Social exclusion and community in an urban retirement village

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A B S T R A C T

Large purpose-built retirement complexes including continuing care options are increasingly popular ways to 'age in place' for older people in New Zealand and internationally. Promoted by their corporate owners as a lifestyle choice offering a wealth of activities and social interaction in manicured settings along with security and increasing care on site as needed, these entities offer new ways for wealthier older people to age. Applying an ethnographic approach to a case study residential complex in Auckland, New Zealand, we explore how residents experience inclusion and exclusion, and sense of community within such environments with a diversity of fit and frail residents. Data was collected from interviews, walk-about conversations, social site mapping and a selection of media material to gain an understanding of the social issues important to the residents. The twelve participants, aged between 70 and 87, were all independent residents living in the independent part of the complex, which is situated in a socio-economically wealthy suburb of Auckland. We identified that social connections were often fragile, and existing social group membership was key to shared community experiences and a sense of belonging. Residents who found themselves on the social fringes, particularly as newcomers or through health decline, were at risk of marginalisation, stigma, and social exclusion. Further, we identified how the design and layout, and tensions in the structure of the resident-management relationship potentially hinder inclusiveness and sense of community. These findings shed light on alternative experiences at odds with the commercial and populist framing of these places as age-friendly and inclusive communities promoting active lifestyles.

Introduction

Anticipation of positive social experiences is consistently noted as one of the top three reasons why older people choose to live in a purpose-built retirement complex, often ahead of access to health care and security (Biggs, Bernard, Kingston, & Nettleson, 2000; Graham & Tuffin, 2004; Petersen & Warburton, 2012). This does not necessarily mean such expectations are met. Despite the variety of social opportunities within most retirement complexes, international research indicates that residents can feel isolated and are subject to social exclusion, marginalisation and stigma, particularly for those with higher health needs (Ayalon & Green, 2013; Shippee, 2012).

In response to demographic changes and an increased demand for housing and care options in later life, large purpose-built retirement complexes including options for continuing care are becoming an increasingly popular choice, especially for wealthier people. These complexes tend to offer a combination of lifestyle for the active retiree, separate housing, and healthcare on a single site. Owned by large (multinational) corporates and managed as commercially-operated residential sites with business expectations of profit and expansion, often in a franchise-style format, retirement complexes are an alternative to charity-based, publicly-funded, or small-scale private care facilities. Yet we know very little about what it is like to live in one of these hybrid forms of housing and care (Bernard, Bartlam, Sim, & Biggs, 2007), or in what ways they enhance community life, well-being and life satisfaction (Jenkins, Pienta, & Horgas, 2002; Petersen & Warburton, 2012).

Here we report on an exploratory research project examining residents' community experiences and sense of belonging within a commercially operated housing and care retirement complex. Firstly, we discuss what community living and participation meant to independent residents through the conceptual lenses of social inclusion and social exclusion. Secondly, we consider under what circumstances a resident is likely to experience marginalisation, social isolation and/or social exclusion.

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Social exclusion

Research on the intersections of social exclusion, ageing, and health and well-being is emerging and timely (Buffel, Phillipson, & Scharf, 2013). Social exclusion has traditionally been understood to have historic roots and structural causes, related to economic, political and social disadvantage and inequality across populations (Levitas et al., 2007). More common conceptualisations tend to emphasise the social contexts of individual experiences and relational aspects of exclusion, rights to social participation in activities, and the power imbalance associated with coercive social structures and group pressure (Warburton, Ng, & Shardlow, 2013). Thus, the importance of different experiences of community living and issues of social exclusion is an emerging and timely topic of research. While the limited research to date on older people and social exclusion has tended to focus on issues of poverty, housing, and socio-political disadvantage, there is a need to include a wider range of experiences, processes and outcomes of exclusion for older people (Walsh, Scharf, & Keating, 2017). Researchers have considered the social connections to a sense of identity and belonging in a retirement village (Bernard, Liddle, Bartlam, Scharf, & Sim, 2012), older people's experiences of place and community during times of exclusion (Phillipson, 2007; Shippee, 2012), and the intersections of health decline, exclusion, and 'age-friendly' communities (Link & Phelan, 2001; McHugh & Larson-Keagy, 2005).

Although there is a growing interest in the social aspects of exclusion, the meaning of 'social exclusion' as a term is not always clear (Atkinson, 1998). While Buffel et al. (2013) argue the term lacks consensus and transferability as a concept, we suggest this level of ambiguity may offer useful opportunities to examine the different purposes and contexts that support the dynamic and multi-dimensional processes of social exclusion; in particular, in contexts that might initially be associated with privilege.

Social exclusion is an active process that impacts the well-being of older people and the equity and cohesion of ageing societies. For the purposes of this study, we adopt Walsh et al.'s (2017; 16) recent definition of old age exclusion as a.

> *'multidimensional, dynamic construct that varies in form and degree across the older adult life course. It leads to diminished access to the activities, resources and relationships, and rights and choices available to the majority of people across interconnected domains of neighbourhood and community, services, amenities and mobility, material and financial resources, social relations, cultural aspects, and civic participation.'*

Following Walsh et al. (2017) and Atkinson (1998) we thus understand the conceptual framework of social exclusion as having three key elements pertaining to older people and their sense of community. Firstly, social exclusion is a relative concept (Scharf & Keating, 2012). This offers a reference point to identify the extent to which some older people might have unsatisfactory experiences of participation and belonging relative to others. Second, exclusion implies an act, with an agent or agents, and therefore involves agency (Atkinson, 1998). Exclusion then, is where one may be excluded by others, or may exclude oneself. Examining agency illuminates the power relations that underpin the process and context of exclusion. Third, exclusion is dynamic (Atkinson, 1998), in that individuals and groups move in and out of exclusion, and different forms of exclusion across time (Walsh et al., 2017). For instance, research in retirement facilities shows that residents can move in and out of exclusion due to their levels of compliance with or deviance from social norms of acceptable behaviour (Shippee, 2012). Additionally, residents can be affected by different forms of exclusion as they experience functional and/or cognitive decline (Link & Phelan, 2001).

Research methods

Approval for this research was given from the [blinded for review]

Table 1
Select participant characteristics.

Characteristic	Participants
Age groups	
70–75	4
75–80	6
80–85	2
Marital status/living arrangement	
Partner/married	5
Widowed/living alone	5
Single/living alone	2
Gender	
Male	7
Female	5
Years spent in the complex	2.5–6

Human Participants Ethics Committee (Number 019397), and from the management of the complex. Residents who responded to invitations displayed in public areas were given detailed information and twelve people opted in. All participants were from independent living, cognitively competent, and gave written consent (see Table 1). Participants ranged in age (70–85 years), marital status (single, married and widow/er), gender, length of residence (2–6 years), level of community involvement, and health status (active to frail); observations suggest this group is similar to the broader community of the independent living portion of the complex. All participants are referred to with pseudonyms allocated by the researcher.

As an exploratory study of residents' experiences of community and their social connections in this context, it was important to employ a methodology that allowed a close-up and in-context examination of how older people's social lives are produced, assembled and maintained (Holstein & Gubrium, 2008). We therefore employed an ethnographic approach. Ethnographic writing involves the reshaping of experience through the act of telling a positioned and subjective story (Madden, 2010). This critical ethnography acknowledges the multiple voices, and the often-contradictory nature of social relations as perceived through the researchers' interpretations, analysis and textual representations (Abu-Lughod, 1991).

Traditional features of ethnography include long periods of field work (O'Reilly, 2005), however, a mini-ethnography was adopted as it is useful for studying a particular issue, and/or a particular group of people when there is a limited time frame (Leininger, 1985). We also adopted a 'step-in-step-out' field work practice, whereby the observing researcher LN spent only portions of the day 'in the field' (Madden, 2010). In this way, she was able to focus on the residents and their particular experiences of community life. Ethnographic methods included participant observation in social events, conversations/interviews with participants from IL, social site mapping, and viewing various types of marketing material.

Participant observation

The residents were aware of the research project and the participants understood that observations and notes would be used as data. LN accompanied participants in the study in a variety of social activities and social occasions such as afternoon teas, Happy Hour activities and music shows. LN also spent time sitting and observing in public places and high traffic areas, in particular, by the 'village' café, the hairdresser, the bowling green, the local store, and the sitting areas for playing cards and doing jigsaws. More quiet areas of observation were also valuable to learn about the importance of casual and impromptu social encounters, particularly at spaces such as at the letterboxes and rubbish/garbage bins. As the focus was on observing different aspects of social engagement, a sense of belonging, and community, fieldnotes were directed to these issues.

Interviews, conversations, and social site mapping

Although friendly and genuine, the character of an ethnographic conversation lies in a tension between having casual conversation and the instrumentality of talking with a purpose (Madden, 2010). Interviews tended to be semi-formal and were conducted in the residents' apartments or townhouse; they ranged from 45 to 60 min and were recorded through hand-written notes transcribed immediately afterwards. Discussions were guided by a list of topics and questions such as the motivations residents had for moving into the complex; their early experiences of finding social connections; and how they understood and experienced 'community' in this space. These conversations were also flexible to allow participants the freedom to construct and respond to topics and questions in a way that was relevant and comfortable for them. Less formal interviews were more conversational in nature, although still intentional 'talk', particularly during time together walking around the complex with participants in the places they considered to be important, or usually avoided, or where they participated socially with other residents. LN was able to take notes during and after these interviews, which were later transcribed for analysis. She also collected data collaboratively with participants as hand-sketched maps, photos, and notes, which became useful ways to understand how social experiences were contextualised and situated.

Data analysis

Thematic analysis was conducted by iteratively identifying patterns within and between data sets (Braun & Clarke, 2006). Initial codes consisted of simple descriptions of patterns of experiences within and across different data sets, which were subsequently refined into larger categories. Accounting for differences, or outliers, within the data by including opposing voices and perspectives as valuable categories was a useful way to build a rich and complex set of data. Through the iterative process of moving back and forth between different sets of data and relationships, and previous themes from the literature such as stigma, health decline and social ties, constructs and themes were refined and used to build and inform the analysis and findings.

Findings

Context

With over 750 residents the complex that is the setting for this study is one of the largest in New Zealand, and is part of a commercially owned and operated chain with numerous similar 'villages' throughout the country. These retirement complexes are typically surrounded by high fences and large security gates, and are situated on large areas with manicured landscapes. They tend to attract white New Zealanders, who have obtained higher educations and professional careers, and have the financial means to buy a lease and pay ongoing fees; in this village the only additional criteria for entry was that residents must be aged 70 and over. With a continuing care philosophy, the retirement complex offers different types of housing and care on a single site so that residents can move from independent active living through the different stages of aged care, including end of life. The complex in this study had 90 independent townhouses, eight independent living (IL) apartment blocks, one assisted living (AL) apartment block, a rest home (RH), a small hospital unit, and a small dementia unit.

Participants frequently commented that both the hospital and dementia units were full and beds were unavailable, so those in need were often relocated offsite. As a corporate, profit-oriented entity, the complex did not employ any personnel to facilitate introductions or social activities despite a heavy emphasis on social activities in their advertising (such as photos of residents happily engaged in activities like bowling, bridge, and billiards). There were also no formal channels which residents could follow in order to participate in management-

resident relations as a collective body.

Participants evidenced a strong focus on active participation and social group membership. An inability to be socially included, to be part of a group, or to participate in an active lifestyle meant residents were at risk of being marginalised, isolated and socially excluded. Our analysis identified several key related themes: (1) Motivations and expectations; (2) Building social connections through participation; (3) Social group membership and belonging; (4) health decline and social change; (5) health decline and stigma.

Motivations and expectations

When asked about the reasons why they wanted to come to this retirement complex our participants' first response was always that they moved for social reasons; typically they followed this response with comments that it also made good financial sense to receive care and housing as a package deal in place. For example, Victor said, "It's so important when you get older to keep up being social, it gets harder to make friends as you get older, being here helps". Their general expectations were firstly that they would make friends, ease loneliness, find companionship, and also that over time it would be cheaper than living in their own home with regular maintenance costs. Many participants also took pride in being able to actively assert their independence, autonomy and power over their own lives by making the decision themselves. They presented this as being in contrast to unnamed others in the complex whom they represented as not being in control of their decisions to move to the complex, or their current or future situation. They felt that such residents who were apparently 'pushed in' against their wishes, were less likely to adjust socially. Jim felt some residents "have a built-in unhappiness straight from the beginning." Pam agreed, and said, "Your social experiences depend on what drove you here."

Building social connections through participation

It has been noted that 'we don't know what newcomers think and feel about this new place in which they find themselves' (Bernard et al., 2012). Nor do we know very much about the early social process residents go through when relocating to a retirement complex, how they begin to make social connections, and what impact these have on their experiences of identity and belonging. In this study, the process appeared to be closely connected to the nature of the participants' previous friendships and new social ties. For those who already had friends living in the complex when they arrived, initial social experiences were spoken of as positive and welcoming. Victor, an active resident, enjoyed being a part of an established social group of friends he had known prior to relocating. He said it was like "an automatic entry card to a country club." However, Victor also spoke about the ease with which people could be propelled out of a social group. He summed up his views by saying "you have to put your best foot forward and talk to people" in order to meet new people and gain access to various social groups within the complex, adding, "and if you're inhibited, well, sorry, life is hard." Victor's own story, and what he has seen for other residents, reveals that his initial positive social experiences sit side by side with the underlying tension of being accepted or rejected, and reveal the effort of participation in order to keep friendships.

Other residents' transitions were not easy, as they did not have ready-made friends. Allan did not know anyone when he moved in and found it difficult to make new friends and penetrate established social groups. He explained that he had made a few individual friendly acquaintances within the first few years but he had also decided to maintain his friendships outside the complex for his social contact. Allan recognised that this was not a practical long-term solution to his problem but was at a loss to know how to increase his friendship network within the complex if others would not invite him into their group. His experiences highlight the problems some new residents had

in negotiating social space to make new friends and trying to gain access to established social groups. Consequently, one's ability to adapt to new and challenging environments became important. Allan felt, "if you can't adapt in here, well, you just won't survive."

When Pam moved in, she had one friend already living in the complex, whom she relied on to introduce her to others. Pam felt cautious about entering a new social space without introductions and spoke of the need to "look about and see who's who before you commit yourself", adding, "there are a lot of lonely people in here looking for friends…there's those just waiting to latch on to you because you're a newcomer and you're seen as fresh blood." Pam, like other residents, adapted to her environment by learning how to navigate a new and unknown social landscape by avoiding and isolating 'undesirable' people.

Social group membership and belonging

Social group identification was so strong for some that they introduced themselves in terms of their membership of a group, for instance, "I'm in the bowling group." 'Communities of interest', such as a bowling group, have been identified as a key dimension to community life in retirement facilities and can be based on a 'shared heritage' and a 'shared occupational background' (Bernard et al., 2012). There were strong communities of interest within this complex such as bridge groups, Happy Hour groups and music groups, however, such communities were also based on social hierarchy.

The group that held the highest social status were the white-collar professionals. Many of these were also a part of the first wave of residents who moved into the complex when it was new, and therefore, they tended to live near each other in the townhouses and apartment blocks on the more spacious part of the property. This group was seen as 'exclusive', and members of this group were tight-knit and socialised together. They also participated as a group in activities. One such member explained, "My bowling group *is* my social group." This made it difficult for non-members to be accepted into some activities or to even recognise that some activities were not open to everyone. Susan and her husband Michael had wanted to join the bowling group but explained that the group was "a very exclusive group that you have to be invited into". Robert, a keen billiards player, told a story of a resident who wanted to join in. He said, "He's been hanging around, trying to muscle in, hoping someone might offer to stand down so he can play, well that's not going to happen!" The newcomer was actively excluded and after several attempts he gave up. When places became available for activities such as bowling and billiards, invitations were offered to close social members rather than 'outside' residents.

Victor, an active resident and a member of the exclusive group explained, "The old boys' club is very strong here. People identify with the school they went to." Victor was a part of this group but he felt he needed to constantly work to maintain a high level of participation as he felt conscious it had been his wife's family background and high social status that had gained him entry to the group. Pam also commented that "it was very easy to be propelled out of a group" by either saying or doing the wrong thing, or through a lack of participation. Being in an exclusive group did not make the member immune to losing one's social position, or protect them from being marginalised or excluded for some reason. These findings reflect other findings that a person's higher social status can actually increase their stress, as they perceive there is more to lose if they cannot maintain their position in a privileged group (Dobbs et al., 2008).

'Communities of interest' and non-exclusive groups also include such things as tight bonds, shared leisure interests and shared meanings (Crow & Allan, 1994). Although many residents relied on their common interests as a basis to form friendships and join groups, having a shared interest did not mean automatic entry to a group. Residents also experienced communities of interest as 'groups of exclusion', where tight bonds between people meant it was difficult for newcomers or

interested individuals to be included. For instance, after Joyce and her husband moved into the complex, they tried to join in some leisure activities to get to know people and make new friends. Their attempts to participate in different activities, such as the 'social' morning tea and the Happy Hour evenings were met with repeated rejection and they were often told "this is our seat", or "you can't sit there". Excluded from participating in such social occasions they chose instead to remain in their apartment, which they felt resulted in their isolation from others.

Health decline and social change

Jim had been disappointed at not being able to get into any "social swing" after moving to the complex, acknowledging that "I cannot get social contacts going in the village as I can anywhere else", and, "it's not easy to make friends after sixty years of age". Therefore, the one friendly acquaintance he had made across the evening dining room table was an important social contact for him. Jim's friend had declined in his health and according to the continuing care model of the complex, if a resident experiences health decline and can no longer live independently, s/he relocates to a different accommodation where s/he is able to receive care, such as AL, the RH or the hospital. However, this process involves a physical and social disconnect between accommodation areas as the resident is required to move their living, socialising and eating to the new accommodation area. Consequently, Jim and his friend discovered that they were no longer allowed to share their evening meal together in the dining room. This separation caused considerable disappointment and anger for both residents, and Jim said, "If a man can't end his days with his mates it's a sorry thing." Jim's friend continued to try and sit in his usual seat but was told off several times by staff, and then, "he just stopped coming and I haven't seen him since".

Aside from relocation, residents found it hard to keep friends due to health issues of cognitive decline and death. Victor was very sorry to lose a close friend two doors along from him when his friend developed cognitive decline and was no longer able to enjoy their friendship. Evelyn, an IL resident but restricted to a wheelchair, explained that a close neighbour and friend broke her hip and was relocated to the hospital care facility. Evelyn had not been able to see her friend before she moved due to her lack of mobility, and her friend had subsequently died. Evelyn said, "I never got to say goodbye."

Health decline and stigma

In addition to being tricky to navigate for newcomers, social occasions were difficult for residents who started showing signs of cognitive decline, which impacted their ability to participate in conversation and was a prerequisite to group membership, and also for those with physical limitations requiring the use of mobility walkers or wheelchairs. LN observed that the seating for Happy Hour was in part set out by staff, but then rearranged by residents prior to the occasion. The physical and spatial layout of the chairs and tables in the room facilitated small group conversations but not general participation. Residents strategically set out tables with the exact number of chairs for the members of their social group, and lounge chairs were set facing each other, which made it difficult for those on the social margins or those with cognitive and physical limitations to join in. Allan said, "It's all cliques and gangs!", and Evelyn agreed, saying "I ended up sitting on my own. I swore I'd never go again."

Stigma is described as the "assignment of negative worth on the basis of devalued group or individual characteristics", and these "contribute to negative evaluations that may become the core of the personal identity" (Dobbs et al., 2008, p. 517). Although some residents were caring and neighbourly to those experiencing health decline, stigmatising labels and responses to illness were common practice. For example, a frequent topic of conversation among the independent residents was the dissatisfaction many of them felt living with residents

who were struggling with their independence. Pam said, "people don't want to socialise with frail people". Susan also felt it was difficult as "those people come and sit with you, when you don't want them to". Victor said that his 'street' in the complex was known as "Happy Street" because there was a number of residents with dementia. Pam blamed the "problem" on management and felt it was more important to them to sell independent apartments regardless of who they sell to. Pam added, "I didn't move in here to be a geriatric nurse. People have moved in because they bought a lifestyle and they want to enjoy it", implying that people in cognitive decline interfered with residents' positive, active lifestyles, and their pleasant group conversations (Shippee, 2012). The ability to participate in conversation was very important to group participation and an entry card to group membership. Without it, residents struggled to maintain their position in a social group.

One of the major challenges for residents in the early stages of transition from IL to AL is managing their physical and social decline without becoming isolated. This puts a large degree of individual responsibility on the resident to 'manage' their own decline, which seems counterintuitive, as individual responsibility is undermined by the very health concerns that created the need for the management in the first place. However, Susan, like other IL residents, explained that "the onus is on the person to go out and get it – help does not come to you". Residents living in independent accommodation were expected to be independent, even as they declined. Health support services, such as personal care, housekeeping or medication support, were only available to purchase when residents relocated to AL. It was problematic when one spouse was independent and wanted to remain living with other independent residents, yet their husband/wife needed to be receiving care in the assisted living apartments. Aside from being socially and physically separated from friends, this would mean purchasing an additional apartment. Unprepared for the high costs of two apartments and additional fees, this option was prohibitive to most residents. Therefore, those with declining health remained as long as possible within the IL accommodation, where the gap in care often fell to caring neighbours. Many participants felt the marketing of 'independent living' as 'continuing care' was misleading because they expected those independent residents in decline to receive care. Jim said, "If the sales management made this clear, people wouldn't want to come." He added, "It goes back to the core business of the owners. First and foremost, this is about real estate, second, it's about care. But the care is the thing they hang it on." Property owners pitch their marketing at having "older people's life as central", however, this is in conflict to "their core interest", as "property development" (Petersen & Warburton, 2012, p. 73). These experiences illuminate the problems older people have, such as isolation, exclusion and stigma, when they lose their independence, and it also raises questions about the responsibility of a commercially operated retirement complex in providing health care for residents as they decline.

Discussion

The retirement complex industry markets itself as providing ready-made communities for residents who want a socially engaging, inclusive lifestyle. This study shows, however, that the social life in this very typical complex did not live up to expectations for many residents; rather, they experienced the relative, active and dynamic elements of exclusion (Walsh et al., 2017). In the absence of one overarching shared community, or of formal social facilitation funded by management, achieving membership in a social group assumed primacy for enabling social engagement and healthy ageing, upheld by on-going participation. Yet access to some groups was by invitation only and based on shared social characteristics and a shared social network, and even when gained, membership was not necessarily secure. Social groups were also hierarchical, and behaved as exclusive groups (e.g., old boys' networks) and groups of exclusion. These groups had tight social boundaries that kept unwanted individuals, such as those on the social

margins, and those in physical or cognitive decline, out. Conversely, these boundaries can keep existing members in, making it difficult for members to reach out and make new friends (Ayalon & Green, 2013).

While such characteristics have been reflected in gerontology literature, where social groups have been identified by homogeneity (Shippee, 2012), shared interests, shared ethnicity (Bernard et al., 2012), and a collective identity (McHugh & Larson-Keagy, 2005), novel findings in our study reveal that although such characteristics helped to form social ties, they did not give a resident automatic entry to a social group. Rather, some residents experienced relative exclusion based on their social identification and their group membership while navigating a complex process of social divisions and hierarchies.

Despite the marketing of social opportunities for residents, retirement complex communities are not always harmonious (Evans, 2009). Exposure to social opportunities did not guarantee close relationships or inclusion for participants, some of whom experienced active exclusion by others, whilst others chose to exclude themselves in response to their discomfort with early efforts to engage. This reflects the literature in that retirement complex communities are not always socially inclusive, particularly for residents who struggle with health decline and 'active' participation (e.g. McHugh & Larson-Keagy, 2005; Shippee, 2012). This study highlights that residents' experiences of community life were often fraught with underlying tensions in trying to make and keep new friends. Accounts of early and ongoing experiences of social inclusion and exclusion highlight the risk of loneliness and marginalisation, as making friendships required active social skills and social capital, as well as the ability to adapt to the dynamic shifts in social alliances. Our findings suggest that the strength of a social connection correlated to the strength of a resident's sense of belonging to places and social spaces through their participation. This suggests that a sense of belonging was located in a person's social biography. Residents experiencing functional and/or cognitive decline found it much harder to form social alliances and participate in social groups, and consequently had a limited or non-existent community experience. Therefore, these residents did not feel a strong sense of belonging. These findings related to residents in health decline reflect similar findings reported for assisted living residents (Perkins, Ball, Whittington, & Hollingsworth, 2012; Yamasaki & Shari, 2011).

The study also revealed several residents experienced grieving and loss of their friendships and daily routines because of the stigma associated with ill health, health decline and/or being on the social margins. Stigma was also attached to the spatial separation of residents as they shifted from IL to AL accommodation due to health decline. These social and physical separations were reinforced (and enforced) through the structural norms and care practices of the complex, thereby shaping attitudes to ageing as active, or in decline. Although many examples of stigma and exclusion may look small, collectively they can establish social norms and boundaries that support, and influence, people's perceptions and experiences of ageing. A resident's capacity to manage their ageing experience would be enhanced with appropriate and timely support from management, such as resources to support social interaction and facilitate integration.

Conclusion

As a place where residents experience their old age the retirement complex affects their understanding about themselves, others they age with, and the meanings they attach to the environment they live in. While commercial retirement complexes purport to promote an environment that fosters social engagement, the residents' social life and community experiences in the complex were varied and affected by a range of social and environmental factors. Findings show that residents accessed community by participating in social groups which provided meaningful social interaction, friendship, and company for many residents, though not all. Social exclusion was identified as multidimensional and dynamic in its different forms and contexts at an

individual, community and structural level. Although there were positive social experiences, these findings shed light on alternative experiences, which were influenced by the challenges of health decline and social exclusion within an environment that promotes active ageing and participation. This study highlights the multiple views and constructions of place and social space experienced by older people living within specialised living environments. Further studies that focus on older people and their living environments, and ways to encourage stronger communities and social well-being, would be timely.

Declarations of interest

None.

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