyubomirsky & Lepper, 1999)	Not reported (mean = 69.5)	622 mw (United States)	4 items. Eu	English	Arabic, Chinese, French, German, Greek, Hungarian, Italian, Japanese, Malay, Portuguese, Romanian, Russian, Serbian, Slovak, Spanish, Turkish, Urdu
*Valuation Of Life Scale (VOL) (Lawton et al., 2001)	70+ y (not reported)	616 mw (United States)	Hope; Futurity; Purpose; Self-efficacy; Perseverance. Eu	English	German, Japanese, Portuguese
Belgian Subjective Well-Being Scale (Marcoen, Van Cotthem, Billiet, & Beyers, 2002)	60+ y (not reported)	366 mw (Belgium)	Psychological; Physical; Social; Material; Cultural; Existential. Md	Dutch	Not available
Spirituality Index of Well-Being Scale (SIWB) (Daaleman, Frey, Wallace, & Studenski, 2002)	Not reported	277 mw (United States)	Self-efficacy; Life scheme. Eu	English	Chinese, Korean, Spanish
Thai Elders Psychological Well-Being measure (Ingersoll-Dayton, Saengtienchai, Kespichayawattana, & Aungsuroch, 2004)	60+ y (mean = 70.9)	460 mw (Thailand)	Harmony; Interdependence; Respect; Acceptance; Enjoyment. Eu	Thai	Not available
*Life Satisfaction Index Third Age (LSITA) (Barrett & Murk, 2006)	50+ y (not reported)	654 mw (United States)	Zest vs. Apathy; Resolution and fortitude; Congruence of goals; Self-concept; Mood tone. Md	English	Portuguese
Geriatric Spiritual Well-Being Scale (GSWS) (Dunn, 2008)	61-100 y (mean = 74.2)	138 mw (United States)	Affirmative self-appraisal; Connectedness; Altruistic benevolence; Faith ways. Eu	English	Lithuanian, Thai
Chinese Aging Well Profile (CAWP)	50+ y	1419 mw	Physical; Psychological; Independence;	Chinese	Not available

(Ku, Fox, & McKenna, 2008)	(mean = 62.1)	(China)	Learning & growth; Material; Environmental; Social. Md		
Life Satisfaction Scale for Chinese Elders (LSS-C) (Lou, Chi, & Mjelde-Mossey, 2008)	60-94 y (mean = 69.7)	1502 mw (China)	Instrumental needs of daily life; Social and relational needs. Ev	Chinese	Not available
*Con-Dis device for measuring perceived well-being (Reijula et al., 2009)	63-89 y (mean = 78.0)	10 mw (Finland)	Buttons of the Con-Dis device: Happy; Neutral; Unhappy. He	Not applicable (emoticon button)	-
Control, Autonomy, Self-realization, Pleasure, (CASP-19) (Hyde, Wiggins, Higgs, & Blane, 2003)	65-75 y (not reported)	286 mw (United Kingdom)	Control; Autonomy; Self-realization; Pleasure. Eu	English	Amharic, Arabic, Chinese, Czech, Lithuanian, Persian, Polish, Portuguese, Malay, Russian, Spanish, Turkish
Meaningful Activity Participation Assessment (MAPA) (Eakman, Carlson, & Clark, 2010)	65-100 y (mean = 80.5)	154 mw (United States)	28 items/ activities. Eu	English	Chinese, French
Thai Spiritual Well-Being for elders (TSWBATECI) (Unsanit, Sunsern, Kunsongkeit, O'Brien, & McMullen, 2012)	60+ y (not reported)	2160 mw (Thailand)	Acceptance of chronic illness; Happiness in life; Life equilibrium; Passion for life; Self-transcendence; Optimistic personality; A purpose in life; Willingness to forgive. Eu	Thai	Not available
Will To Life (WTL) (Carmel, 2017)	78-99 y (mean = 83.9)	868 mw (Israel)	5 items. Eu	English	Not available
Meaning in Life Scale (MLS) (Lee & Hong, 2017)	65-90 y (mean = 75.0)	371 mw (Korea)	Value of life; Source of life; Will to live. Eu	Korean	Not available
*SODdisfazione dell'Anziano (SODA) (Fastame, Penna, & Hitchcott, 2019)	60-98 y	474 mw (Italy)	SODA-health; SODA-religious; SODA-time. Md	Italian	Not available

Note: articles are listed in chronological order. * Identified in the manual search.

Abbreviations: Eu (Eudaimonic well-being); Ev (Evaluative well-being); He (Hedonic well-being); Md (Multi-dimensional well-being). Sample: y= year(s); m= men; w= women; mw= both

The overall level of quality of the included instruments was adequate, with three instruments showing an excellent quality (LSS-C, HHS, and MLS), and six reaching four among the total of five positive ratings (PWBS, MUNSH, SCLSES, PWB, LSITA, and SODA) (Table WP1.2).

Table WP1.2 Quality appraisal of measurement properties according to the questionnaire (Martín-María et al., submitted to *Journal of Positive Psychology*).

Questionnaire	**Internal consistency**	**Reliability**	**Content validity**	**Structural validity**	**Hypothesis testing**	**Total level**
Evaluative well-being						
SWLS (Diener et al., 1985)	-	+	+	?	-	++
Life-satisfaction construct (Closs & Kempe, 1986)	-	?	+	+	?	++
Congruity Life Satisfaction Scale (Meadow et al. 1992)	+	?	+	?	-	++
LSS-C (Lou et al., 2008)	+	+	+	+	+	+++++
Eudaimonic well-being						
* **PWBS** (Ryff, 1989)	+	+	+	+	-	++++
* **HHS** (Herth, 1991)	+	+	+	+	+	+++++
SHS (Lyubomirsky & Lepper, 1999)	+	-	+	?	+	+++
VOL (Lawton et al., 2001)	+	?	+	?	+	+++
SIWB (Daaleman et al., 2002)	+	?	?	?	-	+
Thai Elders Psychological Well-Being measure (Ingersol-Dayton et al., 2004)	+	-	+	+	-	+++
GSWS (Dunn, 2008)	+	-	+	-	-	++
CASP-19 (Hyde et al., 2003)	-	?	+	?	-	++
MAPA (Eakman et al., 2010)	+	+	+	?	?	+++
TSWBATECI (Unsanit et al., 2012)	+	?	+	+	?	+++
WTL (Carmel, 2017)	+	?	+	+	-	+++
MLS (Lee & Hong, 2017)	+	+	+	+	+	+++++
Hedonic well-being						
Con-Dis device for perceived well-being (Reijula et al., 2009)	?	?	+	?	-	+
Multi-dimensional						
RPCGMS (Lawton, 1985)	+	?	?	-	?	+
MUNSH (Kozma & Stones, 1980)	+	+	+	?	+	++++
SCLSES (Salamon, 1988)	-	+	+	+	+	++++
* **PWB** (Reker & Wong, 1984)	+	+	+	-	+	++++
LSS-A (Salokangas et al., 1988)	+	?	+	?	-	++
II (Ruffing-Rahal, 1991)	+	?	+	?	+	+++
Wellness Index (Sliviske et al., 1996)	+	-	+	-	-	++
Belgian Subjective Well-Being scale (Marcoen, 2002)	-	?	+	?	?	+
* **LSITA** (Barret & Murk, 2006)	+	?	+	+	+	++++
CAWP (Ku et al., 2008)	+	-	+	+	-	+++
* SODA (Fastame et al., 2019)	+	+	+	?	+	++++

Note: The results were classified as positive (+), indeterminate (?), or negative (-) according to the quality criteria for each measurement property. When more than one test was used for hypothesis testing, the one with the lowest score was considered. In the same way, when studies informed about correlations with subscales as well as with the total scale, the latter score was selected. Dark orange indicates the best instruments, whereas light orange points out the satisfactory ones.

Conclusions

This was the first systematic review of instruments evaluating MWB in the older population, findings including some reliable and valid measurement tools. The majority of the tools were created for use in North America and Europe, none of which originating from Africa, Australia or South America, making their applicability in other contexts debatable (Torres, 1999).

An important aspect to consider when assessing these instruments in the context of older age is age range, from 50 years in one study, to 78+ in another study. This scenario reflects the general disagreement and the difficulties in defining old age. Most high and middle-income nations assume the chronological age of 65 years (traditionally corresponding with retirement) as a definition of old age, although this does not adapt well to the situation in many low-income nations, such as African countries (Kowal & Dowd, 2001), where old age may begin when active contribution is no longer possible and new roles emerge, corresponding to 50 years of age and older (Gorman, 1999).

Interestingly, none of the measurement tools were specifically created for the oldest-old population aged 80 years and older, a segment of the population that is growing and that is projected to increase dramatically in future decades (He et al., 2016). This reflects a general lack of research in this age group (Liljas et al., 2017), and in older people (Miret et al., 2015). Therefore, not only are reliable and valid instruments for older adults scarce, but specific measures of MWB for people aged 80+ appear to be non-existent.

The dynamic and multi-dimensional nature of MWB (Lara et al., 2019) is reflected in measurement tools evaluating different aspects of MWB, and the existence of subscales in most of these. Subscales about moods, perceived health, social relationships, and values of life were the most common. Only one tool assessed the hedonic well-being component. Such momentary evaluations throughout the day may be needed for the older population to better understand their hedonic experiences. It is important is to include the target group in the development of new instruments, in this care including older adults.

In conclusion, this review provided a comprehensive synthesis of the existing measurement tools that assess MWB in older populations. Instruments evaluating different aspects of MWB simultaneously and the existence of subscales in most of them are support the notion of the multi-dimensional nature of MWB. A specific MWB tool designed to be used for the oldest old is needed.

Work Package 2 - Welfare System Outcomes

Overview

Work Package 2 (WP2) assessed the impact of welfare systems on mental wellbeing (MWB) in oldest old age in comparison to younger ages using existing data from the European Social Survey (ESS).

The ESS has been performed in 7 rounds and includes core modules, as well as rotating modules covering topics relevant to mental wellbeing. We used data from Round 6 (2012) which includes a range of questions relevant for measuring MWB. To ensure comparability the analyses were restricted to the 24 EU and EFTA countries participating in round 6 Round.

System level variables were derived from different web-based data sources such as ESS Multilevel Data, Eurostat, OECD, WHO. Different approaches to measure welfare system were used, including a welfare state regime typology (five types: Nordic social democratic, Continental European Bismarckian, Anglo-Saxon Liberal, Southern Europe, and Eastern Europe post-communist regimes), one welfare state variable (constructed using factor analyses including eight non-overlapping measures related to the welfare state) and four welfare state factors (based on factor analyses including 18 partly overlapping measures related to the welfare state; the first factor representing high levels of health and social services, gender equality and high life expectancy at 65 years, the second representing long work life duration, the third representing income equality and the fourth representing individualism and social trust at country level). Four main analyses were performed

1. Investigating the structure of mental wellbeing in oldest old using the ESS data which is used as the starting point for measuring MWB.
2. Investigated whether the welfare system impact on MWB differ with age.
3. Comparing different approaches to measuring welfare systems, as well as different care regime measures in explaining variation at country level in MWB of the oldest old.
4. Finally, analysing intervening factors of welfare state influence on MWB in oldest old. Welfare system impact on MWB is analysed using multilevel regression analysis.

1. Structure of MWB in oldest old

Using exploratory factor analysis and exploratory structural equation model (ESEM) on 28 items representing the different wellbeing aspects, the MWB among the oldest old were found to be representable by six or alternatively 5 factors (in the latter case the two first factor below constitute one common factor) including the following:

- *Evaluative wellbeing* (life satisfaction)
- *Positive emotional wellbeing* (positive affect)
- *Positive psychological functioning* (autonomy, competence, self-esteem)
- *Meaning and flow* (presence and engagement);
- *Positive and supportive relationships* (support, respect, appreciation).
- *Social engagement (*social activities and interactions)

To keep the analyses of welfare system impact on MWB manageable we combined evaluative and emotional wellbeing into one dimension named Subjective wellbeing (SWB), and positive psychological functioning, flow and positive and supportive relationship into a further dimension named Psychological Wellbeing (PSW), excluding variables with low loadings. The items included in the social engagement were found to be less reliable and could therefore be viewed as determinants of MWB (rather than dimensions) and are included in the analyses around intervening factor.

Welfare state, MWB and age

Age differences in MWB were found to be associated with welfare state measures. Low score on a welfare state variable (factor) was associated with a negative age gradient for both SWB and PWB, these differences increasing with age.

When four separate welfare state factors are applied, all four are associated with SWB but only the first broad factor is associated with PWB.

Finally, using the Nordic welfare model as reference category (see Figure WP2.1), we found no differences in MWB for the Bismarckian (continental) regime type, decreasing difference for the Anglo-Saxon regime, and increasing differences with age between the Nordic and the Southern (SWB) and Eastern regimes. For Anglo-Saxon regime we find an increase in MWB with age (for middle aged+) while for Eastern the opposite is found. Also, for Southern regime we find a negative age effect for SWB (until middle age).

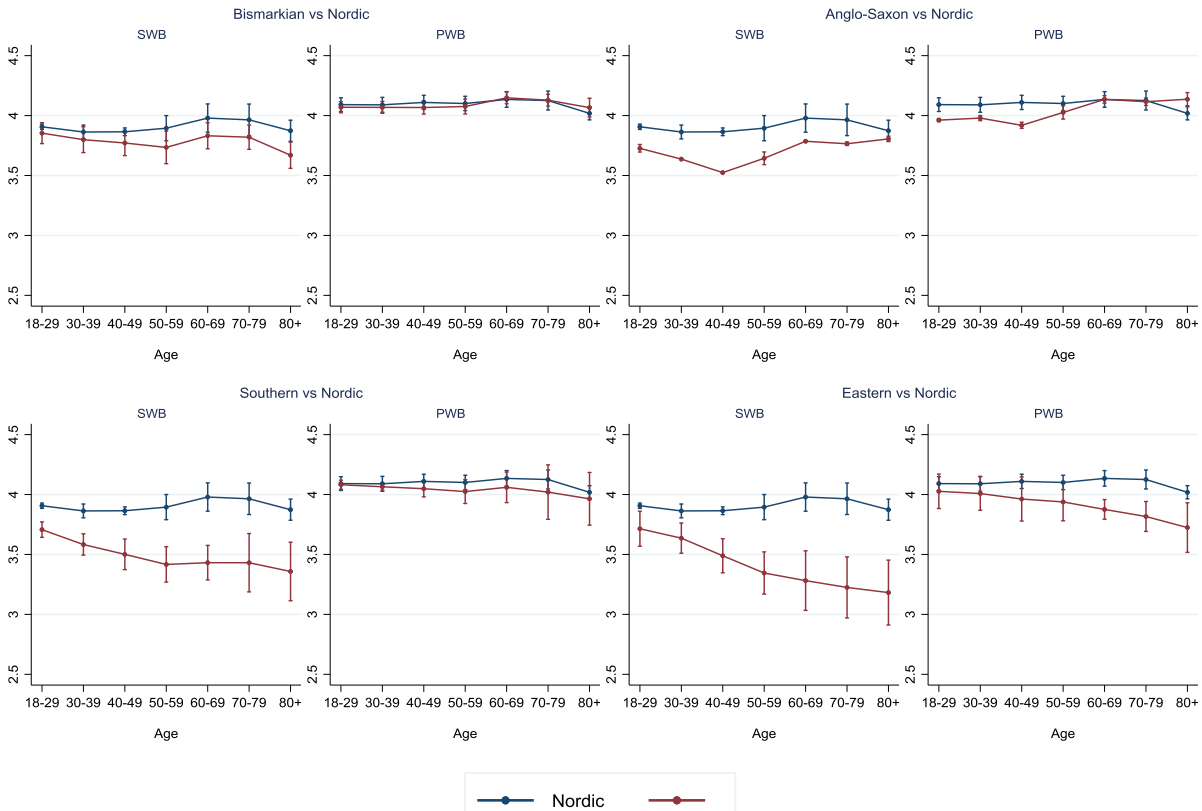


Figure WP2.1 Mental wellbeing prediction by age-group and welfare state regime type. Nordic regime type is reference category.

Comparing different approaches to measuring welfare systems and care regimes

Three different care regime typologies were compared with the welfare state measures described above. The three care regime typologies apply slightly different approaches to separating the regime based heavily on family care from more service-based care regimes. The following findings were notable in terms of differences in SWB and PWB according to different welfare systems and care regimes.

Firstly, country level variation was higher for SWB than PWB in the oldest old age group. Additionally, welfare systems and care-regimes explain more of country level variation in SWB than PWB. In terms of measurement approaches, welfare state measures explain more of country level variation than care-regime approaches.

More developed welfare state and universalistic, service based care regimes are associated with higher MWB than poorly developed welfare state and family based care regimes

Intervening factors of welfare state influence on MWB in oldest old

Several individual level variables were analysed to select the variables which were significantly associated with either SWB or PWB.

The following were found to be associated with SWB; lives with partner (+), hampered in daily activities (-), physical health (+), physical activity (+), coping on income (+), place in society (high +), benevolence oriented (+), social trust (+), social meetings (+), learn new things (+), notice and appreciate surroundings (+), feel close to people in local area (+). The same variables, except for lives with partner, coping on income and social trust, adding power oriented (-), were found for PWB.

Intervening factors were analysed by comparing the result for welfare system impact with and without individual level variable (one at a time). For SWB the following variables affected the estimated impact of welfare system most; coping on income, physical health, place in society and social trust, and for PWB; physical health and place in society.

Summary of main results

- Welfare state matters for MWB in oldest old
- Age pattern for MWB differs between welfare systems
- More developed welfare state is associated with higher MWB in oldest old
- Universalistic, service-based care regimes are associated with higher MWB than family-based care regimes
- Welfare state is more important than care regimes for variation in MWB among oldest old in European countries
- Welfare state impact MWB by improving health outcomes and reducing inequalities and enhancing social trust

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Work Package 3: Comparative Policy

Provisional note on Work Package 3:
A considerable complication to Work Package 3 has been the severe delay in funding for the Italian partners who to date (31.12.2019) have still not yet had the funds transferred.

Work Package leader Prof. Francesco Amaddeo, in agreement with the EMMY Consortium will make an internal amendment to continue to develop Work Package 3 outputs in the post project period.

Two amended deliverables have been agreed with the EMMY Consortium 1) a publication on "qualitative analysis of legislation, policies and plans", looking in details at the four dimensions (functional, social, personal and environmental); 2) a web site for the consultation, dissemination and update of the Legislation Repository, and

The following summary is therefore provisional and will be revised on receipt of updated results.

Legislations, policies and plans to improve Mental Wellbeing (MWB) of "oldest old" in Europe: eight cases studies from Finland, Norway, Italy and Spain

INTRODUCTION

In 2013 Katherine Swartz[4] wrote an article on the Annal Review of Public Health identifying two main factors that are changing the face of OECD countries. First of all, the rapid aging of the populations; Japan was leading this process with 23% of its population with 65 years age or older. Germany, Italy, and Sweden are close behind with 20–21%; Belgium, the Netherlands, Portugal, Spain, France, Austria, Hungary, and the United Kingdom have 16–18%; and the United States has just over 13% 65 years of age and older.
The second factor is the financial crisis in Europe, with spill over effects on the United States and other countries, which has greatly heightened concerns about financing the aging populations' needs for health care, income support, housing subsidies, and long-term care services. Debates about intergenerational responsibilities are evident in recently published research papers that examine how countries are revising programs for the older population.

In Europe, there is a great diversity in welfare models and their emphasis on institutional support vs. support from the family. The Nordic model is builds on progressive taxation, and offers highly developed institutional social welfare, encompassing countries with low income disparity and growing economies (represented in the EMMY Project by Norway) and countries with higher income disparity and economic stagnation (represented by Finland). The Mediterranean model of familistic welfare systems builds on

[4] Swartz K (2013). Searching for a balance of responsabilities:OECD countries' changing elderly assistance polizie. *Annal Review of Public Health 34, 397-412.*

generous state pensions, employment-related welfare benefits and labour market regulation (Italy and Spain).

METHODS

A large scoping review of legislations, policies and plans approved from 2007 to 2018 in four European countries was performed. The repository contains a fairly comprehensive selection of legislations, policies and plans which are considered to have an effect on the mental wellbeing (MBW) of the oldest old.

All the documents in repository have been classified using a list of *dimensions* and *sub-categories* (see Appendix 1) derived from the qualitative study[5] and a recently published rapid review on determinants of mental wellbeing in oldest old age.[6] In this study, two cases were selected from each representing more innovative approaches which could potentially inform future policy development in Europe for the oldest old age group.

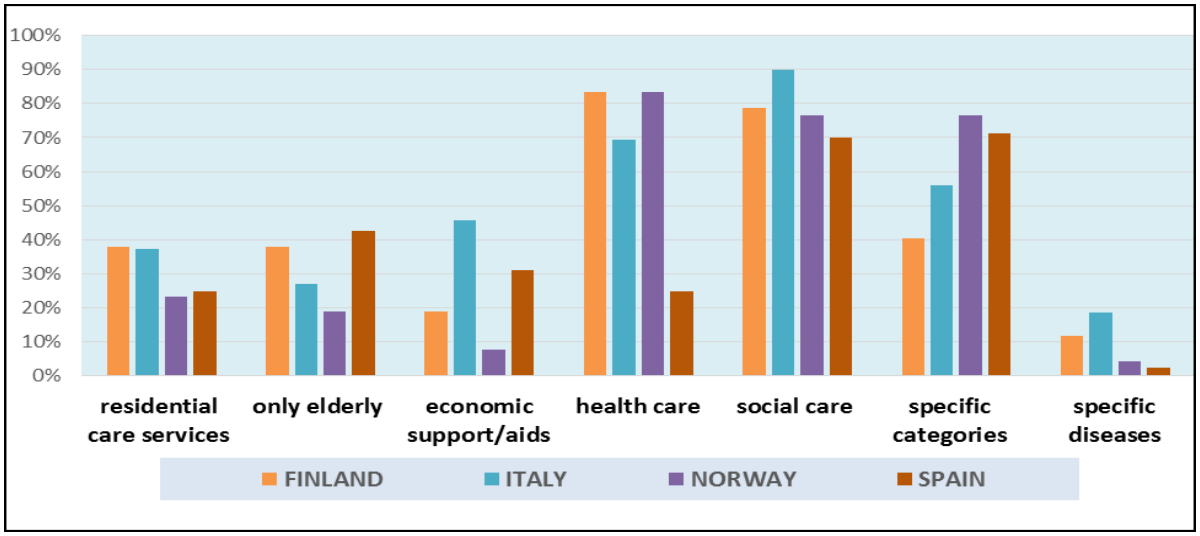
RESULTS

The scoping review of legislation, plans and policies in relation to the oldest old age group were included a repository containing 271 documents, 42 from Finland, 90 from Norway, 59 from Italy and 80 from Spain.

Looking at the geographical level of legislations, plans and policies, differing approaches can be seen to be taken in the Nordic countries (Finland and Norway) which include predominantly national coverage, in comparison to southern countries (Italy and Spain) where the coverage is distributed nationally, regionally and locally. Italy has more decentralised regulations with only 32% of national rules, Spain had 58%; while in Finland (100%) and Norway (98%) legislations, plans and policies were found to be at national level.

In each of the four countries the main topics are health and social issues, and most of them are related to specific categories of citizens (see Figure 1).

Figure 1. Contents of legislation, plans and policies

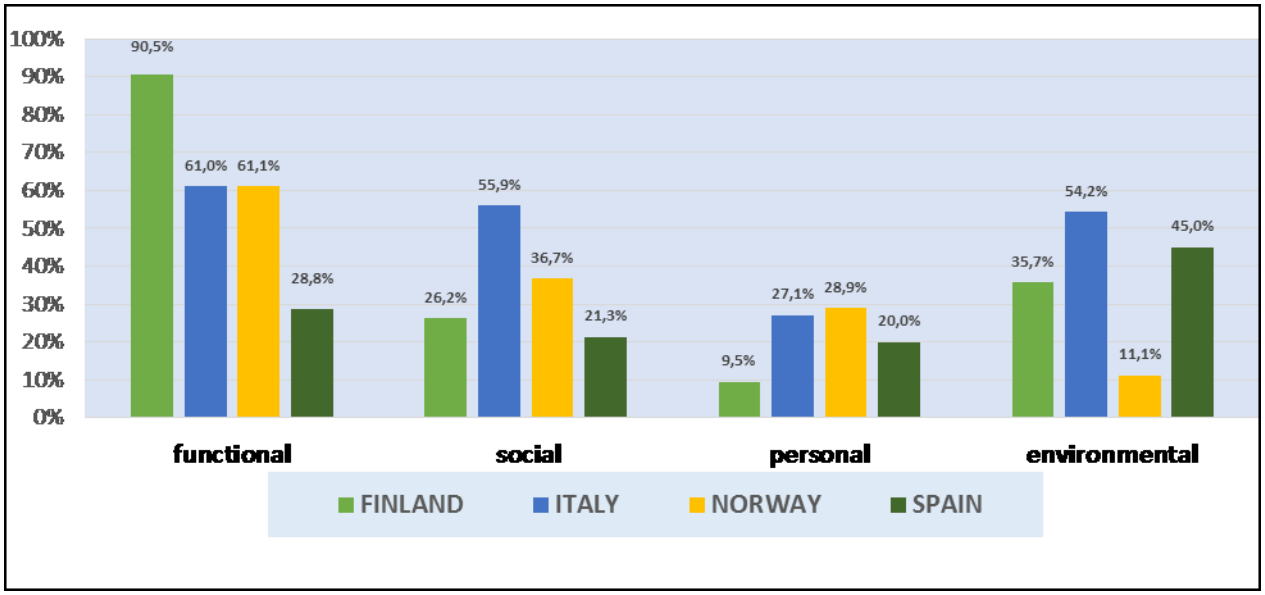


[5] Lara E, et al. Mental Well-being in Late Life: Evidences from the Perspective of the Oldest Old Population. Journal of Happiness Studies, 2019; 1-20

[6] Cresswell-Smith J, Amaddeo F, Donisi V, Forsman AK, Kalseth J, Martin-Maria N, Miret M, Walhbeck K. (2019). Determinants of multidimensional mental wellbeing in the oldest old: a rapid review. Social Psychiatry and Psychiatric Epidemiology 54, 135-144.

In terms of policy relating to the dimensions of mental wellbeing outlined by the qualitative study, one can see that policies tended not to include the personal dimension (see Figure 2). It therefore appears that there is a lack of documents pertaining to concepts like 'personal outlook', 'autonomy', 'awareness', 'being active', personal development', 'privacy and self-comfort', rest and relaxation', 'spirituality' and 'stability'.

Figure 2. Dimensions of legislations, plans and policies



Preliminary analyses selected two case studies from each country outlining innovative approaches which covering topics and dimensions of mental wellbeing given less policy attention despite being deemed relevant by participants in the qualitative study. Dimensions of mental wellbeing paid differing amount of attention in the focus groups as follows; the *functional* dimension had 13.6% of statements, *social* 44.1%, *personal* 39.8% and *environmental* 2.5%.

Case studies

Finland - Case 1

The first policy case selected from Finland is a national law called "**Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons**" approved in 2012. The objectives of the Act were to:

1. support the wellbeing, health, functional capacity and independent living of the older population;
2. improve the opportunities of the older population to participate in the preparation of decisions influencing their living conditions and in developing the services they need in the municipality;
3. improve the access of older persons to social and health care services of a high quality as well as guidance in using other services that are available to them in accordance with their individual needs and in good time when their impaired functional capacity so requires; and

4. strengthens older adults' opportunities to influence the content and way of provision of the social and health care services provided for them, and to contribute to deciding on the choices regarding them.

This Act lays down provisions on:

- local authorities' responsibility for supporting the wellbeing, health, functional capacity and independent living of the older population and for securing the social and health care services;
- investigation of older persons' service needs and responding to them;
- ensuring the quality of services provided for older persons.

This particular Act obligates local authorities to regularly gather feedback from service users (ie older adults), their family members and others close to them, as well as municipal staff. An older adults' need for social and health care services supporting his or her wellbeing, health, functional capacity and independent living is therefore investigated comprehensively together with the older person and, as necessary, their family members or an appointed guardian. Furthermore, when developing a service plan, the older adult and (as necessary) significant others, must discuss the options to ensure a comprehensive set of services. The older adults' views on these options must be recorded in the plan, and services must be developed on the basis of the feedback gathered on a regular basis from the older adult, his or her significant others, as well as the service provider. Local authorities must publish information on how long older adults must wait to obtain social services at least every six months.

The Act encompasses those who have reached the eligible age for receiving retirement (old age) pension, as well as any older adults whose physical, cognitive, mental or social functional capacity is impaired due to illnesses or injuries that have begun, increased or worsened with older age.

The law supports individualised social and health care services in regard to content and way of provision, with the overall aim of promoting and maintaining wellbeing, health, functional capacity and independent living. It also supports possibilities of older adults' being heard on a collective level via 'Councils for Older People'. The oldest old age group is not separately or specifically mentioned in this legislation. Mental wellbeing is not the focus of the evaluation and follow-up activities.

Finland - Case 2

The second case selected from Finland is the **Active Age programme 2012-2017** which is a national programme carried out in 2012–17 involving 31 development projects by Non-Governmental Organisations (NGO's) in the areas of welfare, public health and human rights. In this programme, a range of methods to promote social inclusion and psychosocial wellbeing among older people were developed, and the scope of the projects varied, i.e. work could be carried out locally, regionally and nationally. The Programme was funded by the Funding Centre for Social Welfare and Health Organisations (STEA) and coordinated by The Finnish Association for the Welfare of Older People (VTKL).

The funding programme focused on the well-being of older people (aged 60+), encompassing projects in the areas of e.g. arts, cultural sensitivity, immigration, inclusion, mental health, mobile wellbeing and peer activities. Aims included:

- influencing attitudes of society and citizens to strengthen positive age identity;

- enabling and creating conditions for older people to be active members of their community and to lead meaningful lives;
- developing local cooperation models for improving wellbeing, identifying problems, and timely intervention and assistance.

Some of the funded projects focus specifically on strengthening older adults' mental health and wellbeing, e.g: Vanhuuden Mieli (2011-2015), MIRAKLE - Mielen hyvinvoinnin rakennuspuut ikääntyville 2012-2016 and Elämäntaidon eväät (2015-2017). Elämäntaidot eväät (Life skills activities) for example, focused on on topics such as self-empathy/compassion, hope, perseverance and mental well-being in daily life. Activities were planned together with older adults and were designed to promote the establishment of mental wellbeing practices in the participants' everyday lives.

The programme features promotion of psychosocial wellbeing as a focal point and supports mental wellbeing through a focus on inclusion (in projects designs and execution), through the project content in itself, as well as through many project activities supporting other older adults' not directly involved in the project itself (e.g. older volunteers supporting other older adults). The programme sub-projects targeted aspects of all protective factors for mental wellbeing, and several wider determinants, as stipulated in the Mental Wellbeing Impact Assessment (MWIA) framework[7]. The oldest old were not mentioned specifically in this case context.

Norway - Case 1

The first case selected for Norway is the Reform "**To Live the Whole Life**" which is a comprehensive national reform for older adults with a main goal on older people being able to master their lives longer, be assured that they get help when they need it, that the relatives can help them without being worn out themselves, and that employees in the health and care services can use their competence and expertise.
The main focus of the reform is to create a more age-friendly Norway and to find new and innovative solutions to challenges within health and care services. The target group of the reform is adults over the age of 65 including people living in their own homes and in supported living institutions. This is a very incongruous target group with large variations in both needs and wishes. The reform is especially aimed at the health and care sector, but it also aims that all sectors of society should help to create a more age-friendly society where older people can live active and independent lives. The reform focuses on the opportunity of individual choice, enjoyment of food, care for relatives, and service innovations.

The reform addresses 25 specific issues within 5 main areas:

1. National program for an age-friendly Norway: a) Plan for your own old age, b) Elderly driven community planning, c) National network for age-friendly municipalities, d) Partnership across sectors, 2) Seniors as resource.
2. Activity and community: a) Good moments, b) Faith and life, c) Generation meetings, d) Society contact (link and coordinator between health and care services and neighbourhoods, family and relatives, volunteers and others in the community), e) Co-use and co-location
3. Food and meals: a) The good meal, b) Meal times, c) Choice and variety, d) Systematic nutrition, e) Kitchen (production of meals) and expertise locally

[7] Cooke A, Friedli L, Coggins T, Edmonds N, Michaelson J, O'Hara K, Snowden L, Stansfield J, Steuer N, Scott-Samuel A. (2011) MWIA: A Toolkit for Wellbeing 3rd ed., London: National MWIA Collaborative

4. Health care: a) Everyday mastering, b) Proactive services, c) Targeted use of physical exercise, d) Environmental treatment, e) Systematic mapping and follow-up.
5. Connected/coordinated/coherent services: a) The needs of the individual, b) Relief and support for relatives, c) Rely on fewer persons and increased continuity, d) Smoother transitions between own homes and nursing homes, e) Planned transitions between municipalities and hospitals

The reform period started in January 2019, lasting for five years with different phases of planning, implementation and evaluation. The government will establish a national and regional support system for the implementation of the reform. Municipalities that change in line with the reform will be prioritised within relevant existing and any new earmarked grant arrangements. This is a broadly aimed reform which clearly addresses the protective factors in the MWIA framework.

Norway – Case 2

The second case selected from Norway is a National Guideline/Manual "**On Preventive Home Visits in the Municipalities**". This policy offers advice and guidance to older adults who do not have municipal care services, or who have limited services from the municipality. It is part of the overall prevention work aimed at the older adults in the municipality. Preventive home visits can help fulfil the municipality's responsibility for preventive health and care work aiming to supporting coping in their daily lives.
The main goals of the manual are to help:

- Establish preventive home visits in the municipality;
- Conduct preventive home visits in the municipality.

The following topics are addressed: Housing, Fire protection, Fall prevention, Nutrition/food/meals, Physical activity, Assistive technology (assistive, adaptive, and rehabilitative devices) and welfare technology, Medication, Mental health, Substance abuse, Social participation/community, Violence.

Preventive home visits are not new or unusual in Norway. The (international) literature shows mixed results which may depend on, how, what, to whom, how often such visits are made. Therefore, interventions evaluated in the literature may not be identical to the one proposed in the national guidelines which was introduced in 2017 (after a circular in 2016). No national evaluation has taken place after the guideline was introduced. There was an increase in the use of preventive home visits before the guideline
was introduced, from 8 % of the municipalities to 25 % in 2013.

Municipalities who introduced preventive home visits in 2013 were in general positive getting positive feedback from the older adults themselves, sometimes also from relatives. The general experience was that older adults appreciated getting information about municipal services and volunteer organisations, that visits created contact, feelings of security and contributed to increased trust in the municipality. A general impression was that older adults appreciated being remembered and (thought of) by municipality. Visits also provided a lower threshold for older adults to make contact at a later date which contributed to being able to live at home for longer. Some municipalities believed that visits helped recruit older adults to exercise and other activities in the local community as well as preventing illness especially fall accidents, by focusing on surroundings, lighting conditions and hazards. Furthermore, the visits were thought to create greater awareness of what the older adults themselves could do to stay active and healthy and living at home for longer. Many municipalities had the impression that if a home visit was declined, it was due to

the older adult feeling too well/healthy, reflections being made of older adults not feeling or identifying as old and were a little surprised by the offer.

The guidelines answer the following conclusion from the report on the status in 2013: "There seems to be a need for more central guidance and training materials that can contribute to the further development of the offer [i.e. preventive home visits] as a municipal service."

As describes in the guidelines, preventive home visits clearly addresses the protective factors in the MWIA. Whether it actually contributes to better mental wellbeing among the elderly remains to be seen, and will depend on how well the implementation in each municipality adhere to the guidelines. But, the feeling of being "seen" and the feeling of increased security due to more knowledge and trust in that they will receive help if the need should arise, as is frequently reported, could in itself contribute positively to the mental wellbeing of old people.

Italy – Case 1

The first case for Italy is a National guideline for an **Integrated Clinical and Social Care Pathway for Dementia**. It is an agreement between Regions and State Government that defines the guidelines about integrated health and social care pathways for people with dementia (Diagnostic and treatment care pathways for dementia). The National Plan for Dementia states aims and actions to be carried on:

1) specific health and social care policies interventions;
2) creation of an integrated network of services for Dementia;
3) strategies and interventions for appropriate treatments and care pathways;
4) improving awareness about dementia,
5) quality of life for patients and relatives;
6) participation and anti-stigma strategies among population.

Guidelines on the information system for dementia is also mentioned and each Italian Regional Administration will have to issue a specific plan about dementia according to this Agreement.

These guidelines underline the importance of disseminating and increasing information on dementia among patients and their family members, with the aim of increasing their ability to choose the pathways of health and social care they preferred. The Diagnostic and Therapeutic Care Pathways suggested by this guidelines focus on the development of a domiciliary care system that allows the person to remain in their own living environment. Another aim of this Agreement is making the care assistance homogeneous, paying particular attention to social inequalities and to the conditions of fragility and / or social-health vulnerability.
The agreement also aims to improve the quality of life and the quality of care and promote full social integration for people with dementia, also through strategies of personal and family involvement. Informal networks, caregivers, volunteering, Associations, Alzheimer Cafes represent an important resource: they are activated to collaborate with the network of health, social-health and social services according to well-defined roles and skills that optimize the answers to patients' needs and families.
The National Plan of Dementia (part of this Agreement) encourages all forms of participation, in particular through the involvement of families and associations, empowering not only the individual but the community too. In this context, regional and local administrations have an important role in involving local

associations. These guidelines actively promote the involvement of user associations and their families in the planning of social and health care services for dementia.

The first monitoring objective is focused on the Regional deliberations about dementia. Each regional administration has to develop their own specific policy. So far 12 Italian regions have approved their own dementia plan and have formally implemented the relative guidelines.

Monitoring of the National Information System on Dementia:
A specific website (https://demenze.iss.it/) called Observatory on dementia (which aims to carry out a survey of the health and social health services made available through an online map) was created. This website contains several information about dementia (epidemiological data, available services, laws and deliberation, European and Italian policies, information on prevention, scientific research).

Several types of indicators are defined by the national guidelines in order to monitor the implementation and the effectiveness of the Diagnostic and Therapeutic Care Pathways for Dementia. Some of these are related to the patient's well-being such as: appropriateness of the pathways (diagnostic, therapeutic and care assistance), service and interventions provided, changes in health status of the individual, changes clinical and economic (direct and indirect costs) outcomes, quality of life and user satisfaction.

Guidelines for the treatment of people with dementia and guidelines for an information system on dementia are states by this Agreement (between Italian Govern and Regional administration). The Diagnostic and Therapeutic Care Pathways place particular attention to the integration between health and social care assets, to multidisciplinary approach and to the collaboration between families, users and local/national associations and professionals. Reducing stigma and discrimination, active participation and social inclusion are also seen as fundamental elements of the care pathways.

Italy – Case 2

The second case study of Italy is the **ITACA Project – Social Housing for low income elderly** approved by the Verona Municipality. This local resolution adopts an agreement with local agencies for social-housing projects for older people (named ITACA Project). The financial details, the aims and the target of the project have been also defined by this resolution.
The major aim of the project is to enhance the level of social capital and wellbeing in two specific zones of the city (public housing areas) which have a higher risk of social isolation for older people.
The main aim of the project is to improve the quality of life of people who living in public housing, reducing the level of isolation to promote a culture of living that can support the independence, autonomy and well-being of the elderly. The project actions also aim to: a) strengthen interpersonal relationships and supportive networks among elderly residents; b) promote a culture of proximity that involves the entire neighbourhood, facilitating relationships that can rebuild inclusive community relationships; c) increase and strengthen the existing social capital promoting the collaboration between associations, volunteering and citizens.
Cultural activities, recreational and creative workshops, healthy lifestyle activities are implemented by the project in specific spaces into the buildings. These activities involve the whole neighbourhood and are open to the all citizens.

The resolution involves local agencies to develop a project with the aims of implementing social capital, active participation, solidarity, cohesion, sense of belonging and safety among older people who live in social housing buildings. The project achieved recreational, educational, supporting activities, home visiting, by specific professional interventions from social facilitators. Local Municipality Agency financed and promoted this kind of project to improve the quality of life and wellbeing of the citizens who live in Municipal social housing.

Spain – Case 1

The first case for Spain is the "**National Strategy for Older Adults for an Active Ageing and for their good treatment 2018-2021**".

This is a Spanish national strategy that includes the priority lines and objectives that should guide policies and action plans for older adults and for people at the end of their working life. It comprises five main action lines:

1) improving older workers' rights and the extension of working life (lifelong professional learning, management of retirement age [e.g. early retirement or longer working life], work-life balance, etc.);
2) supporting participation in society (promotion of volunteering, reduction of the digital gap, decision-making participation, etc.);
3) promoting a healthy and independent life with accessible and appropriate environments (services and accommodation) to increase autonomy;
4) non-discrimination, equity and attention to situations of frailty and vulnerability;
5) reducing risk of abuse (awareness and professional training).

The strategy encourages active ageing through the access to services, to political, social, cultural and recreational activities, and to volunteering, all of which help to maintain social networking and to reduce social isolation. It promotes the extension of working life through training and continuous learning activities. The strategy also aims to increase the social participation of older adults in the process of decision making, especially in the sectors in which they are involved, with the regulation of their presence and function, and also in the participative and consultative bodies of public administration. It also aims to guarantee financial security to maintain autonomy and dignity. The strategy highlights the need for public pensions systems to maintain purchasing power of pensions, in particular the lowest, reduces the relative poverty rate, and removes the differences between the pensions of men and women.

The strategy is a way to offer the same opportunities of participation in the society through social, political, and cultural activities, recognizing the importance of leisure time. Moreover, it emphasises the need for training in information and communication technologies to address the oldest old's heterogeneity, effective participation, and social integration.

The strategy also encourages public administrations to implement measures for housing rehabilitation, and public transportation, so that it can be safe and affordable in order to promote autonomy and active participation in the society. In addition, the strategy strengthens the need that public and urban spaces (such as parks, sidewalks, pedestrian crossings) meet the needs of universal accessibility.

Furthermore, this strategy declares that the social protection system has to guarantee older adults an adequate and stable pension to maintain financial independence and to live with dignity, and that the public administration has to ensure the importance of ageing at their place.

The strategy emphasises the need to guarantee flexibility in the retirement age, with the possibility of continuing the work-life. It also promotes lifelong professional learning and training to avoid age discrimination, taking into account the work-life balance.

The strategy also aims to fight social exclusion and isolation of older adults, offering the same opportunities to participate in the society through cultural, political and social activities: to offer information and training activities about the retirement preparation (presentation of options to participate in physical or social activities), to encourage volunteering, to promote socialising and intergenerational relationships, opening senior centres to people of other age groups for joint activities.

The strategy promotes the active participation of older adults in the formulation and application of public and political activities, as well as in the media, not only as object of information, but also as producers.
It promotes the reincorporation or continuation in the labour market with the creation of job advice services, and the integration in the process of optimization of human resources through functions as mentoring, tutoring and internal consulting. Indeed, older adults could contribute to strengthen and stabilize the knowledge of new generations thanks to their extensive experience.

Although the strategy has not been evaluated yet, the indicators for a future evaluation are specified in the document and they are based on the Active Ageing Index (AAI)8. This instrument assesses the life conditions of older adults, their participation in paid jobs and in social activities and their capacity to grow old actively and healthy. Its main aim is to contribute with empirical data to the development of public policies in Europe, which should not only be oriented to older adults' wellbeing, but also to their possible contributions to public economy and society.

Moreover, it is specified that the strategy will run from 2018 to 2021 and a follow-up will be made with the necessary periodic assessment about the provided services and resources, to identify the shortcomings and, whenever necessary, to formulate proposals of improvement. This document tries to outline the different aspects that should be promoted or changed in order to guarantee older adults an active ageing.

This strategy is based on the indications for an active ageing of the European Union Council Declaration of the 6th December 2012 and of the European Communication Commission of the 20th February 2013, that were elaborated by the European Union Committee of Job and Social Protection as part of the European Year of Active Ageing and Intergenerational Solidarity 2012. Moreover, the proposals and the measures of this program are part of the Strategy for the Spanish Demographic Challenge (Estrategia para el Reto Demográfico de España), that will be developed in line with the Royal Decree (Real Decreto) 40/2017 of the 27th January.

Spain – Case 2

The second case study for Spain is the "**Tourism Program of the Spanish Institute for the Elderly and Social Services**". This is an annual social tourism program for pensioners of the public retirement system, to widow pensioners aged 55 or more, to other recipients of benefits (e.g. unemployment related benefits) with 60 years or more, and insured or recipients of the Social Security, aged 65 or more. The program aims

[8] Zaidi A, Gasior K, Hofmarcher MM, Lelkes O, Marin B, Rodrigues R, Schmidt A, Vanhuysse P and Zolyomi E. (2013). Active Ageing Index 2012. Concept, Methodology and Final Results. European Centre Vienna March

to promote tourism among this segment of the population (by having important discounts in hotels and transportation) as well as mitigate seasonality in the tourist sector, creating employment and economic activity. The program runs from September to June and is carried out through companies of the tourism sector, granted in a public concourse convened by the Spanish Institute for the Elderly and Social Services (IMSERSO). This Institute handles the selection process of the users and it carries out the evaluation of the program to check that the provision of services is conformed to what was established. The budget of the program was about 70,000,000€ in 2017 and IMSERSO funded 20.87% of the total cost.

The tourism program started in 1985 to improve the quality of life of older adults and to enhance active aging by the participation in trips and touristic activities for a reasonable price. This recent national law comes to regulate the old program, providing a better transparency and resulting in benefits to older adults. The tourism program provides older adults the possibility of participating in cultural and recreational activities, contributing to the improvement of their health and quality of life, the promotion of active aging and the encouragement of personal autonomy as well as developing relationships with people of similar age, interests and lifestyle. Also the spouse or partner can join in even if they do not meet the requirements. Also children with disability can accompany.

The main goal is to improve older adults' quality of life and to encourage an active ageing through the participation in trips and touristic activities for reasonable prices. It also offers a range of possibilities, as holiday trips, tourism in the nature, cultural tours, and trips to different cities. The program includes a transport service to encourage participation. The transport from the city of residence to the destination hotel, and back home, is always included. Moreover, it promotes lifelong informal learning and the access to cultural activities. The tourism program has run for more than 30 years and is periodically updated, as it is an important law for the wellbeing of older adults.

Table WP3.1 Overview of legislations, policies and plans cases studies.

Country	Level	Title	Year of approval	Dimensions	Sub-categories	Evaluation (Yes/No)
Finland	National	Act on Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons	2012	Functional	Being healthy, independence, care assistance	Yes
	National	Active Age programme 2012-2017	2012	Functional Social Personal	Being healthy, social interactions, personal development	Yes
Norway	National	To Live the Whole Life	2018	Functional Social Personal Environmental	All	Yes
	National	On Preventive Home Visits in the Municipalities	2016	Functional Social Personal Environmental	Being healthy, being active, independence, social networks, social interactions, social support, being active, living conditions	Yes
Italy	National	National guideline for an Integrated Clinical and Social Care Pathway for Dementia.	2017	Functional Social Personal Environmental	care assistance, being healthy, independence, social interaction, social networks, social support, awareness, personal development, living conditions	Yes
	Municipal	ITACA Project - social housing for low income elderly	2017	Social Personal Environmental	social engagement, social interactions, social networks, social support, being active, personal development, living conditions	No
Spain	National	National Strategy for Older Adults for an Active Ageing and for their good treatment 2018-2021	2018	Social Personal Environmental	Living conditions, social networks, being active	Yes
	National	Tourism Program of the Spanish Institute for the Elderly and Social Services	2018	Social Personal Environmental	Being active, social interactions, natural surroundings	Yes

Appendix WP3.1 Classification system for legislations, policies and plans.

DIMENSIONS	CATEGORIES	SUBCATEGORIES
FUNCTIONAL		
	Being healthy	
	Care assistance	
	Energy and restful sleep	
	Independence	
	Physical activity	
SOCIAL		
	Social engagement	*Help others*
	Social interactions	
		Communication
		Companionship
		Gathering and celebrations
		Getting to know other people
		Harmony in relationships
		Participation in society
		Shared interests
		Visits and phone calls
	Social networks	
		Family
		Friends
		Residents
		Neighbours and acquaintances
	Social support	
		Attention and support
		Being appreciated
		Being connected
PERSONAL		
	Personal outlook	
		Gratitude for life
		Optimism
		Peace of mind
		Positive lifestyle
		Temperament
		Willpower
	Autonomy	
	Awareness	
		Acceptance
		Enjoyment of the present
		Life adjustment
		Life evaluation
	Being active	
		Engaging activities
		Keeping busy
	Personal development	
		Competence
		Identity
		Learning
		Purpose in life
		Self-realization
	Privacy and self-comfort	
	Rest and relaxation	
	Spirituality	
		Religion
		Transcendence
	Stability	
ENVIRONMENTAL		
	Natural environment	
	Living conditions	

Work Package 4: Wellbeing Impact Assessment

Rapid Review

A rapid review was published entitled ***"Determinants of multidimensional mental wellbeing in the oldest old: a rapid review"***[9] exploring current research on determinants of mental wellbeing for the oldest old.

This review was explored determinants of mental wellbeing in oldest old age in order to inform other areas of the EMMY project, and in order to place greater attention to mental wellbeing in the oldest old population group and advocate for a policy shift towards more focus on mental wellbeing.

An iterative rapid review approach was used to review existing literature in line with the four dimensions of mental wellbeing defined by the European Welfare Models and Mental Wellbeing in Final Years of Life (EMMY) study; functional, social, personal and environmental.[10] A specific focus on articles employing multidimensional definitions of mental wellbeing was adopted.

Mental wellbeing was defined around three separate domains; evaluative wellbeing which relates to satisfaction with life, hedonic wellbeing which is linked to positive and negative emotions or affect, and eudaimonic wellbeing with a focus on positive functioning, self-realisation and meaning.

This iterative process resulted in a final 15 articles being selected for the review, comprising of 10 quantitative studies and 5 qualitative studies, as reported in table WP4.1.

[9] Cresswell-Smith J, et al. De-terminants of multidimensional mental wellbeing in the oldest old: a rapid review. Soc Psychiatry Psychiatr Epidemi-ol.2018 doi.org/10.1007/s00127-018-1633-8
[10] Lara E, et al. Mental Well-being in Late Life: Evidences from the Perspective of the Oldest Old Population. Journal of Happiness Studies, 2019; 1-20

Table WP4.1 Summary of articles reviewing multidimensional mental wellbeing in oldest old age

AUTHORS	RESEARCH DESIGN	DIMENSION	YEAR	TYPE OF STUDY	N	AGE	MENTAL WELLBEING MEASURES	OTHER MEASURES
Cooper R, Stafford, M, Hardy R et al [33]	Quantitative	Functional	2014	Longditudinal	3096	53 to 82 years and 63.6 to 86.6	WEMWBS	Four physical capability measures
Berg AI, Hassing LB, Mcclearn GE, Johnsson B [35]	Quantitative	Functional	2006	Longditudinal	315	80-98	Life Satisfaction Index-Z	Demographics, health, Activities of Daily Living (ADL), cognitive, depression, LOC, social network,
Fänge and Dahlin	Qualitative	Functional	2009	Cross-sectional	40	80-89	Interview	
Berg AI, Hassing LB, Mcclearn GE, Johnsson B [35]	Quantitative	Social	2006	Longditudinal	315	80-98	Life Satisfaction Index-Z	Demographics, health, ADL, cognitive, depression, LOC, social network,
Litwin H and Stoeckel K [41]	Quantitative	Social	2013	Longditudinal	13879	60-79 and 80 plus	CASP-12 quality of life scale, and global measure of life satisfaction	Socioeconomic indicators, ADL
Forsman A, Herberts C, Nyqvist F, Wahlbeck K, Schierenbeck I [43]	Qualitative	Social	2013	Cross-sectional	11	73-90	Focus group interviews and open-ended questioning	
Berg AI, Hassing LB, Mcclearn GE, Johnsson B [35]	Quantitative	Personal	2006	Longditudinal	315	80-98	Life Satisfaction Index-Z	Demographics, health, ADL, cognitive, depression, LOC, social network,
Nebayer AB, Schilling OK, Wahl HW [46]	Quantitative	Personal	2017	Longditudinal	111	87 to 97	The Satisfaction with Life Scale, Positive and Negative Affect Schedule	Need fulfilment using the subscales “autonomy” and “environmental mastery”, Cognitive functioning, perceived health

Enkvist Å, Ekström H, Elmståhl S [47]	Quantitative	Personal	2012	Longditudinal	681	78-93	Neugartens' QoL Scale	Subjective health, ADL, Mini Mental State Examination, Psychiatric Rating Scale, health, LOC scale
Thauvoye, E, Vanhooren, S, Vandenhoeck A, Dezutter J [49]	Quantitative	Personal	2017	Cross-sectional	279	70–91	WEMWBS	Socio-Demographic, Spirituality
Douma L, Steverink N, Hutter I, Meijering L[50]	Qualitative	Personal	2017	Cross-sectional	66	65-83	Word clouds	
Pirhonen J, Ojala H, Lumme-Sandt K, Pietilä I [51]	Qualitative	Personal	2016	Cross-sectional	45	90-91	Life-story interviews	
Read S, Grundy E, Foverskov E [52]	Review	Environmental	2015	Review				
Avidor S, Ayalon L, Palgi Y, Bodner E [54]	Quantitative	Environmental	2016	Longitudinal	1534	40-64 and 65 -93	Satisfaction with Life Scale, Positive and Negative Affect Schedule	Perceived age discrimination, Subjective life expectancy, demographic infomation
Finlay J, Franke T, McKay H, Sims-Gould J[55]	Qualitative	Environmental	2015	Cross-sectional	141	65–86	In-depth qualitative interviews	

Multidimensional indicators reflect the multifaceted and multidirectional dynamics of wellbeing in very old age. Considerable variety in both measures and terminology was found within the literature making precise comparison difficult.

The rapid review took steps towards comparability by focusing on studies implementing multiple measures of mental wellbeing including evaluative, hedonistic and eudaimonic factors. Clearly defined and multifaceted measures of mental wellbeing are needed to sharpen evidence used in policy development, appraisal and evaluation in light of the considerable diversity of health and functional states experienced in later life.

Previous studies appear to line up the four main dimensions of mental wellbeing identified in the EMMY study.

Actively improving opportunities for older adults to produce benefits to society can be done via a stronger focus on resources such as mental wellbeing.

Åbo Akademi University

Work Package 4: The Delphi Survey process

During February-April 2019, the content of the first round of the Delphi survey was developed by the project team under the coordination of team members at Åbo Akademi University (FIN). The content of the survey questionnaire was based on a synthesis of the findings in the project work packages 1-2, questions related to Work package 3 as well as relevant indicators derived from the *Mental Wellbeing Impact Assessment: A Toolkit for Wellbeing*[11]. The final version of the questionnaire was completed and translated in to Finnish, Italian, Norwegian, Spanish and Swedish in mid-April. The questionnaire used in round 1 of the Delphi survey can be viewed in Appendix WP4.1. The items were arranged in two broader introductory questions and three main batteries of items. Respondents were able to comment in free text on all the batteries of items and to suggest further priority areas of importance.

The teams for each participating project institution compiled lists of relevant survey recipients. For each country, 50 recipients were selected representing the following categories: authorities, decision-makers in various capacities, senior citizens' or pensioners' organizations and experts (researchers, opinion leaders) in health promotion and other relevant fields. Each category comprised 10-13 people. The e-mail addresses of the 200 recipients were identified through public websites. The survey links were distributed along with translated invitation e-mails at the end of April 2019, with deadlines set for mid-May. Two reminders were circulated during the time period. As the number of responses was fairly low by the original deadlines, tailored invitations were subsequently circulated from each participating institution with an extended deadline set for the last day of May.

The final number of responses from the first survey round was 66: Spain (27); Finland (19); Italy (12); Norway (8). The results from round one were subsequently summarized, with the items listed in order of perceived importance (based on the number and percentage of respondents indicating items as very important as well as item mean scores).

The first two questions in the questionnaire of round one were not included in the second round. The results of these questions were as follows: 70 % (n = 46) of respondents found it very important that *"Policy should support mental wellbeing among the oldest old (people aged 80+)"*, followed by 26 % (n = 17) who found it important to some extent and 4 % (n = 3) who expressed a neutral stance. Similarly, 70 % (n = 46) found it very important that *"Policy in my country should to a larger extent target the mental wellbeing of the oldest old (people aged 80+)"*, followed by those who felt that this was important to some extent (21 %, n = 14) and those who indicated a neutral stance (9 %, n = 6).

[11] Cooke A, Friedli L, Coggins T, Edmonds N, Michaelson J, O'Hara K, Snowden L, Stansfield J, Steuer N, Scott-Samuel A. (2011) MWIA: A Toolkit for Wellbeing 3rd ed., London: National MWIA Collaborative

In the second round of the Delphi survey, the items from the first two batteries of questions in the original questionnaire were merged and listed in the perceived order of importance established in the first round. Furthermore, some items that were suggested as important by multiple respondents from the first survey round were added to this list. The new items included: Ensuring access to senior or day care centres; Promoting health education initiatives targeting the oldest old to support physical and mental wellbeing; Supporting informal care; Supporting access to digital services and prevents digital exclusion. It was clearly indicated in the list which items had been added. The questionnaire content of the second survey can be viewed in Appendix WP4.2.

The second survey questionnaire was circulated to the original 66 respondents from round one. The Spanish and Italian recipients received the invitations in June with deadlines in July. Due to the month of July being the primary month of summer holidays in the Nordic countries, the surveys were distributed and deadlines set within August for Finland and Norway. Survey recipients received one reminder. In the second round, 39 responses were received: Spain (13); Finland (12); Italy; (8); Norway (6).

In the second round, participants were instructed to choose which ten topics they find the most important to address in policy, considering the mental wellbeing of people aged 80+. The results can be seen in Table WP4.2.

Table WP4.2. Topics the survey respondents of round two of the Delphi survey (n = 39) found the most important to address in policy considering the mental wellbeing of people aged 80 years and over. Ten items could be chosen.

Item	**Number of votes (descending)**
Safeguarding against age related discrimination and negative stereotypes of the oldest old	25
Promotion of access to informal social (including intergenerational) networks (family, friends, residents, neighbours and acquaintances)	24
Housing security (choice of housing, secure tenure)	24
Possibilities for independence (functional, social and financial)	24
Access to adequate formal care assistance	23
Opportunities for autonomy and sense of control (decision making)	23
Opportunities for social interactions (communication, companionship, gatherings and celebrations, getting to know other people, shared interests, visits and phone calls)	23
Ensuring that physical health in oldest old age is given the same level of attention as in younger age groups	19
Access to social support (being appreciated, being connected)	17
Meeting disability needs	16
Physical security (safety of neighbourhood)	15
Supports informal care (NEW ITEM)	12
Quality of living environment (for example public spaces, quality of built environment)	11
Financial security (for example adequate income, credit and wealth options)	11
Opportunities for personal development (competence, identity, purpose in life, self-realization)	11

Promotes health education initiatives targeting the oldest old to support physical and mental wellbeing (NEW ITEM)	11
Good quality food (affordable, healthy and accessible food)	10
Opportunities for being active (engaging in activities, keeping busy)	10
Opportunities for social engagement (helping others)	10
Ensures access to senior / day care centres (NEW ITEM)	10
Adequate transport access and options (choice, affordability and accessibility)	9
Access to natural surroundings	8
Access to leisure (for example arts, creativity, sports, culture)	7
Opportunities for physical activity	7
Access to education (life-long learning, training)	6
Supports access to digital services and prevents digital exclusion (NEW ITEM)	5
Opportunities for privacy	4
Enhancing social trust between citizens	3
Taking socioeconomic position into account	3
Enhancing trust in the political system (government, politicians, economic system, public institutions)	3
Ensuring gender equality	2
Possibilities for spirituality (religion, transcendence)	2
Safeguarding LGBT rights (for example inheritance, housing, discrimination)	1
Taking race and ethnicity into account	1

The respondents were also asked to rank five items to address in policy supporting the mental wellbeing of people aged 80+ in order of importance (number 1 indicates the area perceived as most important). The results can be seen in Table WP4.3.

Table WP4.3. Areas to address in policy to support the mental wellbeing of people aged 80 years and over, rated in order of importance by the respondents in round two of the Delphi survey (n = 39).

Item	**Placement (number of votes)**					**Mean (descending)**	**Rank**
	1	**2**	**3**	**4**	**5**		
Enhancing control: The extent to which individuals and communities have control over their lives	20	4	4	5	6	2.31	1
Social Inclusion: The extent to which people are able to access opportunities, for example employment, education, leisure, or rather how much people are excluded from these.	7	15	10	2	5	2.56	2
Resilience: The assets which help individuals and communities withstand adverse conditions they may face, allowing them to do better than expected in the face of adversity	11	10	4	7	7	2.72	3
Community assets: Assets that rely on social connectedness which can be promoted through public policy relating to tolerance, tradition, safety, social networks, trust, and cultural heritage	4	6	11	15	3	3.18	4
Participation: The extent to which people are involved and engaged in the community, for example volunteering, local decision making groups, collective action, civic engagement	4	4	6	7	18	3.79	5

Appendix WP4.1
EMMY project Delphi survey questionnaire (Round 1)

Supporting mental wellbeing among the oldest old

This survey focuses on mental wellbeing among the oldest old (people aged 80+) and defines mental wellbeing as: *"a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society".*

Mental wellbeing can be supported by different types of policy. Policy in this context can be defined as *national and/or regional legislation, plans, strategies, programmes and recommendations*. Your response will help us prioritise what is important when it comes to promoting a stronger focus on the mental wellbeing among the oldest old in policy.

Name ----------
Organization----------

Please rate the following statements on a scale from 1-5 (1 not at all important to 5 very important, where 3 indicates a neutral stance):

- Policy should support mental wellbeing among the oldest old (people aged 80+)
- Policy in my country should to a larger extent target the mental wellbeing of the oldest old (people aged 80+)

Comments regarding the statements above:----------

Policy may support different population groups in different ways. Please rate how important it is that public policy safeguards the following in oldest old age (1 not at all important to 5 very important, where 3 indicates a neutral stance):

- How important is it that public policy ensures gender equality in oldest old age
- How important is it that public policy takes race and ethnicity into account in oldest old age
- How important is it that public policy accounts for socioeconomic position and class in oldest old age
- How important is it that public policy ensures that physical health in oldest old age is given the same level of attention as in younger age groups
- How important is it that public policy safeguards LGBT rights in oldest old age (for example inheritance, housing, discrimination)
- How important is it that public policy safeguards against age related discrimination in oldest old age
- How important is it that public policy meets disability needs in oldest old age.

Comments regarding the statements above: ----------

Various dimensions of mental wellbeing among the oldest old have been identified in the EMMY project. Please rate how important it is to acknowledge the following in policy for the oldest old (1 not at all important to 5 very important, where 3 indicates a neutral stance):

- Access to natural surroundings
- Quality of living environment (for example public spaces, quality of built environment)
- Financial security (for example adequate income, credit and wealth options)
- Physical security (safety of neighbourhood)
- Housing security (choice of housing, secure tenure)
- Adequate transport access and options (choice, affordability and accessibility)
- Good quality food (affordable, healthy and accessible food)
- Opportunities for physical activity
- Possibilities for independence
- Access to adequate care assistance
- Access to social support (being appreciated, being connected)
- Access to social networks (family, friends, residents, neighbours and acquaintances)
- Opportunities for social interactions (communication, companionship, gatherings and celebrations, getting to know other people, shared interests, visits and phone calls)
- Opportunities for social engagement (helping others)
- Enhancing trust in the political system (government, politicians, economic system, and public institutions)
- Enhancing social trust between citizens
- Opportunities for autonomy and sense of control (decision making)
- Opportunities for privacy
- Opportunities for personal development (competence, identity, purpose in life, self-realization)
- Opportunities for being active (engaging in activities, keeping busy)
- Access to leisure (for example arts, creativity, sports, culture)
- Access to education (life-long learning, training)
- Possibilities for spirituality (religion, transcendence)

Comments regarding the statements above: ----------

Please rate how important it is that policy impacts/supports the following protective factors for mental wellbeing in oldest old age (1 not at all important to 5 very important, where 3 indicates a neutral stance):

- Resilience: The assets which help individuals and communities withstand adverse conditions they may face, allowing them to do better than expected in the face of adversity
- Community assets: Assets that rely on social connectedness which can be promoted through public policy relating to tolerance, tradition, safety, social networks, trust, and cultural heritage
- Participation: The extent to which people are involved and engaged in the community, for example volunteering, local decision making groups, collective action, civic engagement
- Enhancing control: The extent to which individuals and communities have control over their lives
- Social Inclusion: The extent to which people are able to access opportunities, for example employment, education, leisure, or rather how much people are excluded from these.

Comments regarding the statements above: ----------

Are there other issues relevant for the mental wellbeing of the oldest old - from a policy perspective - that you think should be added to the statements above? Please describe and rate the items below according to perceived importance (1 not at all important to 5 very important, where 3 indicates a neutral stance)

Appendix WP4.2

Contents of EMMY project Delphi survey questionnaire (Round 2)

Supporting mental wellbeing among the oldest old

Survey round two

In this survey the topics from the previous survey round are presented according to how respondents rated their importance and you will now be asked to select which topics you consider to be the most important in relation to mental wellbeing in oldest old age (80+). We have also incorporated some suggestions made in the first round. Feel free to make further comments in the open fields also in this round. We appreciate your opinion regarding the importance of these added items.

Name ----------

Organization----------

The topics below are listed in order of importance from the first round. The items at the top were rated as the most important. We have also added a few items to the end of the list which were suggested by participants in the previous round. Please now choose which ten (10) topics you find the most important to address in policy, considering the mental wellbeing of people aged 80+:

- Safeguarding against age related discrimination and negative stereotypes of the oldest old
- Meeting disability needs
- Access to adequate formal care assistance
- Promotion of access to informal social (including intergenerational) networks (family, friends, residents, neighbours and acquaintances)
- Physical security (safety of neighbourhood)
- Housing security (choice of housing, secure tenure)
- Ensuring that physical health in oldest old age is given the same level of attention as in younger age groups
- Access to social support (being appreciated, being connected)
- Possibilities for independence (functional, social and financial)
- Opportunities for autonomy and sense of control (decision making)
- Ensuring gender equality
- Quality of living environment (for example public spaces, quality of built environment)
- Good quality food (affordable, healthy and accessible food)
- Financial security (for example adequate income, credit and wealth options)
- Opportunities for personal development (competence, identity, purpose in life, self-realization)
- Opportunities for social interactions (communication, companionship, gatherings and celebrations, getting to know other people, shared interests, visits and phone calls)
- Adequate transport access and options (choice, affordability and accessibility)
- Opportunities for being active (engaging in activities, keeping busy)
- Safeguarding LGBT rights (for example inheritance, housing, discrimination)
- Opportunities for privacy

- Access to leisure (for example arts, creativity, sports, culture)
- Opportunities for physical activity
- Access to natural surroundings
- Enhancing social trust between citizens
- Opportunities for social engagement (helping others)
- Access to education (life-long learning, training)
- Taking race and ethnicity into account
- Taking socioeconomic position into account
- Enhancing trust in the political system (government, politicians, economic system, public institutions)
- Possibilities for spirituality (religion, transcendence)
- Ensures access to senior / day care centres (NEW ITEM)
- Promotes health education initiatives targeting the oldest old to support physical and mental wellbeing (NEW ITEM)
- Supports informal care (NEW ITEM)
- Supports access to digital services and prevents digital exclusion (NEW ITEM)

Comments regarding your choice of topics: ----------

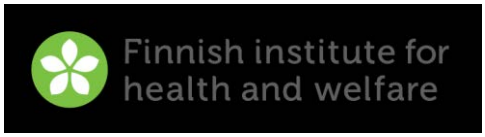
General comments on the list:----------

Please rate the following five items in order of importance to address in policy supporting mental wellbeing of the oldest old (choose number 1 for the most important, number 2 for the second most important etc.):

- Enhancing control: The extent to which individuals and communities have control over their lives
- Resilience: The assets which help individuals and communities withstand adverse conditions they may face, allowing them to do better than expected in the face of adversity
- Social Inclusion: The extent to which people are able to access opportunities, for example employment, education, leisure, or rather how much people are excluded from these.
- Community assets: Assets that rely on social connectedness which can be promoted through public policy relating to tolerance, tradition, safety, social networks, trust, and cultural heritage
- Participation: The extent to which people are involved and engaged in the community, for example volunteering, local decision making groups, collective action, civic engagement

Comments regarding the order of importance: ----------

General comments on the list: ----------



Work Package 4: Decision Support Tool

EMMY project outcomes were summarised in a Decision Support Tool (www.emmydecisionsupport.com/) which guides the user through a series of assessments around how well a proposed project, policy and initiatives takes mental wellbeing into consideration for the oldest old population.

The main aim is to raise awareness about mental wellbeing in oldest old age, and to encourage decision makers (users) to include mental wellbeing in their assessment procedures.

The methodology behind the EMMY Decision Support Tool.

The Decision Support Tool was based on results from the EMMY focus group study[12] which explored the meaning of mental wellbeing for older adults aged eighty years and over, as well as the EMMY Delphi study which gauged the opinion of a broad set of stakeholders with specialised knowledge of the oldest old age group (as described in the previous chapter).

The decision support tool is intended to support the development of actions with develop mental wellbeing in oldest old age and consists of two sections;

1. A Dynamic Model of Mental Wellbeing summarising how social determinants of mental wellbeing impact the oldest old
2. A Policy Assessment Tool which allows for policy assessments to be made.

The structure of the decision support tool comes from the Mental Wellbeing Impact Assessment (MWIA)[13] toolkit developed by National MWIA Collaborative, using data from the EMMY project.

Dynamic Model of Mental Wellbeing

This model was based on one developed by the National MWIA Collaborative, and includes links to findings from the qualitative focus group study performed by the EMMY project. Focus group transcriptions were explored for the wider determinants of mental wellbeing.

Policy Assessment Tool

In order to develop Policy Assessment Tool of the EMMY decision support tool, a Delphi survey gauged the opinions of stakeholders with a solid understanding of the oldest old population group.

[12] Lara E, Martín-María N, Forsman A, Cresswell-Smith J, Donisi V, Ådnanes M, Kaasbøll J, Melby L, Nordmyr J, Nyholm L, Rabbi L, Amaddeo F, Miret M. Mental Well-being in Late Life: Evidences From The Perspective Of The Oldest Old Population. Journal of Happiness Studies, 2019; 1-20.
[13] Cooke A, Friedli L, Coggins T, Edmonds N, Michaelson J, O'Hara K, Snowden L, Stansfield J, Steuer N, Scott-Samuel A. (2011) MWIA: A Toolkit for Wellbeing 3rd ed., London: National MWIA Collaborative

The content of the survey questionnaire was based on a synthesis of the findings from the qualitative and quantitative parts of the EMMY project as well as the framework used in the Mental Wellbeing Impact Assessment framework.

Results from the Delphi study were used to weight the answers in the Policy Assessment Tool. Each answer on the likert scale was weighted according to the ranking order of the Delphi process and the value given by the end user.

These wider determinants of mental wellbeing were then collated into corresponding protective factors for mental wellbeing producing the end result. If the wider determinant impacted more than one protective factor, its weight was divided over all three.

Project Recommendations

- The oldest old age group needs to be included in mental health promotion actions and research endeavours to a greater extent.
- Developing MWB measures specifically for the oldest old age group will improve likelihood of it being included within policy development.
- Welfare states including universal care regimes sustain mental wellbeing into older age.
- Mental wellbeing should be included in routine impact assessment of policy actions.
- Further attention is needed to make evidence more accessible to those in decision making positions.
- Actively improving opportunities for older adults to produce benefits to society can be done via a stronger focus on resources such as mental wellbeing