

Implementing a Senior Community Care Model: An Italian Top-Down Cohousing Project and Nursing Home

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Abstract

Not ageing in place is an increasing reality for many older Europeans. For several decades societies have applied different care models in developing initiatives to provide safe and age-friendly spaces. This article presents the community care model implemented by the Italian service provider ISRAA in Treviso (Italy) in one of its nursing homes and senior cohousing projects. The aim of our study was to analyse this senior community care model and find out how residents have responded to it. Participants were both the older adult residents in the two ISRAA facilities and professionals responsible for their social attention. A qualitative methodology was used: questionnaire, interviews, and focus groups with professionals and care facility residents. Results reveal the care philosophy implemented, residents' experiences, the main barriers to creating a community, and how this model could be improved by following community development principles, with the older people's help, participation, and engagement. The conclusions highlight the importance of applying principles of self-determination and social inclusion in a preventive care model for the senior community. In addition, a key factor in promoting community development is for professionals to act as community development practitioners and to allow older adults to be part of the change.

Keywords

ageing; care; cohousing; community; community care; elderly; gender; nursing home; social inclusion

1. Introduction

This article addresses the topic of community development within a residential care setting for older people to support their well-being. The rise in life expectancy and subsequent increase in the population aged over

65 in European countries (Corselli-Nordblad & Strandell, 2020) calls for actions that maintain individual well-being for as long as possible. This consideration is particularly relevant to the Italian case. In Italy, 21.4% of the population are aged over 65, of which 7.7% are over 80 (ISTAT, 2022), making it the country with the oldest population in Europe (EUROSTAT, 2023). In this article we refer to the concept of community development both “as a participatory process by which communities of place, identity or interest grow and change; [and] as a practice of stimulating and supporting communities to participate in change” (Banks et al., 2023, p. 2). According to Kam (1996), in response to the social and political changes in contemporary society, a community work approach can be a useful way of transforming old people from passive clients into active and empowered individuals with a positive self-image. It is effective in strengthening older people’s contact with the community, eliminating their negative self-image, protecting their rights, and increasing their capacity to influence policymaking.

Considering older adults as active members of society and providing them with the tools (spaces, networks, activities) for their inclusion in social life are crucial elements to consider in social care prevention policies. In this regard, new housing environments are required for the ageing population that invest in preventive solutions, self-care, and rehabilitation within the community (Pennestrì et al., 2022). A related issue to consider is the public perception of care and residential facilities for older adults, such as nursing homes. These institutions still carry a stigma in our societies and are considered oppressive, dehumanising places detached from the surrounding social context, often exclusively associated with illness and death. Similar stereotypes are frequently extended to residents, who are perceived as physically or mentally impaired, disabled, ill, unproductive, inactive, isolated, and unmotivated (Dobbs et al., 2008; Kornadt & Rothermund, 2011). A paradigm change is needed to reverse this way of thinking, which first implies challenging the taboo associated with old age. Change must come from a political position that coordinates a network where the public, the private sphere, and the community are woven together to promote shared responsibility (Martínez-Buján, 2019).

An increasingly viable alternative to the problem of social exclusion is cohousing, understood as “a form of community living that contains a mix of private and communal spaces, combining autonomy and privacy with the advantages of community living” (Riedy et al., 2017, p. 1). The cohousing approach has been implemented in northern Europe since the 1980s (Pedersen, 2015) and involves a way of living both “apart and together” (Brenton, 2013). According to Durrett and McCamant (1988), one of the main characteristics of cohousing is the presence of collaborative lifestyles and a democratic, non-hierarchical decision-making process. These authors are referring to bottom-up cohousing, which are communities created, designed, and managed by their residents (Arrigoitia & Scanlon, 2015; Riedy et al., 2017), often with shared values or based on a commitment to a central ideology (Korpela, 2012). However, not all cohousing in Italy has this structure. According to Durante (2011), cohousing is an umbrella concept that includes a variety of experiences (*condomini solidali*, *ecovillages*) previously embedded in different categories, which were incorporated into this concept once “cohousing” became a buzzword in public discourses on housing and social policies. Considering this, the experience we present here is a top-down cohousing or “institutional mediation cohousing,” a term used by our informants. It refers to a place where the residents’ opportunities for choice and autonomy are reduced to a minimum, that is, all the main decisions on forming the groups, participatory planning, legal assistance, and building the community and its rules are mediated by the institution that guides and oversees the constitution of the cohousing (Bianchi & Roberto, 2016). This is the type of cohousing managed by the Italian service provider ISRAA (Istituto per Servizi di Ricovero e Assistenza agli Anziani), which we discuss in this article.

The objective of this article is to present, discuss, and analyse the senior community care model implemented by ISRAA using the findings of the AGORAge: Ageing in a Caring Community project, based on the following notion of community as a reality that necessarily requires people's participation in one or several processes, a participation that generates elements or psychological components of identity or belonging (Zuñiga Ruiz de Loizaga & Arrieta Frutos, 2021).

1.1. From the Community to Community Care

This research is framed within the concepts of community and care, which we introduce separately before analysing them together under the concept of "community care."

The concept of community has a long theoretical history in the social sciences and has been used as an analytical category in many studies since the 19th century. One of the first notable contributions in this respect is that of the German sociologist F. Tönnies (1887/1979), who distinguished between the concepts of community and society. Community, he argued, was mainly found in limited social spheres (family, neighbours) and was characterised by the coincidence between "individual will" and "collective will," while society was based on the domain of "arbitrary will," a mechanical formation in which individuals are not linked to each other (Galli et al., 2005). Subsequently, other authors have focused on the relationship between community and solidarity, highlighting the difference between mechanical solidarity, typical of so-called simpler societies, and organic solidarity, typical of complex societies (Durkheim, 1893/2016); or on the holistic character of the community as a "human whole" where members live for and as a result of the community (Redfield, 1965).

Throughout the 20th century, the community became a classic object of study in anthropology, initially within the framework of the colonial model, centred on the primitive/indigenous–civilised binomial, and then turning its attention to peasant communities (Trapaga, 2018) or, in the Italian context, to the subaltern population (Cirese, 1973; De Martino, 1949).

With the rise of feminism from the 1970s onwards, people began to speak of community in different terms, breaking with previous oppositional categories and binding the concept of community with that of care. Domestic work and the naturalisation of women's role as carers were debated (Dalla Costa, 1972; Gerstein, 1973), and the community began to be critically considered as a vertical space that helped to reproduce the subaltern position of women (Vega Solís et al., 2018). Care eventually became an analytical category linked to Marxist feminist studies that postulated the centrality of women's role as reproducers of the labour force, essential for the development and sustenance of the capitalist system (Federici, 2004).

In this article, we refer to the concept of care as the set of practices necessary to sustain life, that is, the physical and emotional well-being of all people in any social context (Pérez Orozco, 2014). Talking about care implies talking about a system of provision, and we are interested in knowing how the community is positioned in this respect. In the care diamond model (Razavi, 2007), devised by feminist economics to identify the institutions involved in providing care, the community is already partially included through its identification with the non-profit sector (which includes voluntary and community provision). However, recent studies propose replacing the figure of the diamond with that of a pentagon, identifying the community itself as one of the key elements, in addition to the state, the market, the third sector, and the family (Zuñiga Ruiz de Loizaga & Arrieta Frutos, 2021).

Following this premise, our research is framed within the concept of community care as a heterogeneous set of practices that involve different actors and different degrees of commitment. These practices may refer to self-managing processes, to the extended family, or the collaboration with or intervention of institutional services provided by the state or by private organisations (Vega Solís et al., 2018). Specifically, community care can be related to the material dimension (which includes maintenance and provisioning tasks), the relational dimension (relating both to accompaniment in difficult moments and to sharing moments of socialisation), and, finally, the domestic-corporal dimension (which involves direct contact with the person and assistance; (Bodoque-Puerta & Sanz Abad, 2021).

1.2. Context

Borgo Mazzini Smart Cohousing (BMSC) began with an open consultation launched by the service provider ISRAA in 2014 to collectively explore social and architectural possibilities with the citizens of Treviso. This initiative was aimed at members of the population aged between 65 and 80 who still lived independently, and intended to offer an alternative solution to nursing homes that would combine a high level of autonomy with soft support and protection provided by the organisation. The cohousing model was therefore identified as a model that could reconcile these instances and, within this framework, the community dimension was seen as a key feature to counteract isolation, encourage forms of mutual support and care, stimulate active participation, and help to sustain mental and physical well-being. The project saw the light of day in 2018 and the cohousing facilities currently consist of six restored historic buildings, which residents and professionals call “houses,” each one divided into single apartments and equipped with common spaces. The buildings are in an area of Treviso’s historic centre named Borgo Mazzini, from which the cohousing takes its name. From an architectural point of view, BMSC can therefore be defined as “diffuse cohousing,” since it consists of several properties distributed across the area, only some of which are spatially contiguous. ISRAA also has extensive experience in service and assistance provision to older adults and in senior care facilities, and currently owns four nursing homes in Treviso. Casa Albergo (CA, a guesthouse) is one of them, based in the city centre in the same area where cohousing is located, home to 167 residents, 42 of whom have some degree of dependency. CA and BMSC are currently involved in a plan of progressive integration in the surrounding area, with the dual intention of creating a living environment that is welcoming and caring for older people even outside their walls and facilitating the spread of a new representation of ageing, also conveyed through the use and experience of spaces. With this in mind, three newly renovated rooms in one of the cohousing buildings will be made available to the public, aiming at putting the bases for the creation of an extended neighbourhood community.

2. Methodology

The methodology was mainly qualitative. Participants were the older adult residents in ISRAA’s facilities and the professionals responsible for their social care (see Tables 1 and 2 for the sample details). Fieldwork was carried out from September 2022 to January 2023. The research techniques selected were considered optimal to meet the objectives. The following activities were carried out:

- Six semi-structured interviews (Int) were conducted with older residents to explore their experiences and sense of belonging to the neighbourhood, their relations with the other inhabitants, and the reasons why they chose to live there. The selection was based on a preliminary open questionnaire administered to 13 CA and BMSC residents, which provided us with general information on their

relationship with the neighbourhood, their socio-biographic backgrounds, and their disposition to be interviewed. The interviews were conducted by one of the authors who works at ISRAA and had come into contact with the residents previously. This was an advantage, as the interviewees felt confident enough to talk because she was familiar.

- An open questionnaire (Qp) was administered to five ISRAA professionals to learn their views on the relationships between the people living at CA and BMSC, the impact of Covid, and the residents' activities both inside and outside the two facilities.
- A focus group (FGp) was set up to investigate the ongoing process of building a community incorporating CA, BSMC, and the neighbourhood. The four ISRAA professionals who participated—a psychologist, a community nurse, an educator, and the CA coordinator—were selected as they had the most contact with users. It was conducted by two of the authors.
- A focus group with eight residents (FGr) from CA and BMSC was conducted to discuss the bases for and barriers to creating a caring community. A community map was used as an operational tool to introduce and address the link between spaces and relationships. The map represented the area of Borgo Mazzini and contained only the main topographical elements, such as the names of streets and squares, and the principal landmarks. The intention was to provide a neutral instrument so as not to influence the participants, who were invited to indicate their points of reference, such as the commercial and recreational establishments they frequent as part of their daily itinerary, or the places where they feel comfortable and like to spend time.

Table 1. Characteristics of the residents' sample.

Code	Age	Place of residence	Activity
Res 1	80	Cohousing	Interview
Res 2	75	Cohousing	Focus group
Res 3	81	Cohousing	Interview, Focus group
Res 4	79	Cohousing	Interview, Focus group
Res 5	75	Cohousing	Interview
Res 6	84	Nursing home	Focus group
Res 7	80	Nursing home	Focus group
Res 8	84	Nursing home	Focus group
Res 9	86	Nursing home	Interview, Focus group
Res 10	86	Nursing home	Interview, Focus group

Table 2. Characteristics of the professionals' sample.

Profile	Sex	Age	Years working at ISRAA	Activity
Community manager	Male	30	3	Questionnaire
Community nurse	Female	47	17	Questionnaire, Focus group
Professional educator	Female	35	7	Questionnaire, Focus group
Facility coordinator	Female	54	5	Questionnaire, Focus group
Psychologist	Female	49	13	Focus group
Trainee	Female	20	2 months	Questionnaire

2.1. Ethical Considerations

The research was conducted in accordance with the Declaration of Helsinki for human research of the World Medical Association and was approved by the ISRAA data protection officer. Participation was voluntary and participants were previously informed about the purposes of the study and gave their informed consent to participate. The data collected were anonymised to protect their identity.

2.2. Analysis

A qualitative approach was taken to collect narratives from the interviews and the focus groups, all of which were digitally audio recorded, transcribed in Italian for text-based analysis, organised, and coded (Leavy, 2014; Taylor & Bogdan, 1987). Participants' discourses were analysed inductively by all three authors in regular team meetings. Users' and professionals' opinions were differentiated and crosschecked to ensure consistency. One of the authors had previously constructed categories according to four main variables: motivations for moving to ISRAA's facilities, inside and/or outside relations and activities, community conception, and barriers to creating community. The same author pre-coded (Saldaña, 2009) the narratives by isolating quotations related to the main research objectives to identify patterns and similar experiences and opinions. Then, after sharing with the other authors and receiving their feedback, a second round of coding was carried out to collectively produce a conceptual framework for further analysis. This method of analysis allowed us to compare perceptions, identify relevant common and differing issues, and obtain a comprehensive understanding of the data to reach general conclusions. The quotations used have been translated into English for this article.

3. Results: ISRAA Philosophy of Care

3.1. Choosing a New Life Project

The process by which people access a care facility is important to understand further community building and development. In the case of ISRAA's facilities, this procedure involves two meetings: The first is between the future resident and the social worker and addresses mainly formal aspects; the second involves the whole team and assesses the person's existing autonomy and suitability for access. The accommodation is then assigned, and the future resident can spend a month in the facility to find out if this new reality is what he or she is looking for. Right from the start, the fact that the person is embracing a new life project is considered, but it is also made easier for the person to understand whether they might feel at ease in this setting:

What we always say, and what I say every time I make an assessment, is that this doesn't want to be a place where you lock the door and throw away the key. We have a lady who stayed with us for a year and a half, and then she decided that it was no longer for her. She took a flat nearby, she comes to have parties with her friends here. (Educator, FGp)

The educator's words go to the heart of the idea that living in ISRAA's care facilities is not always for everyone, and it is not necessarily a permanent arrangement. For this reason, they are given the chance to experience the project and ascertain whether it suits them or not. There are several reasons why people decide to move into one of ISRAA's care facilities. As mentioned above, a minority of residents have some degree of dependency.

Other people apply when their partner passes away or when they realise that they no longer want to or can manage a home on their own:

I don't have any relatives, so I came here because I had 25 stairs to climb, I had a big house with a garden, and I wouldn't have changed it at all. It was just that, suddenly, I realised I wasn't drinking wine anymore because it was too heavy to carry up, I was throwing the sheets out of the window to wash them, I was limiting what I did because I was starting to struggle [to climb the stairs]. (Res 3, FGr)

In this regard, the ISRAA professionals are keen to point out the importance of older adults' autonomy, understood not only in the physical sense but also in terms of decision-making. According to one respondent, "the institution is not the panacea for all ills; it's an institution made up of people, where there may be errors; but there are not only requests to solve problems, we also sit down together and solve them" (psychologist, FGp). The involvement of the subject in decision-making and the expectation that the person is willing to cooperate is therefore the basis of this new experience of life.

3.2. Key Elements of the ISRAA Senior Community Caring Model

Giving a voice to older adults and caring for their well-being in a broad sense are key elements for the ISRAA staff, who emphasise the need to spread what they call the philosophy of care. This expression underlies the concept of what the team understands by caring: "Learning to go beyond labels, caring absolutely, with kindness, with compassion, with a genuine acknowledgement that there is suffering, because sometimes there is a lot of it, but also with the genuine willingness to alleviate it" (psychologist, FGp). The idea is to understand care from different perspectives, including above all the notions of empathy, sensitivity, proximity, and inclusion. In this framework, the person must be placed at the centre:

We are not talking about older people, but we are talking about people who are cultivating their own life projects and their own autonomy. We are there and we are part of their life project choice, but to the extent that they want to include us. (Educator, FGp)

It is crucial to bear in mind the importance of interdisciplinary collaboration and trying to understand the needs of older people in a broad sense, as they have "not only health care needs" (psychologist, FGp), but also social, emotional, or material needs. As a result, part of the professional work is to personalise the attention to and care of the person, as expressed by one of the nurses:

If I do an activity and [only] two people take part in it, but those two people like it...then the activity continues. That's how it is, at least I really feel free to make proposals....That's certainly because this is an organisation that allows us to do that. (Nurse, FGp)

Even though the residents of a care facility tend to be perceived as a group, as a community, they are individuals, each with their characteristics, habits, thoughts, and plans. This is important "because, in a nursing home, it can happen that you lose sight of the fact that everyone is a person, a unique individual" (educator, FGp). Providing several kinds of activities and giving residents the chance to choose or propose what they would like to do is another important part of the philosophy of care, as highlighted by the coordinator:

On the one hand, there are the activities proposed by ISRAA; on the other hand, the idea is to accommodate the wishes of the residents and support them, so we offered gym classes with a teacher who we paid for a couple of months and they liked her, so they started paying her directly, self-managing [the activity]. The third kind of activities are those managed in a completely autonomous way. (Coordinator, FGp)

ISRAA thus proceeds by proposing activities and carrying them out when they receive a positive response from the residents, sometimes even pushing for autonomous management (especially in the case of the cohousing), and acting as an incubator for spontaneous proposals from the older people themselves. To support encounters between residents, activities are open to both CA and BMSC residents, regardless of where they take place.

3.3. From Inside to Outside: Opening the Community to the Neighbourhood

Ideally, this philosophy would not be limited to ISRAA spaces but extended to the whole neighbourhood in which these people live, through processes of integration, interchange, and collaboration that enable older people to maintain a role and be recognised in society. In this respect, the work on the community map showed that there is already a connection between residents and the surrounding neighbourhood, as expressed in the following quotation (Res 7, FGr):

Researcher: Why do you go to this pharmacy and not the other one [which is closer]?

Res 7: Because I knew her mother and her grandfather and I get attached to people; now her daughter is there. She is also close by, logically, but yes [the reason is that] I know everyone.

It is also interesting to note that several points of reference are located within the CA and BMSC premises, such as the terrace or gardens where they like to sit and chat. A continuity between inside and outside can therefore be detected in the residents' individual geographies. In this regard, the location of the housing is of great value to residents, as it naturally facilitates contact with the neighbourhood:

[The street where we are] is the centre of all the events: cycling, marathons, carnival, market. Everything starts from here and we thank God that we are in a central place. (Res 6, FGr)

However, the relationship with the surrounding area is not limited to these locations. Some members of the care facilities' communities are involved in weekly activities with the neighbourhood shopkeepers, as explained by one of the professionals:

And that's why we're grateful to the girls in the bar opposite, who allow the lady to go and clean the tables. Because this lady is so happy to clean the tables. And then, let's say, indirectly some of us [referring to ISRAA professionals] go there for a coffee, and thank the girls or ask: "I haven't seen that lady [referring to one of the residents], how is she?" Even if this seems like a very basic thing, this is important. (Psychologist, FGp)

Interaction with the territory also involves proposals put forward by the residents themselves. For example, in the winter of 2022, a group of BMSC residents decided to make figures for the nativity scene together

with a professional painter and a craftsman. A procession through the neighbourhood was organised by one of the residents:

My intention is to start at CA [with the 14 nativity scene figures] with people who want to come, including those in wheelchairs. Then we'll go to the garden where the nativity scene is set up. (Res 3, Int)

The garden she talks about belongs to one of the cohousing buildings and is open to the public.

By encouraging an open, dynamic community that is integrated with the surrounding neighbourhood, the ISRAA staff are aiming to break down stereotypes of care facilities as bleak places of suffering and isolation. The intent behind this approach is therefore to build a caring community encompassing the CA, the BMSC, and progressively, the surrounding neighbourhood.

4. Residents' Experience

4.1. Basis of a Community

Any discussion of caring communities must be based on an understanding and interrogation of the concept of community in relation to the nursing home and cohousing.

According to the nursing home residents, the daily sharing of activities and routines is what makes them feel part of a community the most. As one resident puts it: "You eat together every day. You're together every day" (Res 10, Int). But this does not mean that residents have to associate with everyone. In fact, the formation of subgroups in a community and an unwillingness to accept new members seem totally normal, especially when it could be interpreted as a "forced" community since people have not chosen to live with each other, as in the case of our study:

Afterwards, you choose them [the people], we are a little group. We chat and play cards. There was this lady who wanted to join our group, with the three of us, and some of us didn't like her so much. I said "let's try," and she is so much fun. (Res 10, Int)

Socialising is, therefore, another fundamental element of a community; in this regard, some people chose to live in the nursing home because they knew they would be able to establish relationships there, as one resident pointed out: "I came here to feel good, to meet people, to do cultural things, to socialise" (Res 6, GFr). There are others who do not necessarily need continuous interaction: "I don't want any obligations either way. In a nutshell, as many pleasures as you like but nobody too clingy" (Res 9, Int). In spite of this, the residents recognise the institution's efforts to encourage a community through numerous proposals: "There are courses, shows, birthday parties I take part in....It's a community" (Res 9, Int). Some cohousing residents were also positive about how stimulating they found the place, as manifested in the following quote: "There is life. Me, coming from a place where there's nothing, here I've got a new life because I like people, I like to talk" (Res 2, GFr). A similar sentiment was shared by another resident: "Here I have more life because they involve you and I let myself be involved. Everything they do interests me and I go see it" (Res 4, Int).

In sum, the numerous organised activities, the chance to socialise, and the everyday life in a care facility (in the case of CA) may be considered key elements for developing a community.

4.2. *Barriers to Creating a Community*

It is important to note that we found discrepancies between the CA and BMSC residents, starting with differences in the types of users:

People in the cohousing were not people who had thought about moving into a nursing home, or who had to make a choice that conflicted with the stereotypes held by their family and friends. With them, we began a project to explore slightly different methodologies related to community development, and we started from the question of desires and commonalities. (Coordinator, FGp)

Thus, the idea of community is experienced and perceived differently in the two living contexts. The sense of community within the nursing home seems to be more evident and deep-rooted, as these people live within the same context, have room neighbours, have meals together, and carry out activities on the premises. Community, therefore, comes out of everyday practices. In this regard, the CA staff provide the conditions for the residents to create ties, some closer than others, both with the other residents and with the professionals, although this inclination to create bonds also depends on their health status and their personality, as one of the employees pointed out: “In general, people with a higher level of autonomy and prosociality manage to establish more positive relationships with other residents” (community manager, Qp).

The cohousing inhabitants, on the other hand, were less enthusiastic about relationships in the facility, complaining that many people are not interested in participating in community activities, as reflected in the following quote: “There are people who don’t participate and don’t even look out of the windows” (Res 4, Int). They also point out the lack of frequent relations: “Regarding the kind of relationships we have, I would say they are very good, because when you get along it is good, but you don’t really hang out that much” (Res 1, Int). And, finally, some expressed disappointment:

For me, cohousing is small blocks where we try to live together to perhaps recreate the relationship we had elsewhere, for example, like the one I had where I lived before for forty-four years, that is difficult to replicate. (Res 3, FGr)

In June we went for a week at the seaside...there were eight of us. We left in two cars, we were happy, so much so that after coming home I was sorry because [there] you were eating together, then you sat outside for a while, then someone went for a rest, then you were on the beach in the evening...But in short, when you’re here, you’re alone (Res 5, FGr).

The data we collected show that some people did not find the community they were looking for in this model. They may have met new people to spend time with and do activities together, but they do not feel like a community in the place where they live. Other people are content to live in a place that offers certain services and care, but basically continue to have the same life they had before; in other words, they may not be interested in being part of a community, or may not have the time to devote to community building, as one of the residents commented: “We struggle because those who have the head for it [referring to community building] have so many commitments” (Res 5, Int).

In addition to the complaints related to the differences in residents' needs, some residents noted how the spread of Covid-19 had slowed down the community-building process initially envisaged by ISRAA. This is not only due to the forced isolation, but also because the people who initially moved to the cohousing were severely affected by the side effects of the pandemic, as highlighted by the following quotes:

Covid was big trouble for everyone, but especially for an old person. It stole two years of our lives. (Res 1, Int)

In these two years we haven't aged two years, we've aged five years. (Res 5, Int).

In other words, two years for an old person is not the same as two years for younger generations, and the impact of the pandemic was harder for them.

Moreover, one aspect that should not be underestimated, which was mentioned several times, is the lack of a place where all the cohousing and, potentially, nursing home residents could meet together. Some of the houses have taken the initiative to create their own micro-community, which the layout of the buildings and the shared garden allow for; this encourages contact between residents: "On Thursdays they play bingo in the other block, maybe because there are eight of them, which is quite a lot" (Res 5, Int). However, other housing blocks, also part of the cohousing, are more isolated: "There is no meeting point, no place, not even three benches arranged [next to each other]" (Res 3, GFr). This situation is currently being addressed as part of the renovation of a new section mentioned above, with three common spaces for the residents of all the housing blocks.

Lastly, both CA and BMSC residents would like to have more direct contact with the institution in order to express their needs: "What is missing is a person who can step in to see how it works, and what is needed" (Res 10, Int). Or they would like to be more involved in community building:

For me it is not a community, not because [the buildings] are separated, but because they are not managed to be a community....For example, they could use the talents of [Res 4, who is an artist], they could even ask me [to help them in the management of some activities]. (Res 3, Int)

What emerged is the need to be listened to by ISRAA or to be able to participate directly in the construction of the care model.

5. Discussion

The study describes and analyses the senior community care model ISRAA implements in its care facilities. The model is intended to be an alternative to both the classic nursing home and the traditional bottom-up cohousing models, since it attempts to create a broader community encompassing the residential environments and, potentially, the neighbourhood community. The philosophy of care underpinning the work of ISRAA's professionals is based on the principles of self-determination and person-centred care and on a representation of the older person as a complex subject, not flattened by age or specific health conditions. This philosophy is reflected in the professionals' efforts to find solutions together with the residents. Their aim is to go beyond simply providing a service to a "user," by also proposing activities and

initiatives that can contribute to increasing their quality of life and well-being in a broader sense (regardless of the number of people involved), and by motivating them to create new networks, thereby encouraging residents to be proactive and seeing them not as users or patients, but as individual people. However, implementing processes designed to change the structural conditions of a community always requires long lead times, engagement, and efforts, as well as constant negotiation, as it involves social actors with different characteristics, needs, and expectations.

As the results of our study show, not all residents feel part of a community. The simple fact that a group of people coincide together in a certain place does not make a community; someone needs to take charge of managing and reproducing the community. In this regard, Covid-19 certainly did not help, striking at the start of the community-building process, just two years after the cohousing opened. In addition, some of the residents involved in the process of cohousing ideation from the outset and who were catalysts of community-building dynamics have left. Moreover, not all the residents are genuinely interested in playing an active role in the community. Several people are satisfied with the daily care provided by the institution and the exchanges with other residents (however frequent they may be). Others recognised that being part of a community is not the main reason why they moved into ISRAA's care facilities.

Returning to Tönnies' (1887/1979) initial binomial, what may be happening here is that a group of people who used to live in society has moved on to live in a community (or an attempt at a community), in some cases trying to replicate—with little success—what Gardner (2011) calls the “natural neighbourhood network,” and in others, continuing along the lines of their previous life based on a more individual than a communitarian model. There are also notable differences in the representation and expectations of the community between the cohousing residents and the nursing home residents. In CA the notion of community derives mainly from the practices and routines of living together and it is not put forward as a core characteristic of this housing solution. In contrast, the community dimension is a founding principle underpinning BMSC. In this regard, cohousing could, in part, be understood as a model of intervention developed to tackle social isolation and loneliness. Consequently, expectations about the community dimension and its centrality (perhaps more symbolic than practical) can differ significantly between the two contexts. This factor should also be considered when analysing the divergences in the residents' opinions.

One of the main problems that emerged is the organisation of the spaces, which is not conducive to residents doing shared activities together. Rather than a single building, the cohousing consists of several apartments that, although close to each other, are not in the same complex. Because of this layout, some people feel excluded from social life or consider that theirs is not favoured. In this regard, Keller Garganté and Ezquerro Samper (2021) highlighted the importance of informal encounters to community building, since cultivating personal relationships creates the necessary space to generate reciprocity and cement mutual support beyond formal mechanisms; this sometimes happens in the nursing home but not in the cohousing. Although the creation of new common spaces is a good starting point in this regard, the difficulty in building a community for the cohousing project may persist if these spaces are not, at least partially, self-managed by the residents with the support of the institution.

The senior community care model ISRAA is working towards could be improved by considering some key issues in terms of community development and citizen participation. The participatory process should always be contextualised and understood at different levels following the desires and situations of the

people involved. For some of the residents who participated in our study, being part of a community and self-determination simply mean having the freedom to decide not only when and how to be involved in activities, but also having the choice not to actively participate in community building. In contrast, for other residents, “the sense of place and belonging is articulated through the availability and accessibility of facilities and opportunities for active living, social participation and meaningful involvement in the community” (McCall et al., 2020, p. 30). These people should be given the possibility to participate in community change. To this end, professionals should act as community development practitioners not only by encouraging and supporting the community to participate in activities but also to participate in the change by taking a cue from other collaborative housing initiatives, such as the *Solidaria Cohousing* in Ferrara (Durante, 2011), or the *Santa Clara cohousing* in Malaga, Spain (Keller Garganté & Ezquerro Samper, 2021) that, as self-managed cooperatives, take full responsibility for the management of spaces and services. Although residents often consider this aspect to be rewarding, they also find it very tiring and regard it as a job (Fernández Arrigoitia et al., 2023). In this case, the residents should not be burdened with all the community management, but they could be involved in developing and reproducing it, which would imply more direct contact with decision-making in the institution. For this reason, top-down cohousing offers a good opportunity to relieve residents of the burden of full self-management, while guarding against any regression into complete institutionalisation.

A first crucial step in this direction could be setting up a board of directors, or commission, chosen by the inhabitants themselves, which would consider the residents’ needs and proposals and could act as a mediator with the institution. This community commission would oversee what García et al. (2021) called “gaseous” care, which involves the emotional management of individuals and the group, and the reproduction of the community. Finally, a closing note concerns the broader process of building an open community by gradually including the neighbourhood. Although among the residents of BMSC and CA the relationship with the surrounding area tends to be positive and several initiatives have been launched in this regard (some arising from the residents’ own spontaneous suggestions), in practical terms this openness and integration has been only partially initiated. As a result, the idea of an extended community seems to be in its infancy and is probably still perceived as too abstract, especially by those living in CA, for whom the community is more a consequence of the living conditions rather than an expectation, as is the case for many older people living in the cohousing. Yet this model of community has now emerged as a goal, as a future development plan mainly overseen by professionals and by a small number of residents.

6. Limitations

It is important to state that the sample of older people involved in the study consisted exclusively of women. The main reason for this is the prevalence of women residents, which in turn reflects the higher life expectancy of the female population compared to the male population. This difference was to be expected, given the context and general demographic characteristics. The residents and staff also offered additional explanations for the predominance of women in the sample: firstly, men are far less inclined to get involved and take part in activities; and secondly, the professionals also attributed this lack of engagement to the poorer health or particular life conditions of the older men. Another limitation to bear in mind is the relatively small number of residents involved in both the BMSC and the CA, which obviously reflects just a partial view of the multiplicity and complexity of experiences, expectations, and opinions of the residents. A larger number of participants would undoubtedly have provided a broader and more multifaceted picture of the situation.

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Conflict of Interests

Author Adele De Stefani is an employee of ISRAA. She is employed in the unit devoted to EU projects and innovations and is not part of the team working at Borgo Mazzini Smart Cohousing and Casa Albergo. Her position in the organisation had no impact on the findings of the research but exclusively facilitated making contact with the target group during the fieldwork.

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