CAROLYN TODD BA Hons MSc

EXPLORING THE ROLE OF MUSEUMS FOR SOCIALLY ISOLATED OLDER PEOPLE

Section A: A literature review: The impact of social prescribing interventions on wellbeing, loneliness and social isolation in older adults
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Summary of the MRP

Section A

This section reviewed the empirical literature on social prescribing schemes that targeted wellbeing, social isolation and loneliness in older people. A total of 24 studies were identified and reviewed, including qualitative, quantitative and randomised controlled trials. The studies utilised different types of social prescribing schemes and activities: computer interventions, horticulture, exercise, arts and culture, male only, and mixed activities. Many of the studies showed improvements to participants' wellbeing or loneliness, however, none looked at how this occurred. The methodology of the studies reviewed was critically evaluated along with a discussion of clinical and research implications, highlighting the scope for future research to further explore how and why programmes might be beneficial.

Section B

This section used a grounded theory approach to understand how a museum programme, designed to support socially isolated older people, created opportunities to enhance wellbeing and change experiences of social isolation. Participants took part in 10-week museum-on-prescription programmes that were being run in six different museums across London and Kent. A theoretical model was developed showing elements of museum programmes, such as the role of the facilitator, activities and physical space, which enabled both individual journeys and relational processes. In addition, individual journeys and relational processes influenced each other, enhancing the experience. These components operated within an interacting social context that was enriched by the museum programme. The model is linked with psychological concepts of attachment theory and self-esteem to explain how programmes could provide opportunities for change in older people. Limitations of the research, implications for clinical practice and recommendations for future research are discussed.

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Section A

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Abstract

With an ageing population coupled with decreasing health and social care budgets, developing interventions to address health, wellbeing and social isolation in older people has become increasingly vital. Social prescribing schemes provide opportunities to bring community and cultural organisations together with people who might need help or support. A review of the literature was carried out to examine social prescribing schemes that targeted wellbeing, social isolation and loneliness in populations of older people. A total of 24 studies were identified and reviewed, including qualitative, quantitative and randomised controlled trials. The studies utilised different types of social prescribing schemes and activities: computer interventions, horticulture, exercise, arts and culture, male only, and mixed activities.

Many of the studies showed improvements to participants' wellbeing or loneliness, however, none looked at how this occurred. Therefore, an understanding of what elements were helpful was limited. Knowing more about why programmes were helpful would enhance our understanding of what makes it more or less likely that people will take part and experience change. The methodology of the studies reviewed is critically evaluated along with a discussion of clinical and research implications, highlighting the scope for future research to further explore how and why programmes might be beneficial.

Keywords: social prescribing; wellbeing; social isolation

Introduction

The link between psychological wellbeing and physical and mental health is well researched and documented (e.g. Department of Health [DOH], 2014a, 2014b). With an increasingly ageing society, the research and planning of interventions that improve the wellbeing of an ageing population, is an area that is of growing importance. Following a World Health Organisation (WHO) report (Commission on Social Determinants of Health, 2008) highlighting huge inequalities across the world, the Marmot report (2010) acknowledges the role that power, money and resources have in shaping health and wellbeing. It also considers the relationship between community capital, social capital, lifelong learning and wellbeing, with physical and mental health.

Defining wellbeing

Aristotle believed that wellbeing was the goal of all human activity (Dodge, Daly, Huyton & Sanders, 2012) and is a view that still influences our thinking today. A review by the New Economics Foundation (NEF) Centre for Wellbeing (Aked, Marks, Cordon & Thompson, 2008) found that incorporating the following actions into our daily lives is important for wellbeing: connect; be active; take notice; keep learning; give (NHS Choices, 2014). In addition, Marmot (2010) states that "well-being should be a more important societal goal than simply more economic growth" (p. 12). However, perhaps one of the hardest tasks is defining what constitutes wellbeing. In their report, Five Ways to Wellbeing, NEF proposed that:

> the concept of well-being comprises two main elements: feeling good and functioning well. Feelings of happiness, contentment, enjoyment, curiosity and engagement are characteristic of someone who has a positive experience of their life. Equally important for well-being is our functioning in the world. Experiencing positive

> relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing (Aked et al., 2008, p. 2).

Some theorists have proposed a distinction between two types of wellbeing: hedonic and eudaimonic. Hedonism refers to the seeking of pleasure and happiness (Dodge et al., 2012) whereas eudaimonism is about realising our potential and gaining pleasure from living a good life (Koppend & Vitters, 2008). This distinction is also considered by NEF, who proposed that any interventions to improve wellbeing need to account for hedonistic needs. Ryff (1989) suggests six key elements are necessary for eudaimonic wellbeing and quality of life: autonomy, environmental mastery, positive relationships, purpose in life, realisation of potential and self acceptance (Dodge et al., 2012). The Foresight Report (The Government Office for Science, 2008) contributes further by suggesting that both mental capital and mental wellbeing are crucial throughout our lives for our behaviour, prosperity, social cohesion and inclusion. Mental capital is said to include a person's cognitive and emotional resources, how flexible and efficient they are at learning, social skills and resilience. Similarly, mental wellbeing is a state where one can develop their potential, be productive, build strong and positive relationships and contribute to their community. The NEF proposes a model showing how actions can operate to influence wellbeing (figure 1). These actions work to make a person feel good and enhance their mental capital. The research also suggests that simply experiencing positive emotions can change how we think and behave, increase optimism and resilience, which in turn leads to increased feelings of self-esteem and life satisfaction (Aked et al., 2008). However, what is not so clear here is the role of society, communities and social networks in enabling these actions to happen in an equitable and accessible way.

All theories propose that the actions we take and the way we think, have an impact on our wellbeing. However, this cannot be taken out of the social contexts in which we live. In

later life, it has been suggested that having a role or purpose, having good social networks, enjoying adequate financial security, and living in a supportive neighbourhood, are all important to wellbeing (Nicholls, 2006).

Figure 1

NEF model describing how actions can operate to enhance wellbeing

Wellbeing in later life

For people over 65, there are a plethora of potential changes and challenges. A study by Davidson and Rossall (2015) for Age UK found that the three main worries for older people were physical pain, memory loss and loneliness. In contrast, the DOH proposes that wellbeing is higher in later life, particularly in terms of feeling worthwhile and happy. However, this declines as we age further, especially after the age of 80. Age UK (2011) and the Mental Health Foundation (Nicholls, 2006) suggested that a sense of purpose, social networks, income and neighbourhood all lead to good mental health. Similarly, a study

exploring successful ageing by Phelan, Anderson, LaCroix and Larson (2004) identified four important constructs: physical, functional, psychological and social. They surveyed over 4000 older adults asking them about their thoughts on ageing and successful ageing and whether these had changed over the previous 20 years. They found that 90% had thought about successful ageing, 60% said their thoughts had changed and these four constructs were the most important. Phelan et al. suggest that in contrast, existing literature on ageing does not describe these dimensions.

The link between wellbeing and physical health is of particular interest to the DOH and is an important consideration to policy makers and those planning and implementing health services. People are more likely to rate their physical health as poor, if they have lower wellbeing (DOH, 2014c). Various studies have shown that behaviours that are detrimental to physical health such as poor sleep, smoking, drinking, poor diet and being sedentary are all linked to poor wellbeing (DOH, 2014c). In addition, mortality rates in over 75s range from 19% for those with high wellbeing to 30% in those with lower wellbeing (Davidson & Rossall, 2015; DOH, 2014c). Moreover, Marmot (2010) suggests that having services that attend to the promotion of health and wellbeing in older people will delay or prevent institutional care.

Defining loneliness and social isolation

Policies and documents that consider wellbeing also discuss loneliness, social isolation and social connectedness (e.g. HM Government, 2007). The experience of loneliness has been described as a threat to human survival, as a social species that relies on relationships with others to survive (Cacioppo & Patrick, 2008). This has been suggested as a possible explanation for why chronic loneliness is so damaging to health and wellbeing (Davidson & Rossall, 2015).

The terms loneliness and isolation are often used interchangeably and assumed to be synonymous. Age UK, however, suggest that they are separate issues. In a review of evidence for loneliness and isolation in older people, Age UK (2015) suggested that loneliness and isolation are different, with loneliness being a subjective concept that can be influenced by more than physical isolation or lack of social contacts. For example, not having a useful role in society, loss of status, or struggles with changing identity, can all impact the feeling of psychological loneliness. Social isolation, however, refers to a lack of contact with people or services (Davidson & Rossall, 2015). That said, it is postulated that one of the ways to combat loneliness is to address isolation, suggesting an intrinsic link. Another area of demarcation is between factors that trigger loneliness (such as change in circumstance) and dispositional factors such as shyness (Pinquart & Sorensen, 2001).

Marmot (2010) considered social isolation and suggested a need to "create and develop healthy and sustainable places and communities" (p. 24) with a priority objective being to "improve community capital and reduce social isolation across the social gradient" (p. 24). Five Ways to Wellbeing (Aked et al., 2008) also claimed that by strengthening and broadening social networks, increases in wellbeing follow. In a paper by Berkman, Glass, Brissette and Seeman (2000), a conceptual framework is proposed of how social networks impact health, drawing on Emile Durkheim's work on social integration and John Bowlby's attachment theory. They proposed that social network structures function to influence social and interpersonal behaviour through the provision of "social support; social influence; social engagement and attachment; and access to resources and material goods" (p. 843). Importantly, these factors affect health and wellbeing. For example, connectedness to social networks impacts smoking, alcohol consumption and activity levels (Berkman et al., 2000) and this can be further influenced by psychological factors such as confidence and self-efficacy.

Social isolation and loneliness in later life

Older people can face multiple life events and adjustments such as retirement, changes to residence and health, bereavement, financial challenges, and a loss of previous roles and identity, all of which can impact social isolation and loneliness. However, research also suggests that such transitions can provide opportunity for new social relationships, and that by creating new social relationships, health can be improved, even when social losses are controlled for (Cornwell & Laumann, 2015). A study by Yen, Shim, Martinez and Barker (2012) looked at whether activities and location would help older people feel engaged and socially connected. They found that mobility, activity and social relationships were important to the participants and that particular places helped social exchanges develop.

Why are wellbeing, loneliness and social isolation important in older people?

With ageing populations across the world, predicted increases in the number of over 65s, increasing life expectancy and improving health outcomes, the concept of living well for longer is vital to citizens, governments, policy makers and service providers. The Government Office for Science (2008) published a report called Mental Capital and Wellbeing: Making the most of ourselves in the 21st century. Looking at challenges and opportunities for our mental capital, health and wellbeing over the next 20 years. The report claims that:

> Life expectancy is projected to grow over the next few decades: by 2071 the number of adults over 65 could double to nearly 21.3 million, and those over 80 could more than treble to 9.5 million. Over the same period, our concept of what constitutes "old age" will change, and notions of "career" and "retirement" will shift in response to longer working lives. The number of older people will also increase as a proportion of the working population, thereby creating possible tensions within society. (p. 11).

Two major challenges were identified: firstly, ensuring older people maintain independence and wellbeing and therefore optimum mental capital, and secondly, addressing the negative stereotyping of older age and consequential under-utilisation of their resources. By improving inclusivity it is claimed that we can buffer against poor wellbeing, poor mental health and social exclusion.

The DOH (2014a) suggested that although variable, the effect of wellbeing on health is substantial compared with more traditional areas of public health targets such as diet. Policy makers, service providers and the third sector need to consider how to develop and integrate services to meet the psychological and social needs of older people. Decreased social isolation and increased wellbeing can lead to improved physical and mental health, which in turn may reduce care needs and provide social benefits. Loneliness can significantly affect older people's wellbeing, with 89% of older people who do not consider themselves to be lonely having high levels of life satisfaction (DOH, 2014c). By understanding what helps people live well in later life, services may be able to adapt and enhance their interventions.

Conceptual issues in researching older people's wellbeing, loneliness and social isolation

Theories that aim to explain these complicated concepts and relationships, are multifaceted. There is not a single theory (or even a reasonably small number) that can helpfully and fully explain the interactions and factors at play. The term wellbeing is used in a variety of contexts, with different theories and definitions being adopted. This is also the case for social isolation and loneliness. Despite researchers and experts defining these as separate issues, the extent to which this demarcation is used by those implementing policies and interventions is less obvious. There is then a danger that interventions are tackling different issues from the ones they were commissioned to address and the original issue is therefore neglected.

Wellbeing research also has difficulty differentiating cause and effect (Aked et al., 2008). For example, are people happier because they experience good psychological wellbeing or do people have good wellbeing because they are happier. Social isolation and loneliness research has similar difficulties; social networks may be sought by those who are happier and have good wellbeing, and hence the effect that social networks have on wellbeing is not clear.

Social prescribing and community referral schemes

Social prescribing (sometimes referred to as community referral schemes) has been described by the CentreForum Mental Health Commission as "a mechanism for linking patients with non-medical sources of support within the community" (2014, p. 6). It has arisen in the context of a changing social care landscape aimed at de-centralising power and giving local authorities more choice over budgets and responsibility (Thomson, Camic & Chatterjee, 2015). Social prescribing can address health, wellbeing, social isolation and loneliness with schemes that are accessible, available and easy to set up. A 2015 review of community referral schemes by Thomson et al. (2015) explored the landscape of social prescribing to date (figure 2). They aimed to provide some context in which social prescribing has evolved and look at the efficacy of different schemes available. The review provides examples of schemes around the UK and how they have been evaluated and researched to date. They conclude with recommendations for future schemes, including the need for further evaluation and formal assessment. The current review aimed to build on the work of Thomson et al. (2015) by pulling together and reviewing schemes specifically aimed at addressing wellbeing, social isolation or loneliness in populations of older people. This was also widened out to include schemes in other countries to incorporate activities and programmes not currently seen in UK schemes, thereby increasing the knowledge base further. Marmot (2010) also clearly stated that the DOH and the NHS alone will not reduce

health inequalities, therefore empowering and enabling communities to play a role is vital for public health and health interventions in the future.

The potential benefits are far reaching across communities in outcomes to health, social isolation, loneliness, education, confidence, self-esteem and wellbeing. However, the question of what is helpful or how they are helpful, is less clear.

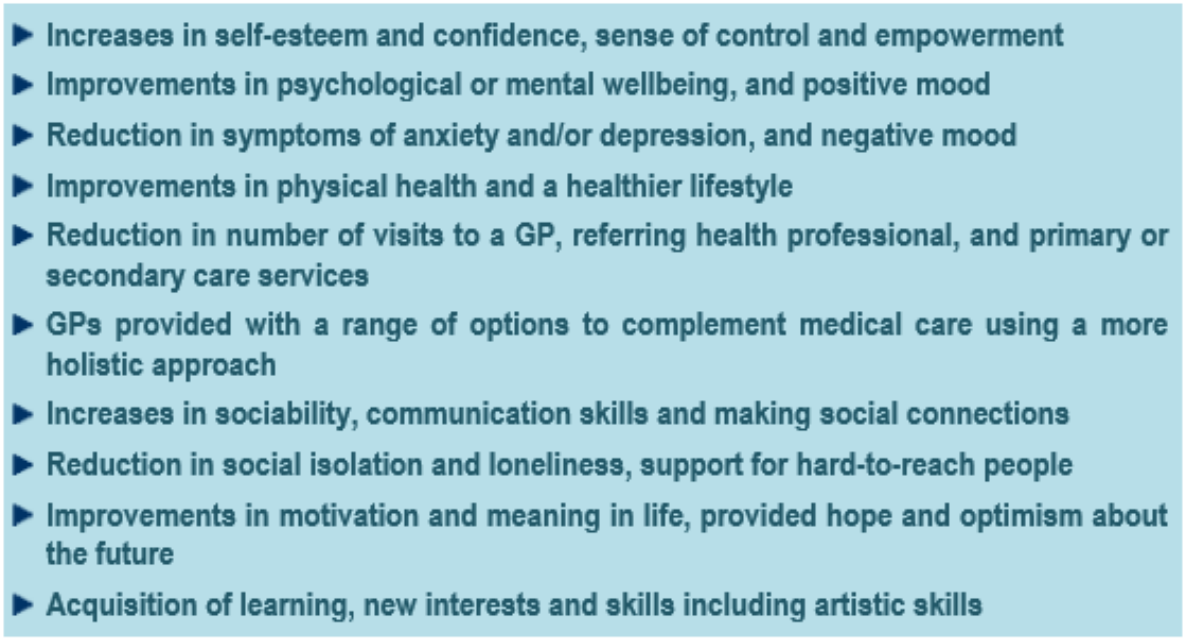

Figure 2

Key findings from a review of evidence published in the Social Prescribing Review (Thomson et al., 2015).

Aim of the Review

This review critically examined studies of social prescribing schemes that targeted wellbeing, social isolation or loneliness in older people. Specifically the review aimed to ascertain whether social prescribing schemes currently being utilised improve wellbeing, social isolation and loneliness in older adults over the age of 65. In addition, by reviewing the quality of the current research the aim was to identify any gaps in knowledge and understanding of what is helpful (or not helpful). The field is complex and fluid, in part due

to the interplay between individuals, society and communities along with a changing political, health and social care landscape. Therefore, the more we know about what is helpful, the more we can create robust and relevant schemes that benefit older people at risk of social isolation.

Methodology

Three electronic databases, Psychinfo, Web of Science and PubMed, were systematically searched. The search terms used were:

- Social Or community OR art* OR museum OR heritage OR culture* OR books OR exercise
- Prescri* OR refer* OR intervention* OR program*
- Wellbeing OR well-being
- Social* isolate* OR lonel*
- Old* OR elder* OR oap OR pension* OR senior*

No date limit was applied as research in the field is relatively recent with none found before 2000. The search process and results are shown in figure 1 (Moher, Liberati, Tetzlaff & Altman, 2009). In addition, Table 1 shows inclusion and exclusion criteria used to select studies for review. Studies have been included if some participants were under the age of 60 however the majority were over 60. Similarly, a service evaluation was included due to meeting criteria of high quality and therefore adding to our knowledge and understanding.

Table 1

Summary of Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Published in peer reviewed journal	Participants had a dementia diagnosis
Written in English	Dissertation abstracts
Any date	Service evaluations (except where high quality)
Any Country	
Quantitative, qualitative, mixed methods or randomised controlled trials	Not a social prescribing or community referral scheme
Older people were the target population (and formed the majority of the pool)	Not including participants over 65
Outcomes being studied were wellbeing, social isolation or loneliness	No outcomes reported
	Not measuring wellbeing, social isolation or loneliness

To guide the review, and the critique of methodological quality of the selected studies, the Critical Appraisal Skills Programme (CASP) tools were used (Appendix A) for Randomised Controlled Trials (RCT) (CASP, 2013a) (Table 1), Qualitative (CASP, 2013b) (Table 2) and Quantitative (CASP, 2013c) (Table 3) studies, and in combination for mixed-methods designs. These tools ask questions about the applicability of the design, methods, recruitment, analysis, and significance of the findings.

Table 2

CASP Qualitative Research Checklist (2013b)

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

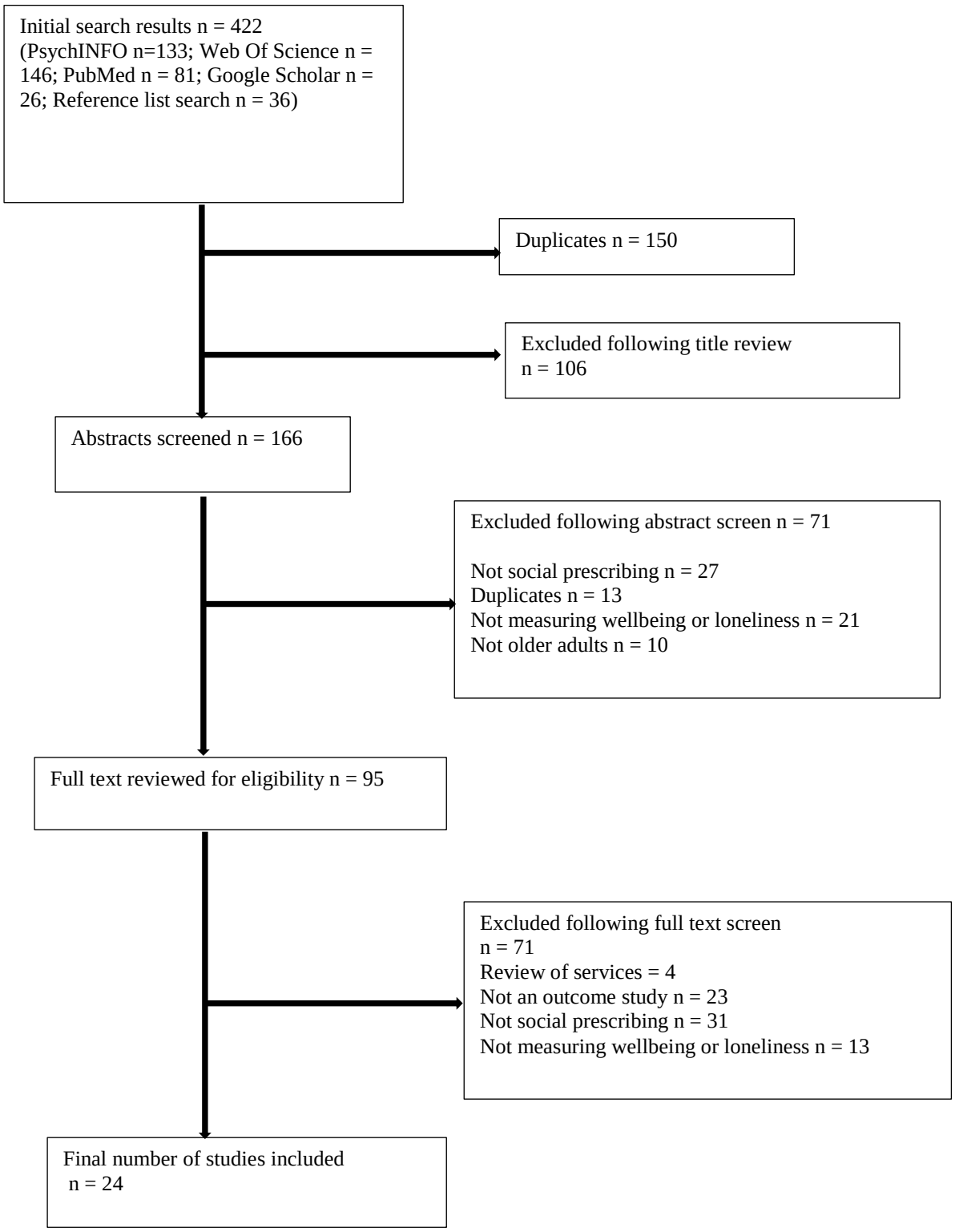

Figure 3
Literature search process to identify papers to be reviewed

Table 3

CASP Cohort Study Checklist (2013c)

1. Did the study address a clearly focused issue?
2. Was the cohort recruited in an acceptable way?
3. Was the exposure accurately measured to minimise bias?
4. Was the outcome accurately measured to minimise bias?
5. Have the authors identified all important confounding factors? Have they taken account of the confounding factors in the design and/or analysis?
6. Was the follow up of subjects complete enough? Was the follow up of subjects long enough?
7. What are the results of this study?
8. How precise are the results?
9. Do you believe the results?
10. Can the results be applied to the local population?
11. Do the results of this study fit with other available evidence?
12. What are the implications of this study for practice?

Table 4

CASP Randomised Controlled Trials Checklist (2013a)

1. Did the trial address a clearly focused issue?
2. Was the assignment of patients to treatments randomised?
3. Were patients, health workers and study personnel blinded?
4. Were the groups similar at the start of the trial?
5. Aside from the experimental intervention, were the groups treated equally?
6. Were all of the patients who entered the trial properly accounted for at its conclusion?
7. How large was the treatment effect?
8. How precise was the estimate of the treatment effect?
9. Can the results be applied in your context?
10. Were all the clinically important outcomes considered?
11. Are the benefits worth the harms and costs?

Results

A total of 24 studies were identified and are detailed in Table 4. The studies are discussed according to the type of intervention as follows: horticultural interventions, exercise programmes, computer schemes, male only activities (sheds and cooking), arts (including music and museums) and mixed activities (where participants had a choice of activities). This allowed for comparisons to be made between the types of activity and for common themes to be highlighted. It also builds a picture of how interventions have been studied thus far and what is helpful (or not) about the interventions to wellbeing, social isolation and loneliness in older people.

Table 5

Summary of studies reviewed

Authors (year)	Country	Sample	Intervention	Design	Data	Outcome	Critical Review
Batt-Rawden, K. B. & Tellnes, G. (2005)	Norway	N=46 (30 males) Aged 30-79 78% were aged between 40-69	Twelve activities that promote healthy lifestyle held at a health centre. Outdoor and cultural activities (the main target intervention) Some p's took part in more than one group	Qualitative evaluation study analysing benefits to health and WB of p's in different group activities Semi-structured interview Explorative approach	Duration, regularity of attendance and social background, subjective opinions and beliefs Patterns, tendencies and main characteristics were explored	Two-thirds reported improved health and quality of life. Enhance existing abilities was particularly helpful. Groups with a specific focus also increased self-esteem. Categories emerging:- Benefits from participating in group activities (good experience and stable relationships – something that was needed). Helped with isolation and loneliness. Humour and mutual understanding Social wellbeing and interaction very important	No follow up carried out so it's hard to know if there was any lasting change. Interview schedule not provided and no information about where the interviews were done or who conducted the interviews. No information provided about how the data was analysed and limited data was presented. No discussion about quality assurance or role of the researcher in analysis. Only one project was researched and it was unclear how these findings were linked to theories and little discussion about the relevance or implications of the research beyond this study.
Blazun, H., Saranto, K., & Rissanen, S. (2012)	Finland and Slovenia	Baseline = 58 Follow-up = 45 Aged 57-93. Mean age Finland 66.37 Mean age slovenia 77.68	3 week computer training courses. Facilitators presented aims, objectives and learning outcomes Finland – 4 hour lesson with 2 breaks Slovenia – 3 hour lesson with 1 break	2 questionnaires with 3 parts (background, quality of life, ICT experience). Mixed open and closed questions Baseline and 3 week follow up	No standardised measurement tool used Subjective indicators of QOL obtained through self-reporting	At baseline, no-one reported feeling lonely but at follow up the p's from Slovenia felt less lonely as a result of the intervention (84.6%) compared to those from Finland (40%). Ps from both countries felt safer for having a computer. Those living alone were less lonely Those in towns were less lonely after the intervention Email use and number of friends were correlated Email use and maintenance of friendships was correlated	Difficulties with comparing the 2 groups due to cultural differences, age differences and the interventions being delivered differently. Therefore the comparison was not like for like. No control group. Findings cannot be generalised or extrapolated to other populations. Participants not blinded and facilitators had an interest in seeing change. Measures were not validated and questionnaires were developed in English and then translated.

Authors (year)	Country	Sample	Intervention	Design	Data	Outcome	Critical Review
Cohen, G. (2009)	USA (New York, San Francisco, Washington)	300 (100 at each site). Aged 65+ (average age 80, range 65-103). Living independently.	Multi-site national study Weekly singing groups meeting for a duration of 2 years. Formed a large chorale at the end.	Quasi-experimental design with comparison group Looked at the influence of participatory programme on health and activity levels of older people.	Self-report questionnaires (details not provided).	This paper only discusses analysis from Washington Positive finding for the effectiveness of the intervention. Improved physical health overall. Better morale and less loneliness in intervention group Comparison group became less active whereas the intervention group's activity levels increased	Details of the measures not provided so it's ddifficult to evaluate them. Also unclear how they were administered (e.g. in person, post, after the intervention). Participants not blinded. Measures the same across both groups. No follow up. No consideration of confounding variables. Statistical analysis of results not given so it's hard to evaluate.
Cohen, G., Perlstein, S., Chapline, J., Kelly, J., Firth, K. M., & Simmens, S. (2007)	USA (New York, San Francisco, Washington)	128 in total – data at all 3 time points. 68 intervention and 60 comparison. Intervention mean age 79 and comparison mean age 79.3	Weekly group activities facilitated by the Levine School of Music Intervention group attended professionally conducted chorale group, comparison group carried on as usual. Weekly singing rehearsals for 30 weeks and 10 public concerts Follow up after 12 months Follow up after another 12 months Baseline, Year 1, Year 2	Longitudinal Quasi-experimental	Repeated measures ANOVA (1 between group factor (group)) Effect size done on health measures Baseline measures of physical and mental health taken Various standard measures for physical and mental health (diagnoses, no. of visits, medication, Phil Geriatric Centre Morale Scale, Loneliness Scale-III, Geriatric Depression Scale-Short Form. Also, inventory of activities undertaken (nature, frequency, duration)	<u>Mental health</u> Sig. main effect of time. Change in findings over time. Decreased morale over time for all (although less in intervention group – intervention group initially increased but then dropped off but comparison steadily declined) Depression – comparison group showed increased depression risk over time compared to intervention group No differences in loneliness between the 2 groups	Strength of this study is that it is longitudinal and a comparison group was used. Also, effect sizes were reported. Participants were not randomised. Ethnocentric sampling – participants were white, female and similar average age (79-80).

Golding, B., (2008)	Australia	211 aged 45+ (50% over 65) from 24 mends sheds programmes in 5 Australian states	Men and sheds involvement (no further detail given)	Focus groups, surveys and interviews Look at the ways in which the sheds impacted learning experiences and lives of men who used them	Thematic analysis	It's the learning that's important to wellbeing Engaged men that were hard to engage historically Provide friendship through activities with other men. High level of commitment, engagement and ownership Benefits seen in health and wellbeing for Ps and their networks 'Virtually all men' felt at home and made good friends and mentor others	Possible researcher bias as the aims fitted with his previous research and the author mostly references himself throughout. No comparison/control group utilised. No details given about how the data analysis was done.
Golding, B., Brown, M., Foley, A., Harvey, J., & Gleeson, L. (2007)	Australia	211 aged 45+ (50% over 65) from 24 mens sheds programmes in 5 Australian states	Examine informal skill development (learning) in men in sheds programmes already established	Qualitative interviews. On-site interview and surveys	Interview data summarised Interview schedule included in appendices	Sample sizes acceptable with a good level of accuracy 1/3 had questionnaire fatigue Overall p's rated meeting others and the social aspect as good to their health and wellbeing	Recruitment was not randomised and the researchers selected participants. Available participants were already within the shed programme which could bias results. Researcher bias not discussed – funded by the government who had an interest in the findings showing positive results.

Goulding, B., (2012)	UK	43 participants Aged 64+ (60-92) Engaged – taken from existing groups (writers, cinema, volunteers). Remained in their existing groups Non-engaged – taken from groups having lower engagement (harder to access)	Visited 3 contemporary art exhibitions in the NE England over 2 years Final visit – participants decided where to go Hoped art would prompt debate and discussion	Interviewed at baseline and then before and after each visit to the art gallery Qualitative	Semi-structured Interviews Aim to look at motivations and barriers to engagement Baseline – taken from methodologies related to defining and measuring QOL	Learning and education important factor Themes:- The social and intellectual impact of engaging with contemporary art Reasons/motivations for engaging in lifelong learning opportunities Impact of previous experience on attitude to learning Intellectual barriers and physical barriers to learning Impact on WB:- Break from usual routine and get out	No discussion of quality assurance. No information about how participants were recruited. Unclear how and where the interviews were done or whether the participants knew the aims of the research. Also no information about who did the interviews or analysed the data.
Greaves, C. J., & Farbus, L. (2006)	UK (Exeter)	Interviews:- 18 programme participants (11 female) 5 carers (3 with p present) 1 focus group – further 8 participants (all female) 4 health professionals Quant:- All 229 programme participants invited to complete questionnaires	Mentors helped Ps find meaningful activities with a focus on social interaction Individually tailored to suit p's interests Activity based interventions – visits from mentors weekly and telephone contact (diminishes as confidence grows)	Mixed methods pre and post Semi-structured interviews and focus groups Observational – questionnaire based on health and social outcomes at 3 time points (baseline, 6 months and 12 months)	Semi-structured interviews content analysis. Good quality assurance Different time points over 18 months. Looking at process and outcomes Mean outcome scores on Quantitative questionnaires: Short form 12 (wellbeing) – valid and reliable Geriatric depression scale MOS social support survey	3 out of 18 no change Remainder reported benefits in psychological, social and physical health Increased social interaction. Confidence in interaction, activities increased, and self-worth Ameliorating depressed mood and loneliness Engagement dependent on access and availability of meaningful activities Mentor support. Key to engagements Initial benefits = psychological wb and reduced depression and a delayed benefit was seen for health and social support Depression improvements maintained at 12 months	No control group used and little control over the intervention. No follow up hence not know if benefits were sustained. Ethical considerations not discussed.

Hillman, S. (2002)	Scotland	361 p's identified Pilot – N=10 (8 females) 1-1 interviews Females aged over 60 and males over 65 Final questionnaire sent to 100 ps 79 returned and 75 usable. (60 females)	Call That Singing (CTS) group over 12 months. Encouraged participation in Glasgow's Capital of Culture celebrations Mass singing group – rehearsals and shows No previous experience needed, free	Survey questionnaire Pilot interviews – over 3 weeks. Revised after every 2-3 interviews. Revised measures then sent to each participant Final questionnaire sent to 100 ps	SNAP survey software	Most go weekly (mostly men). Took part in shows 96% made friends at CTS and 57% socialised with them outside of rehearsals 49% this was their only weekly activity 100% had sung before and many had music experience Slight shift in self-confidence Emotional wb and QoL were stat sig improved 14% noted no changes Some noted improvements in physical health Many noted music skills as the main benefit 76% noted qol good before starting but this rose to 94% after joining Single ones most active in making friends outside the group More women than men socialise outside the group Positive improvement in EWB was statistically significant	Only females recruited. No control group. Generalisability limited due to small group and specific and limited intervention. Aims of the research were not clear.

Keller, H. H., Gibbs, A., Wong, S., Vanderkooy, P., & Hedley, M. (2004)	Canada	19 men. 65+ (75-85 years old). Retired	Small group of about 15 men Once a month for 8 months to cook and eat a meal Coordinated by an EAN registered dietician Group direction decided by group members Each session lasted 2 hours Worked in small groups to prepare and cook Nutritional value discussed Aims of the group were about food and nutrition but also to improve wellbeing and gain pleasure and satisfaction from doing something in a group	Interviews – 30-60 minutes carried out by research dietician	Ps experiences of the group Pre and post questionnaires. Chi square to provide summary. (brief written questionnaire about cooking etc. and attitudes and demographic) Thematic analysis of interview data Dietician kept a journal. Provided triangulation	Benefits in cooking abilities and nutritional awareness Social aspect = camaraderie, cooperative and fun improved self-worth and relationships with others Hard to find a way to improve the group Social component important and others suggest that having a relevant and appropriate activity helps this. Also learning and mentor element	No control group utilised. Participants knew they were being evaluated and wanted to present well. The study design was appropriate with good analysis and clear findings.

MacLeod, A., Skinner, M. W., Wilkinson, F., & Reid, H. (2016)	Canada	16 volunteers and participants recruited from local organisations via media 8 female volunteers (aged 55-75) and 8 isolated OA (cognitively well) – 2 male and 6 female (aged 65-95). Expressive arts diploma graduates, artist, social worker, teacher, infant MH specialist and nurse Volunteer-participant dyads were based on geographic location, artistic interests, similar life histories, and experience of the volunteer	Programme to communicate to others the lives of vulnerable people, using art. Expressive art created in participant homes over 10 weeks.	Qualitative interpretative	Art, logs, evaluations and field notes used to analyse experiences	Themes:- (from artwork and narrative logs) relationships; personal development; created meanings; aesthetic appreciation; extensions; logistics	No justification as to why IPA was chosen as the method of analysis. No control group and sample not randomised. Unclear how much experience the participants had of art. Researcher bias is not discussed and could have impacted the analysis. No discussion of ethic considerations, for example not clear how the research was presented to participants and how confidentiality and consent was addressed.
McAuley, E., Blissmer, B., Marquez, D. X., Jerome, G. J., Kramer, A. F., & Katual, J. (2000)	USA (Illinois)	N = 174 (mean age 65.5). (125 females) Previously sedentary	6 month exercise trial. 2 groups, 1 aerobic and 1 stretch and tone All groups were 3 times a week for 6 months, 40 minute sessions	RCT Assigned to one of two treatment groups	Health and physical activity history at baseline Measures included:- Exercise frequency; subjective wellbeing; happiness scale, UCLA loneliness scale; satisfaction with life scale; social provisions scale Activity logs kept Pre, end of intervention and 6 months post (by mail)	Exposure to physical activity leads to increased happiness and satisfaction with life and decreased loneliness over the 6 month period This reversed at 6 month follow up Social support was a significant predictor of changes in loneliness	Small sample limits generalisability. No consideration of the researchers' role in the results and analysis. No details given of how the data were analysed.

Milligan, C., Gatrell, A., & Bingley, A. (2004)	UK (Carlisle)	30 participants recruited - 11 dropped out 13 male (aged 65-79 median 70) 3 withdrew after 3 months due to ill health and personality differences	Gardened in 2 allotments over a 9 month period (March to November) with a qualified gardener	Ethnographic, grounded theory analysis	Focus group prior to intervention with 10 Semi-structured interviews with another 10 Self-assessment of their health and wellbeing After intervention more focus groups and interviews Standard weekly diaries	Feeling useful and needed was important. Benefits from the natural landscape. Sensual and place for reflection. Safe – away from threats. Mix of abilities can come together. Social aspect – share knowledge and skills enhanced social interaction. Collective activity and decision making. Reciprocal support	Small sample and those that dropped our were not included in the data analysis. Generalisability difficult due to small sample and specific intervention. Unclear how the interview data was analysed and no consideration of quality assurance.
Milligan, C., Payne, S., Bingley, A., & Cockshott, Z. (2012)	UK	N= participants (53 shed members, 2 carers and 5 staff) Participants aged 50+ Four focus groups with shed members (one with 6, the others with 9 (and one carer)) 26 face to face interviews with shed members (2 with partners and carers) 5 interviews with shed managers and coordinators (3 face to face and 2 by phone)	Aim was to improve health and wellbeing Age UK pilot – engage isolated and lonely older men on low incomes and improve QOL and WB 3 shed groups in Nottinghamshire, Greenwich and South Lakeland	Service evaluation Mixed methods – 3 sites (each with different objectives)	Forms, diaries, case studies Interviews and focus groups Coordinator interviews Telephone interviews with managers	Men in sheds appeals to older men when they encounter change. Makes it easier for older men to discuss health and emotional issues Vital support mechanism (especially for isolated men) Reduces isolation and contributes to WB through social contact and meaningful activity Those with impairments find it harder to access these interventions Coordinator was a vital factor in the success of the sheds	Many strengths to this study including researcher influence considered, ethical considerations discussed, rigorous data analysis and good quality assurance. Results limited to the UK however three different areas were utilised to provide some diversity. Convenience sample used which might influence results – participants were enthusiastic about the project and wanted it to continue.

Newall, N. E. G., & Menec, V. H. (2015)	Canada	26 interviews completed Average age 71 (range 57-85). 92% female	Telephone intervention for socially isolated older people Calendar offering 30+ social and educational sessions. Daytime and evening, one time or longer term Facilitated by a range of people both professional and volunteers. Call in and link up with other participants	Evaluation	Sociodemographic. Health and limitations (yes/no). Loneliness question. Social isolation and meaningful social contact question Quant questions – 1-5 satisfaction Qual feedback questions about access, satisfaction, impact of the program Qual analysis – key words and categories identified	Half reported not being socially isolated Social isolation limited by health, finances and residence Some thought the programme gave them meaningful social contact All would recommend programme to others Staff and facilitators were important factor Isolated p's were more satisfied than non-isolated ps Phone offered good access	Measures were not reliable or valid. Isolation and loneliness were analysed as different but unclear if participants would differentiate these as different constructs. Results not generalizable.
Ormsby, J., Stanley, M., Jaworski, K. (2010)	Australia (Adelaide)	2 shed programmes were chosen as sites to recruit 5 participants aged 65+, retired and participating in mens shed Age range 67-92	Sheds operated 1-2 days a week making woodwork products Paid coordinator and run by local government organisation 1 shed purpose built. 1 in a church hall	Descriptive qualitative approach to understand the experiences of participants Canvass lived experiences according to their perspectives Semi-structured, in depth interviews	Interviews. What bought them to the shed The activities they did What they experienced Recorded and transcribed Data analysed thematically. Transcripts read several times. Line by line coding then codes clustered Grouped into sub-themes and themes Reflexive journaling and documented interpretive trail. Sent to p's for checking	Six themes emerged representing perspectives of the men interviewed Company of fellas. Social gathering rather than work. Bonds and companionship valued. Relaxed and informal Everybody's got a story to tell. Relating and making comparisons. Pass on to spouses Still got some kick. Keeping occupied Valued and something to give Passing on your experiences Get on your goat. Lack of equipment and space were frustrations Nobody's boss. Equal status	Small sample size. No discussion about this as a limitation or how this could have been addressed. Saturation and triangulation not discussed. No interview schedule provided. No information about where or when the interviews were done. No information about how long participants had attended the intervention. No information given about how themes and codes were developed throughout the analysis.

Perkins, P. (2012)	USA (Illinois & North Carolina)	N=31 (age 57-87) mean 72. 30 female 13 – Illinois (subsidised apartment complex) 18 – North Carolina (age community duplexes with community centre).	Adapted manualised horticultural therapy program Once a week for 6 weeks for 90 minutes 4 components: Herb of the day. Learning and planting Main activity Cooking a snack 1 facilitator and 2 assistant	Mixed-methods wait list control Outcomes measuring elf-esteem, self efficacy, psychological wellbeing, social connectedness & quality of life Pre and post and 6 weeks post	WHO WB index; Rosenberg Friendship scale; Garden Questionnaire 6 weeks post – qualitative data on the intervention via questionnaire ANOVA for demographic differences. No sig diff so combined the 3 groups into 1 treatment group with the WL control Repeated measures ANOVA – compare pre-test and post-test scores between 2 groups	Significant difference between the groups for self-esteem and garden knowledge Waiting list decreased self esteem but intervention only slightly increased Qualitative surveys found learning, growing and using herbs, participating (social aspect) were most helpful	No information about how participants were recruited. Not clear how the qualitative data was analysed. No validity or reliability data. Confounding variables not considered or discussed.
Shapira, N., Barak, A. & Gal, I. (2007)	Israel	N=22 aged 70-93 (mean 80.25) (13 female) 26 comparison group (17 female) aged 70-93 (mean 82.60) Either assigned to a computer intervention or comparison. Participant chose which group 9 dropped out (6 intervention and 3 comparison)	Computer operation and internet use. Email, web browsing, forums and virtual communities Instructors were teachers of computers used to working with older participants 15 weeks. 1-2 lessons per week. 60 mins long Comparison group did other activities	Quasi-experimental Control group. Pre-post 2-4 weeks follow up	Repeated measures MANCOVA (controlled for no. of children and positive life events and pre-treatment differences) Difficulties in physical functioning scale Life-satisfaction scale Depressive adjective checklist. Revised UCLA Self anchoring scale Perceived control scale (All reliability and validity scored quoted and description of q's and scales)	Internet group improved on all 6 measures No differences when nursing home residence controlled for Internet group – improvements in all areas Deterioration in WB of comparison group Interview data:- Learning, social benefits of online, involvement, internet stimulated positive feelings Feel proud of themselves, use what they found online in social situations Empowerment, personal growth	Comparison group were not a control group – they still did activities. No effect sizes reported. Small sample used at a single time point. Not randomised.

Solway, R., Thomson, L., Camic, P. M., Chatterjee, H. J. (2015)	UK	42 older people from inpatient services 29 female (age of participants not provided)	Object handling group sessions 9 sessions with 5-12 per group 20 attended a single group session, the remaining 22 participated in 2-5 sessions Facilitated by museum professional and an occupational therapist	Qualitative Inductive	Thematic analysis Session audio recordings Audio recordings of 9 sessions were analysed.	Five main themes identified with 16 subordinate codes:- "Responding to object focused questions Learning about objects from each other Enjoyment, enrichment through touch and privilege Memories, personal associations and identity Imagination and storytelling"	Small, convenience sample. Researcher was absent from the analysis. Results could have been strengthened by some triangulation of data. Generalisability to other interventions and populations is difficult.
Stathi, A., McKenna, J., & Fox, K. R. (2003)	UK (South West)	13 community living retired older people (8 male) aged 63-79	Exercise referral scheme	"Process-oriented research shifting attention away from 'exercise' towards 'exercising'"	Semi-structured 60 minute interviews (group or individual) Taped and transcribed Open ended questions asking about experiences of the scheme Thematic analysis	Positive experiences, improvement and successful ageing Improved mood and sleep and wellbeing. More optimistic self-perceptions and stress reduction Successful social experiences less consistent. Some thought it was a good way to expand social network but some didn't experience this. Didn't extend outside the gym Goal setting and achievement Change of activity from the norm Didn't like the structure. Not interesting or meaningful to them	Small sample and no information about how they were recruited. No data about drop-out rates. No follow up. No information given about how interviews were conducted, by who and when. Good reporting of the findings and analysis.

Thomson, L. J. M., & Chatterjee, H. J. (2016)	UK	40 older people (aged 65-85) in 3 health care settings (hospital – n=11 (9 female); 2 psych wards – n=20 (15 female) and north London residential home (n= 9, 5 female) No diagnosis of dementia	Museum objects comprising archaeological artefacts, artwork, geology samples, zoology specimens selected from uni collects based on visual, tactile, properties 6 boxes of 6 objects with fact sheets Audio recorded after consent gained	Mixed methods Pre-post design with repeated measures of score and between factors of setting	Self report measures PANAS, VAS	Large effect sizes Significant differences seen in all settings except psychiatric inpatient.	Structured questionnaires could have limitations in how participants respond. Confounding variables not controlled for. No follow up. Hard to generalise beyond this study.
Tse, M. M. (2010)	Hong Kong	Convenience sample from 4 selected homes. N=53 (26 in experimental group and 27 in control group). 45 female Age 65-95 years (mean was 85 for experimental and 83 for control)	8-week manualised indoor gardening programme	Quasi-experimental pre and post test control group design	Explored activities of daily living and psychological wellbeing and examine the effectiveness of the programme in enhancing their socialisation, life satisfaction and loneliness Measures analysed and interview data subjected to thematic analysis	Sig improvements in all psych measures for experimental group compared with baseline but no improvements for control group. But no changes in ADL for either groups Factors that did not relate to increased in psychological measures include age, experience or education Themes from interviews with gardening group:- Feelings of engagement and contentment along with activity Sharing with others	Researcher also carried out the intervention. Control group still had visits – not TAU. No details given of post-intervention interview analysis. No follow up. Confounding variables not considered/discussed.

White, H., McConnell, E., Clipp, E., Branch, L. G., Sloane, R., Pieper, C., & Box, T. L. (2002)	USA	4 housing sites (residential communities) and 2 nursing homes 100 p's started and were randomly assigned to intervention (n51) or control group. Mean age 71. 39 of the intervention group completed and follow up interview after 5 months 45 control group were included in the analysis	9 hours of computer training over 6 sessions over 2 weeks Included email and internet use together with basic computer usage	After initial interview, randomly assigned to intervention or control Follow up 20 weeks after ending	Demographic info UCLA Loneliness Scale CES-Depression Scale Perceived Control of Life Situations Attitudes towards personal computers and WWW and email. And a life satisfaction question added Asked about:- No. of confidents, goals, concerns, benefits expecting from study Follow up asked if goals met and perceived benefits Also estimated no. of hours spent on computer	No sig differences between groups at baseline Few symptoms of depression across the board (at baseline) Improved life satisfaction Change scores not significantly different between both groups BOTH groups became less lonely. Other measures showed little change for both groups	No blinded – obvious to participants which group they were in. Effect sizes not reported. No results were statistically significant – any changes were small. Little change in these participants but they were not lonely or isolated before the intervention.
Wilkinson, F., MacLeod, A., Skinner, M. W., & Reid, H. (2013)	Canada	8 female older volunteers (aged 55-75) 8 isolated seniors aged 65-95 (6 females) Volunteers experienced in arts or caring	15 hours training for volunteers Paired with participant 10 x in person sessions not prescribed Debrief offered to volunteers via 4 group sessions Final session exhibition/presentation of work	Practice based paper Descriptive evaluation	Volunteers' records Photographs of the artwork Transcripts of 4 volunteer debrief meetings Evaluations by volunteers and Ps	Mostly positive quotes presented Some difficult sessions discussed Physical environment and boundaries problematic for some Personal and emotional issues were stirred up	Details of data analysis are not provided. No links to theory. Small sample size with a wide age range.

Horticultural interventions

Three studies looked at horticultural interventions (Milligan, Gatrell & Bingley, 2004; Perkins, 2012; Tse, 2010) two of which were carried out in the community dwellings from which the participants were recruited: residential homes, community duplexes and a subsidised apartment complex. Milligan et al. (2004) used a community allotment and carried out an ethnographic study using self-report questionnaires, semi-structured interviews, focus groups and weekly diaries. The study drew on theories that considered the importance of the allotment space to older adult health and wellbeing. For example, geographical work that suggests environments enhance human feelings and vice versa, and that landscapes and environments can have therapeutic benefits, particularly to health and wellbeing.

Despite proposing that the data provided evidence for the ways that the landscape and gardening contributed to the health and wellbeing of older people, there were limited details about how they analysed their data, other than quoting excerpts from participants that fitted with their hypothesis. That said, benefits reported by participants included, feeling useful and needed, social interaction, relaxation, being in a place of safety, sharing knowledge and skills, collective decision making, and enhancing social networks.

Similar benefits were reported by the participants in a study by Tse (2010) in Hong Kong. This was a quasi-experimental design of an indoor gardening programme with older people living in nursing homes who participated in an eight-week manualised programme where participants were required to keep a weekly growing diary. The researchers wanted to explore the effectiveness of an indoor gardening programme in enhancing quality of life, psychological wellbeing, activities of daily living, socialisation, life satisfaction and reducing loneliness in nursing homes. The qualitative data from interviews found, similar to the allotment study, that participants reported feelings of pleasure, happiness, responsibility,

engagement and physical activity. They also welcomed the sharing of knowledge and skills with each other. There were many confounding variable that were not accounted for and therefore it is difficult to conclude that it was the gardening that created change; rather it could be that any group activity might be helpful.

Perkins (2012) highlighted the benefits to self-esteem from a gardening programme, with learning and participating being key factors. Drawing on biopsychosocial theories of successful ageing, the intervention was a manualised programme delivered in 90 minute sessions, once a week for six-weeks with three main components: herb of the day, learning and planting, and cooking a snack with the herb. Groups were run by one facilitator and two assistants and measures were administered for self-esteem, self-efficacy, psychological wellbeing, social connectedness and quality of life. The findings showed a significant difference between the groups for self-esteem and self-efficacy. They also found that the control group showed decreased self-esteem but the intervention group's self-esteem only slightly increased. The qualitative questionnaires revealed that learning, growing, using herbs and participating, were all helpful aspects of the intervention. However, no detail is given about how the qualitative data was analysed and there is no information about the characteristics of the facilitators.

The above studies provide support for the benefits to participants such as feeling more useful, improving social interaction, providing opportunities to share knowledge, learning, enhancing social networks and feeling more able to participate. Although quantitative measures showed improvements in self-esteem and self-efficacy, there were some methodological problems. For example, despite having a control group in the Tse study, the group still received weekly visits rather than treatment as usual. In addition, whilst the use of external facilitators was a strength in reducing demand characteristics, the use of an intervention devised by the researcher could have biased the results.

Exercise programmes

Exercise referral schemes have been used for various client groups in recent years, particularly for people with health problems, and these are now expanding as a preventative intervention for older people. Two studies looked at exercise interventions (McAuley, Blissmer, Marquez, Jerome, Kramer & Katula, 2000; Stathi, McKenna & Fox, 2003). The first was an RCT exploring the effect of two types of physical activity on changes in subjective wellbeing over a 12-month period. Participants were randomly assigned to either an aerobic intervention or a stretch and tone intervention, both of which were conducted three times a week for six months and run by a trained specialist. Measures included subjective wellbeing, loneliness and satisfaction with life, and were completed at baseline, at the final exercise session and again at six months. They found that for both exercise groups, exposure to physical activity led to increased happiness and satisfaction with life and decreased loneliness over the first six month period. However, this reversed at the six month follow up. They also found that social support was a significant predictor of change in loneliness measures.

A qualitative, interpretive study aimed at shifting research away from the role of exercise to one of exercising (Stathi et al., 2003) also found improvements in wellbeing. They interviewed community living older people who were already taking part in three different exercise referral schemes across five leisure centres. They were asked to provide information about the issues arising during different phases of the scheme. Thematic analysis found that participants reported improved mood, sleep and wellbeing, with a more optimistic self-perception and reduction in stress. In terms of social experiences, the findings were not universally positive. For some it was a good way to meet people whilst for others it was not. Even among those that did meet people, the relationships did not extend outside the gym. Moreover, personal barriers often needed to be overcome, such as embarrassment and

attitudes to attending a leisure centre. However, the role of the exercise specialist was an important factor in helping with engagement and participant experience.

Overall, mixed benefits were found in these exercise studies, such as a short term increase in happiness and decreased loneliness while taking part, but not necessarily at follow up (McAuley et al, 2000). Similarly Stathi et al. (2003) found that social relationships that built up at the gym, did not extend outside. With no matched control groups and no account of confounding variables such as the gym environment or personal characteristics, it is difficult to hypothesise about what the helpful components were of these schemes. Similarly, the small sample sizes make generalisability impossible.

Computer schemes

With an increasingly digital world, encouraging older people to connect electronically seems vital, particularly with large numbers of those over 65 feeling alienated from technological advances (Davidson & Rossall, 2015). There were three studies aiming to improve loneliness or wellbeing using internet or computer training (Blazun, Saranto & Rissanen, 2012; Shapira, Barak & Gal, 2007; White et al., 2002). White et al. (2002) carried out an RCT (N=100) looking at the impact of internet training on various psychosocial factors including loneliness, depression, life satisfaction and perceived control of life situations. The intervention consisted of nine hours of group computer skills training over a two week period. The results showed no significant differences between the groups, with both groups becoming less lonely, but little change for both groups in any other measures. With more than half (60%) in each group having previous computer experience at various levels, the intervention was perhaps enhancing skills, rather than introducing new skills, and this may have contributed to the lack of change.

In contrast, improvements in all measures were found in a study by Shapira et al. (2007). Participants were recruited from three day centres and two nursing homes and the

intervention consisted of one to two computer skills lessons per week over 15 weeks. They found the internet group improved on all measures and follow-up interviews highlighted benefits including: increased learning of an innovative field; involvement; positive feelings stimulated by internet use; using their learning to expand online social networks. Moreover, not only was there an improvement in wellbeing in the intervention group, but a decline in wellbeing in the control group. Reasons for this were not discussed but the knowledge that they were missing out on something may have temporarily impacted their scores. A longer follow up for both groups would have allowed confounding factors to be further investigated.

While the authors speculated that psychological processes led to change and in turn contributed to healthy ageing, future research could help us further understand the internal processes that occur when older people use computers. For example, was it the process of learning something new, being in a group, the facilitators creating a nurturing environment, or other factors, that were helpful. Moreover, we could postulate that there were nuanced internal differences between the two groups at baseline with some people more likely to choose to take part in the computer group.

Both these studies provide a mixed picture about the impact of computer training on wellbeing, but a consistent reduction in loneliness was highlighted. A study by Blazun et al. (2012) looked at the impact of computer training on loneliness in Slovenia and Finland. A three-week computer course was offered and participants completed two questionnaires before the intervention and again at the end with a mix of open and closed questions. Results found that at follow-up, 84.6% of Slovenian participants were less lonely compared with 40% of Finnish participants. Furthermore, all participants reported an increased feeling of safety due to having a computer and those living alone were significantly less lonely. Interestingly, participants who lived in rural areas reported no difference in loneliness after the intervention but those who lived in towns were less lonely. They found that using email to stay connected

helped reduce loneliness and that email use and number of friends was correlated. Moreover, the more emails that were sent, then the less lonely people were.

However, comparing the differences between these sample groups is problematic. For example, the participants from Finland were volunteers, self-funded and more self-motivated to enrol on the college course. In contrast, the Slovenian volunteers were recruited via caregivers and all resided in state-funded residential homes. Moreover, Finnish participants were significantly younger (M = 66.37 years), compared with Slovenians (M = 77.68 years). In addition, the courses were conducted differently, adopting unique teaching styles and support structures.

Overall, these computer studies provide a mixed picture about the impact of computer training on participants' wellbeing but all studies suggest an improvement in loneliness. As with other interventions reviewed, learning and connecting with others were common factors reported to be beneficial.

Male only activities

Addressing the problem of the over representation of females in the research, five studies looked at men only interventions. Keller, Gibbs, Wong, Vanderkooy and Hedley (2004) carried out a study in Canada with men who attended a cooking group that ran once a month for 8 months with each session lasting 2 hours. It was run by a registered dietician with the aim of improving nutrition, wellbeing, pleasure and satisfaction. The participants worked in small groups to prepare and cook a meal and then eat together.

A thematic analysis found that there were nutritional and cooking skill benefits; however, the social benefits appeared to be the more substantial finding, with participants reporting that camaraderie and fun impacted their sense of self-worth and connection to others. The authors concluded that the social component was the greatest benefit to participants but that having a relevant and appropriate activity, together with learning with a

supportive mentor, were the catalysts to this benefit. This study had clear aims, appropriate methodology, and analysis that produced relevant and novel findings. However, there was no comparison or control group and it could be argued that the participants were aware that the scheme was being evaluated and had an invested interested in providing positive feedback.

The remaining men only studies emerge from the Men-In-Sheds movement that began in Australia in the 1990s. Golding, Brown, Foley, Harvey and Gleeson (2007) funded by the Australian government, provide lengthy and detailed evidence addressing the government's aim of exploring the role of skills development, barriers to learning, work and social connectedness. Drawing on data from 24 shed programmes in five Australian states, using on-site interviews and surveys, they found that meeting others and socialising were the main factors beneficial to health and wellbeing. Using this same data, together with data from shed managers, Golding (2008) found that shed programmes also engaged men who tended to be historically difficult to engage, providing friendship and a sense of belonging through activities with others. He also found that they achieved positive health, happiness and wellbeing for themselves and their partners and communities, concluding it was the learning aspect that was important to wellbeing. This adds important context to the previous survey findings and gives us some explanatory data about why such programmes might be beneficial to participants. In addition, addressing the issue of including those that are hard to engage, and the benefits to wider networks, provides us with new information. However, the researcher appears to report results that fit with the aims and no detail is provided of how the analysis was carried out and how rigorous it was.

In a separate study of two shed programmes in Australia, Ormsby, Stanley & Jaworski (2010) recruited retired participants to a programme that operated one or two days a week producing children's toys and nesting boxes. This was a descriptive qualitative approach aimed at exploring the lived experiences of participants using in-depth semi-

structured interviews and theories about the impact that activities and physical environment have on wellbeing. Using thematic analysis with demonstrable quality assurance, six themes were identified: company of fellas; everybody's got a story to tell; still got some kick; passing on experiences; get on your goat; nobody's boss. The overall commonality between all these themes was the relational component. Despite initially being attracted to the activity in the shed, the chance to meet other men and share stories in a communal environment became the most important benefit: "sheds become conduits for social relationships" (Ormsby et al., 2010, p. 612).

This study offered an alternative to survey data and provided insight into the meanings for participants beyond learning new skills and being with others. However, conclusions are limited due to the small number of participants and shed programmes, and it being conducted at one point in time.

The final men-in-sheds study was a UK based pilot programme run in conjunction with Age UK by Milligan, Payne, Bingley & Cockshott (2012). This was a qualitative study from three shed groups in Nottinghamshire, Greenwich and South Lakeland. The aim of the pilot programme was to engage isolated and lonely older men on low incomes, to improve quality of life and wellbeing. Using a mixture of focus groups, face to face interviews, telephone interviews, project meetings and diaries, data was gathered from all three sites to assess the impact of the shed on participants' sense of wellbeing and inclusion. Results found that the programmes appealed to older men, especially if they were encountering change, for example retirement or loss. They also found that the physical setting made it easier for participants to discuss health and emotional issues and offered a vital support mechanism, especially for isolated men. Furthermore, the findings suggested that the programme reduced isolation and contributed to wellbeing through social contact and meaningful activity. However, for participants who needed additional support and were experiencing increasing

impairment, it was also found that the co-ordinator was a vital factor in the success of the sheds, particularly in aiding access to those who found it harder.

Male only interventions proved beneficial according to the findings reported here, with improvements in wellbeing and an appeal to men who were previously hard to engage. Learning, doing activities and socialising with others were all reported as important. The facilitator also played a key role although why this was, and the components involved, were not explored.

Mixed activities

Interventions where participants could choose what kind of activity they did, help us consider the role of choice in wellbeing. Greaves & Farbus (2006) explored the effects of creative and social activities on the health and wellbeing of socially isolated older people in Exeter in the UK. Mentors worked with participants who had been referred by health professionals, to help them re-engage with activities they found meaningful, such as creative, physical or cultural activities, with an emphasis on social interaction. Results found that three out of the 18 participants reported no change in their mood but the remainder reported improvements in social interaction, confidence in doing new activities, engaging socially, and increased optimism and self worth. They also found that access and availability, together with mentor support, were key to engagement. Quantitative analysis of the questionnaire data revealed that initial benefits of reduced depression, were also maintained at 12 months. Moreover, after 12 months, additional social support and health benefits emerged. This has important implications for other studies where follow up is not carried out.

With accessibility and availability being important considerations, telephone interventions can provide additional benefit. A study by Newall & Menec (2015) evaluated a telephone social and educational group intervention (Without Walls) for socially isolated older people in Canada. The programme offered over 30 social and educational telephone

sessions in the daytime or evening, either as one-offs or longer-term courses. Participants who had taken part in at least two terms, were then interviewed about their experiences. Despite half of the participants reporting not being socially isolated at the outset, participants who did identify as socially isolated were more satisfied with the programme than those who did not. Some thought that the programme gave them meaningful social contact, and all participants would recommend the programme to others. They also claimed that the staff and facilitators were an important factor.

Batt-Rawden and Tellnes (2005) looked at a Nature-Culture-Health Centre in Norway. Activities on offer included hiking, gardening, music, singing, painting, dancing, and local history groups, with outdoor and cultural activities being the main focus. They found that themed groups played a role in increasing self-esteem, with two-thirds of participants reporting improved health and quality of life, particularly when given opportunities to use their creativity. The process of taking part in group activities particularly helped with isolation and loneliness. However, the authors also note methodological limitations such as difficulties with recruitment, a heterogeneous sample, and a lack of data from those that did not participate in the research.

These mixed activity interventions show additional benefits to participant wellbeing including improved confidence, self-worth and social connectedness. The mentor or facilitator stood out as a key factor to positive outcomes but this variable was not explicitly explored.

Arts

This was the field with the most research and included collaborations with museums as well as expressive arts and musical interventions (Cohen, Perlstein, Chapline, Kelly, Firth & Simmens, 2007; Cohen, 2009; Goulding, 2012; Hillman, 2002; MacLeod, Skinner,

Wilkinson & Reid, 2016; Solway, Thomson, Camic & Chatterjee, 2015; Thomson & Chatterjee, 2016; Wilkinson, MacLeod, Skinner & Reid, 2013).

There were two museum studies looking at the impact of an object-handling intervention carried out in healthcare or residential settings, including psychiatric inpatient facilities. Solway et al. (2015) reported on object-handling group sessions, facilitated by a museum professional and an occupational therapist, in a psychiatric ward. The aim was to explore the psychological and social experiences of participants in this novel intervention. A thematic analysis of nine audio recorded sessions revealed five main themes: responding to object-focused questions; learning about objects from each other; enjoyment through touch; memories and identity; imagination and storytelling. Similarly, a mixed-methods study by Thomson & Chatterjee (2016) carried out object-handling groups in three different healthcare settings: a general hospital, a psychiatric ward and a residential home. Self-report measures and audio recordings of the sessions provided significant data describing to what extent object-handling enhanced wellbeing. They also found there were large effect sizes with significant pre-post mean differences in all settings except psychiatric care.

Other studies explored the role of music in older people's wellbeing and social functioning. Cohen et al. (2007) looked at the impact on physical health, mental health and social functioning of older people attending professionally conducted weekly singing rehearsals for 30 weeks and then performing in public. The study found that daily activity levels actually decreased in both groups (intervention and control) but more so for the comparison group, particularly at the 24 month follow-up. However, weekly activity levels increased in both groups and significantly for the intervention group. There were no significant effects found in monthly activity levels but in yearly activities the intervention group increased over time and the comparison group decreased. They also found that the comparison group showed an increased depression risk over time. Interestingly, there were

no differences in loneliness between the two groups. Cohen (2009) utilised a weekly singing group intervention that came together after two years to form a large chorale; the findings showed that the intervention group had better overall physical health (with fewer doctor visits, less medication use, fewer falls and health problems), better morale and reduced loneliness. In contrast, they found the comparison group showed a decline in activity levels whereas the intervention group showed an increase. However, why these results were found is not discussed and this highlights an ongoing gap in the research.

The studies discussed so far all provide information about the benefits to various aspects of participants' lives. Hillman (2002) expanded these findings and explored participant experiences of another singing group. The study collected questionnaire data from people who took part in a year long singing programme, 'Call That Singing (CTS)'. The findings showed high levels of sociability with 95% making friends and 57% socialising with them outside of the singing sessions. Emotional wellbeing and quality of life also improved significantly although 75% reported good quality of life before starting the intervention. However, 14% also reported no change in wellbeing or quality of life.

Goulding (2012) considered the impact of an art gallery intervention in terms of lifelong learning from a social constructionist position. The study aimed to increase understanding of their experiences, motivations and barriers to engagement. Participants visited three contemporary art exhibitions over two years with a hope that the art would prompt discussion and debate. Using thematic analysis Goulding found that learning and education were important factors in engaging with contemporary art but that intellectual factors were a barrier to engagement. The most salient factor impacting wellbeing was taking a break from the usual routine and going out. The author also highlights an important point: the heterogeneity and range of life experiences in the older adult population means that there are vast beliefs and events throughout the lifecourse that are likely to impact current

experiences. Despite providing useful insights, there is no detail provided about quality assurance or the process of thematic analysis.

An intervention using expressive arts (The Visible Voices Programme) (Wilkinson et al., 2013) aimed to harness and acknowledge experiences and narratives, incorporating some of the rich life stories of older people. Expressive art was created in participant homes together with facilitated supportive group sessions for the volunteer facilitators. The research questions explored the opportunities and challenges of facilitating such an intervention for both participants and volunteers. Data was gathered from field notes, volunteers' weekly logs, photographs of artwork, transcripts from volunteer debrief meetings, and program evaluation questionnaires completed by volunteers and participants. The interpretive analysis provided a rich and varied source of data with themes being validated by participants at a public showing and through dialogue with those involved. Themes included relationships, personal development, meanings, and aesthetic appreciation. There was also acknowledgement that some sessions were difficult, with personal and emotional issues being highlighted.

Taking the evidence from the arts interventions together, we see improvements in wellbeing, depression and activity levels. Overall, the studies provide evidence from a range of settings, utilising both quantitative and qualitative methods, with some also recruiting control groups, longitudinal follow-ups and reporting of effect sizes. As with other interventions, learning in a group, socialising with others and taking part in a meaningful activity, all emerge as beneficial.

Discussion

Summary

In reviewing the empirical literature of social prescribing schemes targeting wellbeing, loneliness and social isolation of older people, the evidence was for a variety of benefits to participants, however, there were methodological issues that impact the validity

and generalisability of the findings. Some of the benefits reported include: pleasure; happiness; relaxation; sharing knowledge and skills; learning new skills; improved self-esteem and self-worth; making new social contacts; and growing social networks. Moreover, in studies that considered the role of the facilitator, they were found to be vital in helping with access and engagement, especially for harder to engage groups. Where longer-term follow ups were done, lasting benefits were seen, particularly in activity levels and mood. However, few studies utilised follow-ups, particularly of longer lasting social benefits or relationships forged during the programmes. Taken together, the evidence provides a picture of schemes being helpful to older people overall. However, there were methodological limitations.

Methodological evaluation

This review has highlighted methodological difficulties with specific studies throughout; however, a more general critique and overarching limitations will now be discussed.

Replicability of quantitative studies. Across the studies reviewed, generalisability of the findings is problematic, predominantly due to small and specific samples taking part in specialised activities in certain settings. Overwhelmingly the samples are dominated by female participants, although this is addressed in the male only studies (with the exclusion of females). Despite this mirroring the gender imbalance in society within this cohort, the studies are still vastly over-represented by females, which limits generalisability. Confounding variables also make replicability problematic, particularly between cultures, residential settings, financial and marital status.

Quality assessment of qualitative studies. Using the CASP Qualitative Research Checklist (2013b) to evaluate the qualitative studies, some strengths and weaknesses were apparent. The qualitative studies provided important evidence to help us understand what

was helpful about the interventions, for instance, the importance of social interaction (Batt-Rawden & Tellness, 2005). However, the quality of the studies was inconsistent and there were some specific difficulties. There was a lack of information about recruitment of participants (Perkins, 2012; Stathi et al., 2003) and limited discussions about the relationship between the researcher and the participants (with the exception of Keller et al., 2004 and Milligan et al., 2012). This has important implications for how participants might respond, particularly if they perceive the researcher to have a decision making role in the future funding of services.

Another issue with quality arises in the reporting of how data were analysed, quality assurance and researcher reflexivity. For example, some of the studies (Batt-Rawden & Tellness, 2005; Milligan et al., 2004; Perkins, 2012) gave no detail about their process of data analysis or how they arrived at their findings. Similarly, Golding (2008, 2012) and Ormsby et al. (2010) provided no details of how quality was addressed in the analysis or how the themes developed in the thematic analysis. The exception was Stathi et al. (2003) who did provide information about how their analysis was verified, including details of how they dealt with discrepant information. That said, personal and epistemological reflexivity (Willig, 2008) was notably absent from all studies. This would have added depth to our understanding of the role of the researcher in drawing out their findings from the data.

Demographic considerations. Despite all these studies recruiting older people, the age range was vast. The majority were in the range from 65 to 85 but this is a 20 year age range that is likely to see distinct differences, especially given the era in question that spans pre and post World War II. Life experiences in this cohort are likely to differ and might even involve adversity and trauma. That said, the fact that the studies reviewed are so varied does offer us data from a range of participants and adds weight to the argument that by pulling all these studies together, we have a heterogeneous cohort from which to find patterns.

Overall evaluation

This review highlights the impact of various social interventions to participants' wellbeing, loneliness or social isolation. However, direct comparison between the studies is problematic due to the variability in interventions, participant characteristics, research measures and methods. Moreover, despite claiming that learning in a group environment with a supportive facilitator was an important factor in improving participant experience, there were no vigorous theoretical explanations as to why.

The majority of studies were not psychologically focussed, for example, many researchers were experts in IT, nutrition, nursing or education. Whilst this does not de-value the findings, the aims and research questions were focussed on areas other than psychological understanding. Therefore, studies found evidence that change correlated with taking part in the programme, rather than an explanation of cause and effect or other nuanced explanations. However, having a range of studies that provide us with robust data showing that interventions are helpful, is a valuable starting point from which to explore the contributing factors further. There was little consideration of what was unhelpful, or of psychological processes such as self-esteem or group process. This means vital information is missing about what might be helpful to participants and also, what barriers there might be to attending such schemes. There is value to exploring what is not there, in addition to what is.

Limitations

Defining social prescribing interventions proved challenging in as much as many programmes do not self-identify as social prescribing or community referral schemes. Therefore, research in other fields using other unique interventions may not have been covered by the search terms and were therefore excluded. For example, religious and spiritual organisations that run groups for older people in various settings, but do not identify as social prescribing or community referral schemes. The studies reviewed were also drawn

internationally and whilst this offers wide reaching evidence of the positive impact of these interventions, it makes it difficult to contextualise results. For example, a manualised indoor gardening intervention from Hong Kong may not be beneficial to a rural population in Cumbria in the UK.

Clinical implications

Taking account of the studies reviewed, the scope for social prescribing interventions to benefit both physical and psychological health is vast. In this vein, clinical psychologists can offer skills to enhance interventions further and harness the benefits to people referred. They can help identify those who might be in need of such interventions and can draw on their therapeutic skills to aid and support people to attend, especially if they are hard to engage. Clinical psychologists can also offer consultation to those involved in developing programmes such as public health organisations, third sector, and cultural organisations such as museums. Using their skills and knowledge in areas such as group process, motivational interviewing, and therapeutic modalities, clinical psychologists are well placed to advise and support staff in facilitating interventions and in matching clients to groups that might offer the most benefit.

Research Implications

Matching participants to interventions and knowing how best to do this is likely to be dependent on building our knowledge base about what it is that is helpful and why. It could be that there is a difference between just doing a group activity and doing an activity and connecting. For example, in a meta-analysis of influences on loneliness in older people, Pinquart and Sorensen (2001) suggest that the literature is demarcated by two different definitions. The first describes the experience in terms of a decline in social contacts and satisfying relationships. The second is a social-cognitive view that suggests loneliness arises because of lack of fit between the type of relationships individuals experience and the kinds

of relationships they would like. This second definition incorporates ideas that people may feel lonely, despite seemingly having many social contacts and experiences. This also takes account of ideas that there is a distinction between quantity (social isolation) and quality (emotional isolation) of social contact (Weiss, 1982). Moreover, knowing what the barriers might be to people and exploring why interventions might not be helpful, is equally important to build our understanding.

Many of the studies reviewed here were from fields other than clinical psychology and mental health. This highlights the benefit of future collaboration with other sectors in providing psychological thinking and intervention. This will help to synthesise the interventions and target specific psychological components, such as wellbeing and loneliness, in clinically relevant ways. Currently, arts and community resources are not being utilised for the potential they have in addressing wellbeing and social isolation of older people. Research is starting to provide promising evidence but larger scale projects and more robust evidence is needed.

Conclusion

The research and evidence reviewed overwhelmingly posits benefits of social prescribing schemes to older people at risk of loneliness, social isolation or declining wellbeing. The plethora of interventions reviewed also suggests that there are common beneficial factors beyond the activity itself. For example, participants reported that camaraderie, fun, sharing skills and knowledge, learning, and social contact were all benefits gleaned from taking part. However, despite evidence showing that change occurs, there is a lack of research exploring how programmes provide opportunities for change or how they interact with internal psychological processes such as self-esteem. Methodological issues were identified and implications for clinical practice and future research were considered,

concluding that future research should build on the evidence to date, and explore how and why social interventions provide opportunities for change in wellbeing and social isolation.

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CAROLYN TODD BA Hons MSc

EXPLORING THE ROLE OF MUSEUMS FOR SOCIALLY ISOLATED OLDER PEOPLE

Section B

Museum-based programmes for self-identified socially isolated older people:

Understanding what works for enhancing psychological wellbeing and social isolation

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Abstract

Introduction: Research suggests that social prescribing schemes can offer health and psychological wellbeing benefits to older people across a range of interventions. The present study sought to understand how museum programmes, designed to support socially isolated older people, created opportunities to enhance wellbeing and change experiences of social isolation.

Methodology: A grounded theory approach was used to analyse initial interviews, 3-month follow-up interviews, and participant diaries, from 12 participants who took part in 10-week programmes across six different museums in London and Kent.

Results: A theoretical model was developed showing elements of museum programmes, such as the role of the facilitator, engaging with artefacts and navigating the physical space, that enabled both individual journeys and relational processes. In addition, individual journeys and relational processes influenced each other, enhancing the experience. These components operated within an interacting social context that was enriched by the museum programme.

Conclusion: The theoretical model links with psychological concepts of attachment theory and self-esteem to explain how cultural group programmes could provide opportunities for change in older people. Limitations of the research, implications for clinical practice and recommendations for future research are discussed.

Keywords: museums; wellbeing; social isolation; social prescribing

Introduction

With the shift away from state run social care towards a more community focus, together with an ageing population that is increasingly isolated, it is clear that innovative ways to improve healthy ageing are needed (The Kings Fund, 2015). Social prescribing is one way to offer interventions focussing on activities of interest, rather than dependence on clinical interventions such as psychological therapies, GP visits, and psychotropic medication, to improve social inclusion and wellbeing in older people. In November 2010, the UK Government published a report setting out a vision for adult social care (Department of Health (DOH), 2010). They suggest prevention as the first of seven principles, stipulating that councils should work with other partners in the community to prevent social isolation (DOH, 2010). There has therefore been a change in focus for policy makers, moving towards multi-agency working and a call for preventative approaches, rather than waiting for crisis (Age UK, 2015; Ander et al, 2013).

Loneliness and social isolation

Social isolation is described as a lack of belonging and engagement with others and limited quantity and quality relationships (Nicholson, 2012), leading to an increased likelihood that people will need to use social care services (Davidson & Rossall, 2015). In 2015, Age UK reviewed the loneliness and social isolation research and highlighted tangible benefits of intervention, including cost savings. However, the report also stated that research considering the benefits of addressing loneliness is lacking.

Research by Pinquart and Sorensen (2001) analysed factors affecting loneliness and social isolation, such as gender, quantity and quality of social contacts, competence and socioeconomic status. They found that quality of social networks correlated more strongly with loneliness compared to quantity, as did being a woman, having low socioeconomic status, and low competence. These findings suggest a complex mix of individual and social

contributors and that for a large proportion of people, interventions that address environmental or social factors, could change their experience of loneliness. In 2012, Nicholson published a review of the literature on social isolation and highlighted an important risk factor; even when social relationships are present, the quality of these relationships may be detrimental, for example if they involve high levels of care. If individuals are identified as socially isolated, Nicholson proposes referral to group interventions where social connections can be made. A review of interventions by Cattan, White, Bond & Learmouth (2005) further suggests that educational group interventions aimed at specific populations, provided optimum benefit in reducing social isolation.

Wellbeing

A definitive theory of wellbeing remains elusive, with many contributions being made by philosophers and researchers over hundreds of years (Camic, Hulbert & Kimmel, 2017). More recently, various components that affect psychological wellbeing, such as loneliness, life satisfaction and self-esteem, have been identified (DOH, 2014; Ryff, 1989). The 'Five Ways to Wellbeing' report (Government Office for Science, 2008) presents empirical evidence for improving wellbeing. The report focuses on mental resources and what needs to be done to encourage and enable people's prosperity and wellbeing potential throughout their lives. Similarly, the Marmot review in 2010 considered the role of social capital and wellbeing, incorporating this into their objectives. Social capital is described as:

> the links between individuals: links that bind and connect people within and between communities. It provides a source of resilience, a buffer against risks of poor health, through social support which is critical to physical and mental well-being... The extent of people's participation in their communities and the added control over their lives that this brings has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes (Marmot, 2010, p.24).

This acknowledges social factors and highlights the interplay between individuals and their social context. However, theories of wellbeing have historically been individually focused, drawing on notions of pleasure seeking and happiness. For example, Aristotle argued that wellbeing was derived from realising one's potential (Boniwell, 2006). More recently, the notion of psychological wellbeing has been suggested as comprising six key components: personal growth; self-acceptance; autonomy; purpose in life; positive relationships; environmental mastery (Ryff & Singer, 2006). The role of social factors is more apparent in this model, recognising that relationships are important to wellbeing. The definition that is sometimes adopted by policy makers and health and social care professionals is the one proposed by the New Economics Foundation (NEF): connect; be active; take notice; keep learning; give (Aked, Marks, Cordon & Thompson, 2008). This further develops the idea of external participation and highlights the shift to recognise the importance of addressing more than just individual pleasure or personal growth.

The links then between wellbeing, social isolation and physical and mental health are well documented and evidenced. However, how these factors interact is less well known and likely to be multifaceted and complex. This suggests that although we can say that certain interventions appear to improve wellbeing and loneliness, it is not evident how this happens.

Social prescribing to address social isolation and wellbeing

Social prescribing interventions provide opportunities for primary care services to link with community and third sector organisations to offer services to people with emotional, social or practical needs (Thomson, Camic & Chatterjee, 2015). The evidence base for the health and wellbeing benefits of various arts and health interventions across the UK and internationally, is growing. The scope of such interventions includes providing meaning and new opportunities to be creative and build relationships (Thomson et al., 2015). Evidence has also shown that participatory arts in older age groups can challenge ideas of decline, re-

connect people to communities and target health needs that threaten wellbeing (Vella-Burrows, 2016). The idea that cultural capital is important to health and wellbeing is said to help by utilising people's social competence, values and skills, and draws on cultural resources to enhance healthy lifestyles (Clift, 2012).

Researchers have proposed that more evaluation and evidence is needed to explore how and why social prescribing might be beneficial and to investigate the impact that programmes have on socially isolated older people. (e.g. Clift, 2012; Thomson et al., 2015). Expanding the evidence base to show benefits that the cultural sector can have on the health and wellbeing of society (Chatterjee & Camic, 2015) will ultimately help address the needs of an ageing population and provide the greatest opportunity to live healthy and meaningful lives.

Research aims

Museums and art galleries, as part of the third sector and working as public health partners with health and social care services (Camic & Chatterjee, 2013), are ideally suited to offer community-based programmes to support the psychological wellbeing of socially isolated older people. This project seeks to qualitatively explore a large scale social prescribing scheme's use of museums to address this major health issue.

The overarching research question addressed by the present study asks, how do museum-based social prescribing programmes reduce social isolation and increase wellbeing of socially isolated older people? Sub-questions include:

1. What are the specific elements and processes of museum programmes that affect socially isolated older adults?
2. How do these interact to create an environment that enhances psychological wellbeing?

Methodology

Design

A qualitative study was carried out using individual interviews with people who took part in a 10-session, once-a-week, Museum-on-Prescription (MoP) programme. A grounded theory approach to data analysis was used to build a theoretical understanding of meanings and experiences and how these might explain the processes that enabled change. Approaching it from a critical realist epistemological framework means that certain constructs are considered to exist, such as loneliness and wellbeing, but that the causal relationships that create these constructs are located in subjective generation (Willig, 2008).

Sampling in grounded theory is often guided by theoretical saturation; data are collected until categories are accounted for and relationships between them validated (Green & Thorogood, 2004). However, "theoretical sufficiency" has been described by Dey (1999, p. 257) as reaching a depth of understanding rather than a point where nothing new emerges. In addition, Nelson proposes "conceptual depth" (2016, p. 6) whereby a range of evidence and subtlety in concepts shows richness in meaning, resonance with existing literature, and external validity. This study achieved theoretical sufficiency and conceptual depth after initial interviews, 3-month follow-up (3MFU) interviews and weekly passports, from 12 participants. After analysis of these, there was sufficient data to develop categories, and for relationships, similarities and differences, to be understood.

Participants

Participant data were drawn from a pool of 115 participants (aged 64 – 84) self-identifying as lonely or socially isolated, who took part in programmes being run in six museums across London and Kent. Table 1 shows the eligibility criteria. Participants were selected to represent a range of different experiences. This included people from the programmes running at all six museums, male and female, from across the age range of 64-84, with

changes and no changes to quantitative scores, with and without previous museum experience, and from museum groups that were cohesive and also from some that were less cohesive.

Table 1

Eligibility Criteria

Inclusion Criteria	Exclusion Criteria
Aged 65-94 years old	Aged 64 and younger, or 95 and older
Socially isolated in own home or care home (where there is evidence of isolation from other residents)	Not socially isolated as living with family/friends or, if in care home, socialising with other residents
Not regularly attending social and/or cultural activities such as clubs or classes	Regularly attending social and/or cultural activities such as clubs or classes
Able to give own informed consent to take part in the research study	Unable to give own informed consent to take part in the research study
Able to take part in interviews and complete questionnaires prior to the first and after each of 10 weekly sessions, and telephone interviews at 3 and 6 months after the sessions	Unable to take part in interviews and complete questionnaires prior to the first and after each of 10 weekly sessions and telephone interviews at 3 and 6 months after the sessions
Able to read and write English sufficiently well to take part in interviews and complete questionnaires and able to speak English sufficiently well to converse socially	Speakers of other languages unable to read and write English sufficiently well to take part in interviews and complete questionnaires and unable to speak English sufficiently well to converse socially
Able to get to museum using public or private transport (this could be with help of carer/befriender or local third sector agency providing transport e.g. Age UK)	Unable to get to museum using public or private transport
Available to attend weekly sessions, one per week for ten weeks (either during morning or afternoon depending on which is offered by the museum)	Unlikely to be able to attend all weekly sessions for ten weeks (this could be due to recurring illness or hospital visits

Inclusion Criteria	Exclusion Criteria
Able to function in a group situation (group size 8-10 older adults plus carers/befrienders and museum facilitators)	Unable to function in a group situation (for example, people who are psychotic, have social phobias, experience panic attacks or epileptic seizures, or have mental or physical symptoms likely to be distressing to other group members)
Able to see and hear sufficiently well to take part in group activities	Unable to see and hear sufficiently well to take part in group activities (local museums may not have induction loop access)
Able to use hands and arms sufficiently well to hold objects and/or participate in arts/crafts activities	Unable to use hands and arms sufficiently well to hold objects and/or participate in arts/crafts activities (particularly where this may represent potential harm to participants and/or museum collections)
Able to move around the museum (this could be with a wheelchair and/or with the help of a carer/befriender)	Unable to move around the museum (this could be with a wheelchair and/or with the help of a carer/befriender)
Able to use museum facilities such as lifts and toilets (this could be with a wheelchair or/and with the help of a carer/befriender)	Unable to use museum facilities such as lifts and toilets (this could be with a wheelchair or/and with the help of a carer/befriender)
With mild, early stage dementia (although museum sessions are not intended for people with dementia they can be included if they fulfil the other criteria)	With moderate to severe/mid to late stage dementia

Data has been drawn from the AHRC-funded MoP study (Appendix B), which is a mixed-method three-year study, examining the impact of museum programmes on social isolation and psychological wellbeing in older adults. A total of 12 participants, each providing multiple data sources (end of programme interviews, 3MFU interviews, and weekly diaries) were drawn from the main study as this was felt to be sufficient to create a theoretical model (Urquhart, 2013). Participants were recruited through convenience sampling from third sector services such as Age UK. Table 2 shows demographic information of each participant and some of their associated quantitative data.

Table 2

Participant Information

Participant number	Age	Gender	Museum attended[1]	R-UCLA		WEMWBS	
				Session1	Session 10	Session 1	Session 10
P1	75-79	Male	London museum 1	28	32	56	61
P2	80-84	Female	Kent museum 6	35	34	61	29
P3	75-79	Female	London museum 2	46	44	61	59
P4	70-74	Female	Kent museum 5	62	56	41	54
P5	75-79	Male	Kent museum 6	53	50	46	48
P6	80-84	Male	Kent museum 5	28	38	59	60
P7	65-69	Female	London museum 2	74	75	47	36
P8	75-79	Female	London museum 3	24	26	53	54
P9	75-79	Female	Kent museum 4	45	45	54	53
P10	65-69	Female	Kent museum 4	37	42	54	48
P11	70-74	Male	London museum 1	45	Not completed	61	Not completed
P12	75-79	Male	Kent museum 4	35	32	69	70

Participants were given details of the 10-week programme in a leaflet (Appendix C). If interested, researchers from the larger project telephoned them to discuss any questions, and ensure eligibility and ability to attend the sessions for 10 weeks. The limited eligibility criteria enabled a range of participants from various backgrounds and experiences. Sampling for the present study included participants that showed change or no change in loneliness, and change or no change in wellbeing, as measured respectively by the revised UCLA Loneliness Scale (Russell, Peplau & Cutrona, 1980) and Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) (Stewart-Brown & Janmohamed, 2008). Both scales were administered before and after participation in the 10-week programme. The WEMWBS is a 14-item scale with five response categories, covering emotional and functional aspects of wellbeing. The

[1] The number denotes which museum was attended by that participant

revised UCLA scale is a 20-item scale measuring subjective feelings of loneliness and social isolation. Other sampling considerations such as age, gender, previous museum attendance, geographical location and group cohesion were also used, along with gaps in the developing theoretical conceptualisation.

Ethics

The study received ethical approval from the University College London Research Ethics Committee (Appendix B). Participants had already provided informed consent (Appendix D) and completed interviews prior to this study starting. Any distress experienced as a result of reflecting on their experiences was identified before the interviews. Data was anonymised and stored electronically on encrypted hardware and password protected files.

The development of the main funded study asked older adults to review the study design, recruitment procedures, consent form and information sheets, and comment accordingly. Also, the research team from the main study met with the project's advisory board which included participants, to discuss dissemination of the main study's findings along with offshoot studies, such as this one.

Materials

A semi-structured interview (Appendix E) was used with participants at the end of the 10-week programme. Further follow-up interviews were done at 3 months (Appendix F) and asked questions about the longer term impact. Data was also drawn from participants' 'Museums-on-Prescription Passport' (passport) (Appendix G), a diary completed at the end of each session asking questions about their experience of the session content and of the group.

Procedure

Participants attended the museum for 10 weeks and completed the passport after each session. At the end of the 10 weeks, face-to-face or telephone interviews occurred followed by interviews three months later. During the interviews, there was an opportunity to ask questions and encouragement to reflect on their experience of the programme content and the process of being in the group. The initial interviews were 45 - 90 minutes and 3MFU interviews, 10 - 30 minutes.

Data analysis

Data were analysed using grounded theory to gain a theoretical understanding of the MoP process (Urquhart, 2013). Audio recordings of the interviews were transcribed verbatim and analysed, along with copies of the passports, using Strauss and Corbin's (1998) approach. In grounded theory, a process of inductive, bottom-up discovery of meaning from the data occurs, rather than the application of deductive theoretical approaches. Grounded theory requires significant time and closeness to the data where theory emerges from relationships between concepts (Urquhart, 2013). The process started with line by line open coding (Appendix H) and then moved to selective coding, identifying initial categories (Appendices I, J and K).

Through a process of constant comparison, the data and categories were integrated to produce theoretical coding. Using coding and theoretical memos (Appendix L), similarities and differences between the codes were identified and explanatory relationships discovered. By developing diagrams and explanations, an initial model was discussed with the research supervisors and a colleague, to help with clarity and quality. The model was then further developed and explanations refined.

Quality assurance and reflexivity

Transparent coding processes were utilised, including the use of a researcher diary (Appendix M) and coding memos (Appendix N) to document and support the process of category and theory development. Moreover, validity was enhanced by regular consultation and discussion with both research supervisors about coding, emerging categories and theoretical models. In addition, keeping a written record of theory development (Appendices J and K) and writing and sorting theoretical memos (Appendix I) about how categories related to each other, meant I stayed open to emergent theoretical codes and integrated them with the developing grounded theory (Appendix O).

Addressing interpretation using a reflexive self-awareness to acknowledge my own implicit assumptions and biases on the meanings in the data, helped to ensure that the findings represented the questions being researched. As new concepts emerged, writing them down and justifying them allowed me to examine their implications. Mays and Pope (2000) provide questions to consider in assessing qualitative studies and this framework was used to consider the quality throughout my research process. I have a vested interest in this area of research for personal reasons and this had the potential to guide my interpretation of the data. A reflective diary allowed me to acknowledge these biases in the interpretation and coding of the data. By taking this reflective stance I was able to note that participants' concepts of wellbeing or loneliness were different from mine, and stay alert to my personal biases.

Results

Four explanatory components emerged, illustrating how a museum programme created opportunities for change in wellbeing and social isolation. These were: interacting social context; museum as enabler; individual journey; relational processes. Figure 1 shows how these components interacted. The social context both enabled participants to approach and engage with the museum programme, but also the programme fed back into this system to

create change; for example, evaluating themselves and others differently as a result of the group experience, communicating more effectively, and being more socially engaged due to increased confidence. Within this social context, the museum programme enabled an individual journey for each participant and provided the opportunity for relational processes. The individual journey and relational processes also interacted with each other.

Interacting Social Context

This provided a background context in which the museum programme operated, influencing how it was experienced and enhancing the potential for lasting change.

Evaluating self and others. Some participants evaluated other people in the group positively, "…she was nice to talk to and she was quite a bright lady as well" [Participant (P) 11] and "I thought they were all friendly" [P2]. However, one of the ways that people distanced themselves was by judging other older people (not participants) negatively, "they sit there all day just doing nothing. Especially old ladies they just sit there looking into space. They don't even talk to each other" [P12], "elderly people they don't want to go out you see, they just want to sit at home in front of the television or whatever" [P3] and "they don't seem to get motivated and do things and organise like I do" [P9, 3 month follow up (3MFU)]. This process was either a protective factor to distance themselves, or a motivating factor to do something different.

One of the ways the museum programme influenced how individuals evaluated themselves was by providing evidence to judge themselves more positively, "it just gave me reassurance, that I was likeable, that's sad isn't it but it's true" [P7]. Similarly, participants described how their own interaction might be influenced by people around them, "if friendly I talk, if not, I just sit" [P5]. When describing how they experienced the group, they felt they might have been judged as "oh, it's that woman again, she's a pest, she's asking silly questions" [P4] but the experience provided evidence to the contrary "very easy, you weren't

sort of dismissed" [P4]. This demonstrates the programme providing alternative experiences, challenging existing beliefs.

Getting to know people. Participants reported specific benefits of communication, despite initial difficulties, helping them to navigate their role in the group, "I think we started to talk to each other and make comments and things because I think at first you feel shy, well I do, embarrassed if you don't know the answers or embarrassed if you do know the answers" [P12] and "well I think we just sort of, being in a small group, you sort of can't ignore people, you've got to talk and, yeh, it gets like that" [P6]. Another way that participants described the value of communication was the importance of sharing, which enhanced their outlook, "to get together and chat about things and compare notes so you don't always look at it in a bleak way, you can share it" [P9] and "sitting together with a drink, opportunity to share ideas and many years of accumulated knowledge" [P8, passport].

The museum also provided topics of conversation and created opportunities to talk, "it's a nice way to start a conversation and it's a very safe conversation" [P1] and "I think it sort of relaxed more, yeh, I think people relaxed more, a bit more interactive and said hello when you came in" [P8]. Communication was also a vessel for social engagement that allowed relationships to be created.

Social engagement. This was a process of building relationships and meaningful connections which in turn increased engagement in the programme:

> It made me feel less lonely. And coming out into places where there are quite a few other people is erm, well it, it makes a place like a museum feel more familiar and that can't be a bad thing [P10, 3MFU].

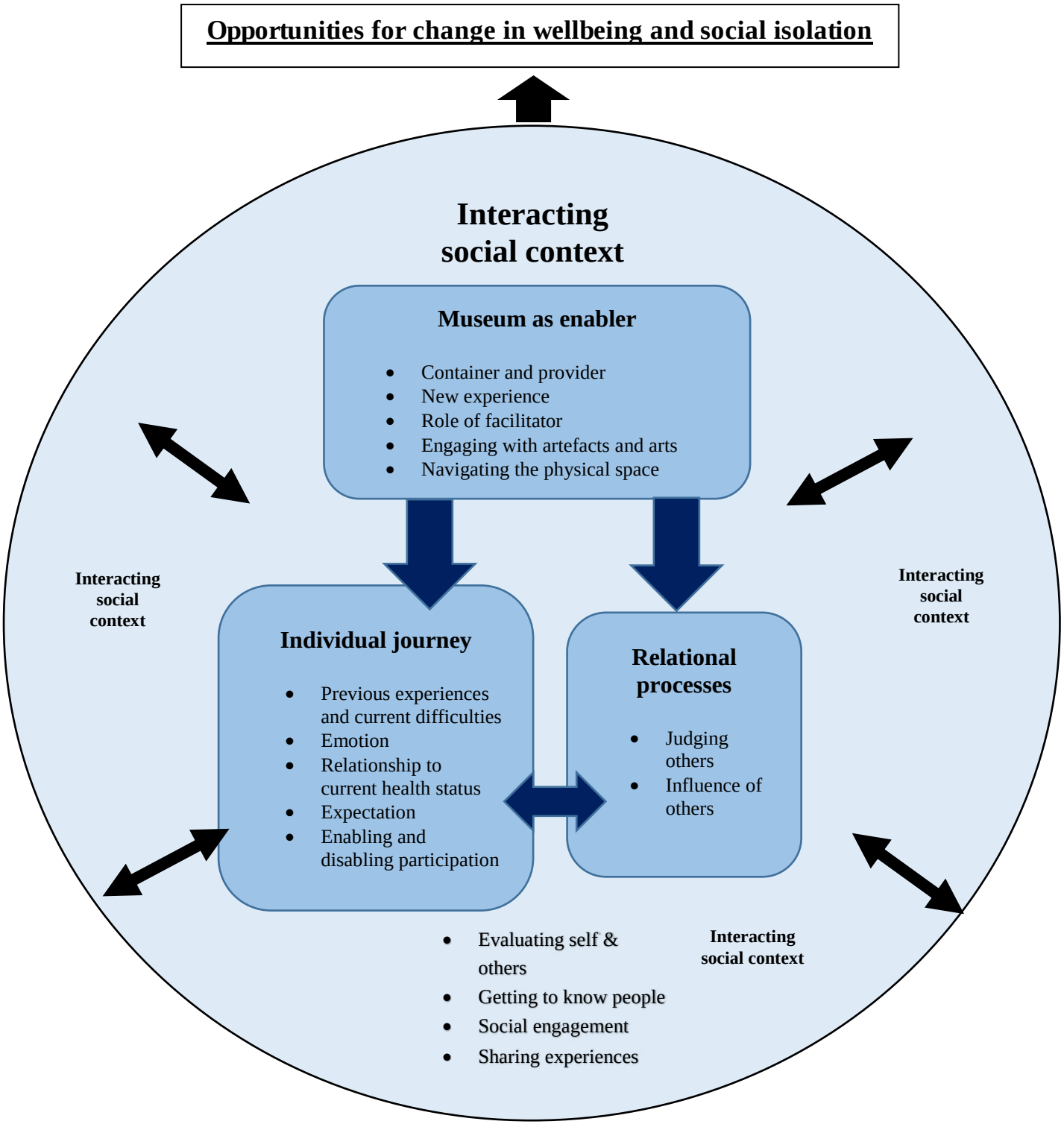

Figure 1. Explanatory processes creating opportunities for change in wellbeing and social isolation as described by participants in a museum programme.

The process of social engagement helped with relationship difficulties that one participant had been having, providing an opportunity to connect with others, thus making the difficulty feel less significant:

> It was actually wonderful for me because… I sat with two other people who really liked me and the thing is I've… felt really let down by a friend and erm, and this lady, she just liked me right away and she said,… you know 'you sit next to me, I like you' and erm she was always so pleased to see me [P7].

However, not all participants wanted to embrace social engagement with one saying "no, I don't think I particularly wanted to make any longer term connections" [P10]. This highlights the influence of individual beliefs affecting the extent to which the programme might engender change. Rejecting the social experience could be a barrier to connection, increasing the likelihood of isolation. For example, one participant described their idea of what the programme was predominantly for, "if you want the social thing you can have it afterwards, you are there to, well, in a way to learn, if you want the social side of it you can do it afterwards" [P4]. This belief makes it less likely this participant would see socialising as the task of the programme and as a result, would be less likely to engage.

Sharing experiences. **S**haring previous knowledge and experience led participants to feel more confident with engaging in the programme, "if someone asked me about something and I knew the answer, I'd tell them" [P12]. They were also able to share their museum experiences with others, "yesterday I was speaking to a friend and she said 'is that what you learned when you went there?' and I say 'yes' " [P2, 3MFU]. Self-esteem is increased through this process, enabling benefit to be gained from the programme.

Sharing their experience was also a catalyst to activity and connection, highlighted by people planning to go to the museum with others, "I'm trying to tell friends so that if I can get company to go along, it would be better" [P9, 3MFU]. Trying to spread the word and engage

other older people is another way the sharing process provided opportunities for connection, *"*I'm trying to stimulate other people into doing it, but erm, it's difficult with really is difficult with this age group" [P9, 3MFU].

Museum as Enabler

The museum programme enabled new experiences, relational processes and an individual journey. The facilitator, physical space and activities were all contributors in this process.

Container and provider. The containment and predictability of the 10-week structured programme, together with the opportunities for learning and meeting others, built confidence and self-esteem, "it opened doors for me, you gave us the opportunity to explore things that we wouldn't have done by ourselves. Normally I would never have dared come into this university*"* [P3], and "you have pinpointed a way to us and said 'look, if you want to come to the museum, this is what you have to do, we showed the way, the ropes, now you can do it by yourself" [P1].

One of the ways the museum built confidence was by providing the space and encouragement to try something new:

> Anything like this sort of thing or going to talk to people, it helps lonely people, helps with confidence as well and I think that's the other thing with being lonely or on your own…..you haven't got the confidence to go in on your own [P12].

Confidence in social interaction was another benefit, "it helps me to realise that you can enjoy people's company in different situations" [P10, 3MFU] and "well it was just sort of, interacting with them and sort of having a laugh and a joke" [P4]. The programme gave people "a chance to get to know each other" [P1] and "…very glad to be out and about and seeing people around" [P5, 3MFU].

Over the 10-week period, one participant's passport showed how the programme enabled the group to change over time. At week two, this participant said "getting to know members of the group" [P8, passport] and by week five, "a lot friendlier and the group seemed to become more relaxed" [P8, passport]. Another participant at week nine described the group as "pleasantly familiar" [P5, passport] highlighting the settling down and cohesion of the group over time. One of the groups continued to meet regularly after the programme suggesting that the environment contained anxiety about socialising, creating opportunity for further connection, "although I was nervous about meeting people, I was looking forward to these and now the last Friday in every month I've got something to look forward to whereas before it was just, oh, you sort of plod on day to day" [P4, 3MFU].

The museum also enabled connection to the past and to the local area, "no, no, I like the town very much too. Well I mean I do feel a part of it now and this course has helped me feel part of the society, very nice" [P5, 3MFU] and "I haven't been to the museum for years, they have more things than when I went and I'm always interested in [Kent town], the history of [Kent town]" [P2, 3MFU]. Participants also acknowledged the mental benefit of learning, "something to get my, keep my mind stimulated, something to do and I like a museum and it sounded very interesting" [P5]. Another participant described the longer term impact, "I've learnt so much from it you know. It's expanded my thinking, it's keeping my brain going because it's given me a different way of looking at things, and I really enjoy that" [P9, 3MFU].

New experience. The museum programme was a new experience for many participants, something they previously thought to be inaccessible or had not considered, "I've lived in [town] for so long…..the X museum and the X art museum, I didn't know they existed. I thought they were wonderful" [P7]. It was also something outside of the norm,

enabling new things to be experienced, "it's different going to the museum, I suppose it's just something new that I got involved in" [P6, 3MFU].

Another way participants experienced it as a new experience arose from their expectations, "I thought it would just be people sitting around with these things and talking. I didn't know we were getting a talk" [P2]. This might include how they evaluated themselves or others or how they had previously interacted with museums and organised programmes, "I always visit the museum, I'm into this thing, but erm this is another incentive" [P1]. These altered expectations are likely to feed back into their social context, changing future expectations of museums and of other people.

Another important new experience was the programme enabling social interaction in a different context:

> because it was totally different things that came into conversational topics in the group, I go to erm you know it was totally different and interesting and it was nice to speak with different people [P9].

These examples capture the essence of a new experience creating the potential for change, both in wellbeing and social isolation, and the programme interacting with individuals' social contexts.

Role of facilitator. The facilitators enabled new experiences, learning and social interaction, providing a human element by imparting knowledge and modelling confidence and enthusiasm for learning. The personal characteristics of the facilitators were pivotal in this, "oh they were great personalities I thought. Nicely outgoing, not pushy. And er, encouraging. They were both very good" [P10] and "the facilitator was very clear and detailed, super person" [P3, passport]. Similarly, the way the facilitators interacted with the participants created a respectful interaction that impacted how people felt, "how generous and giving the experts were of their time and their knowledge……erm each of them they just

spoke to us nicely" [P7]. The participants felt privileged to have the experts giving their time and knowledge and this changed participants' self-evaluation by suggesting they were important enough to have the time and attention of these experts. Facilitators also enabled participants to feel confident, "if there was any questions we could raise them, you weren't made to feel stupid" [P4] and "I'm not a great question asker, but, anything I wanted to ask I managed to get out and get an answer, I would normally sit back but in this little group it wasn't difficult" [P5].

Engaging with artefacts and arts. One of the ways activities enabled change is captured by a participant describing how the activities enabled her to try something new, "I'd never painted on canvas before and something I'd never thought of trying either" [P4]. Ability and expectations were influenced by previous experiences and evaluations of self and others. However, the museum enabled them to have a go and the feeling of being alongside other participants was a catalyst, "if you got stuck on perhaps one of the crafts or something, there might be somebody from the group to help you" [P4]. This experience was something to share with others allowing connection, communication and changed evaluations of themselves or others.

Engaging with artefacts was important to self-esteem, giving a sense that they were trusted with important items, "I liked the Tunbridge Ware, seeing it and feeling it, because all I've done is see it on telly on antique things" [P2, passport]. Moreover, it evoked a feeling of connection to the past and individual memories, "the warden helmet reminded me of my father because he had one during the war" [P2, passport]. It was also enriching to the learning experience, and created opportunity to use the imagination, "I think the tactile aspect is very important, like yesterday when we looked at the cones after seeing them in the showcases……it brings the people who created the objects closer to you" [P10].

Navigating the physical space. Some described the layout creating a feeling of confidence, "it's nicely laid out, it's very easy to find your way around" [P11] and, "it's quite a welcoming building, it does include you. There's no feeling of things not being accessible, everything seems to be there for you and it's a welcoming place" [P10].

The navigation of the space enabled confidence and alleviated anxiety about entering daunting places, "I loved the confined space i.e. not over three floors of giant square footage and the closeness of the specimens to see up close" [P7]. The space also contributed to an easier interaction, "we even had access to all the equipment we needed, you know, there was no crowding or fighting you know over everything, it was very well planned and laid out" [P4], and was a factor in how the artefacts were experienced, "I just absolutely loved it because it was contained, it was a small space and it was very easily accessible even though you couldn't touch it, the stained glass, it just felt in such close proximity" [P7].

In contrast, one participant described an experience of the physical space leading to a feeling of exclusion and highlights one of the ways that space interacts with internal states:

> I felt as though we were in a back office of the university, we weren't really where it was going on and the rest was for everybody else. I found that disappointing. I think that being older what you're looking for when go somewhere like this, is for it to be exciting because there's all these young people around, learning, discovering and you want to see that energy [P8].

Individual journey

The 10-week experience was something novel and created opportunities for learning, emotional experience, and personal connection to something within themselves.

Previous experiences and current difficulties. The programme created a reflective process for participants to think about their activity levels and their abilities, perhaps connecting with some sadness or loss. For example, *"*well, recently I have stopped doing a

lot of things, I don't watch television anymore" [P1] and "you know, it's the weekend as well, alright I'm knitting but you can only do so much" [P4]. For other participants, the programme led them to reminisce and connect to activities that they used to do but also the sadness that physical health limitations meant it was no longer possible, "I used to do, you see the cakes that I did, I made for people and wedding cakes and everything and then with this, it just kept me back" [P2]. Participants also talked about roles they have that might limit their capacity for activity:

> I'm rather tied up with my wife's operation but I'd like to, I might find something useful and interesting to do…..I've really been too busy and occupied trying to catch up with other jobs necessary [P5].

These examples capture the interactive nature of experiences and stressors people bring to the programme and the potential for the programme to offer something different.

Emotion. Positive change to emotions from the museum experience were described in terms of confidence, mental stimulation and privilege, "I just felt privileged" [P7] , "I think I'm happiest when learning, I felt engaged with the topic" [P8, passport] and:

I'm very much better if I mentally engage with something, some activity which stretches me, the programme was very beneficial in that way. I think it's given me some confidence, I have lost confidence in recent years but it felt a good place to be and I did feel more confident [P10, 3MFU].

More generally, participants described feeling "a lot more cheerful than I was" [P4], "I felt happy being in the museum" [P1, passport] and "felt happy and wanted to learn more" [P3, passport]. Others described how they might have felt if they had not been, highlighting an emotional shift, "I would've felt low and erm, low and unloved and erm, just I might've been more erm, yeh just a bit more low" [P7].

Relationship to current health status. Part of the personal journey created by the programme was how people spoke about physical and mental health. Many participants either talked about their limitations, "I can't do volunteer work in my condition" [P2] and "I can't stand as much as I used to and exhibitions you need to stand for a long time" [P1], or in contrast played down their problems, "I'm fairly mobile, a few aches and groans but I manage most things" [P6]. However, the programme enabled people to take part regardless, "I suffer badly from depression and she found the piece of paper which advertised in the Beaney and she thought it sounded like the sort of thing that would interest me……so I went ahead and applied" [P7]. Another participant described how she struggled to go sometimes, but the benefit outweighed this struggle, "There was a couple of times when I really felt 'oh dear' and I wasn't feeling up to it but it spurred me on to come, because of what I was going to get out of it and I would far rather do that than take tablets" [P9].

These responses highlight the accessibility and inclusivity of the programme for those with health limitations and the motivational influence it had in creating an alternative to medical interventions. Moreover, the learning and mental stimulation provided evidence for participants that they were cognitively able despite being concerned about decline. This increased self-confidence and alleviated anxiety:

> I loved the talks but I felt as if the retention of the information, but now when I'm talking about it I think I have got more retention, I realise when I speak about it that erm, it's probably just how it felt at the time [P7].

Expectation. As part of their individual journey, participants described how they felt when the programme was suggested to them, "I thought it was 10 weeks geology which I was interested in and they said no, it's not…..but if you turn up they might allow you to join in, so I turned up*"* [P7] and *"*I wasn't clear about the nature of the project but anyway, it sounded, I

was interested in it anyway, I'm not sure I ever quite understood the purpose actually but, I enjoyed everything very much*"* [P5].

These expectations may have influenced their experience and how much they participated. For example, one participant expected the primary function of the programme to be for learning, rather than socialising, "if you want the social thing you can have it afterwards, you are there to, well, in a way to learn*"* [P4]. This might have limited the extent to which this participant engaged in the social component of the group.

Participants could either have been passive or active group members and this is likely to be influenced by individual characteristics, social context and expectations. Perhaps being shy or anxious about socialising, or sceptical about the programme, might lead someone to hold back and not fully engage. Conversely participants who were keen to connect with new people were likely to gain the most benefit.

Enabling and disabling participation. Some people spoke about their feelings and personal attributes that might have helped them engage with the programme. The way participants presented themselves either protected them from rejection or allowed them to participate, feeling more equipped to take on the challenge of joining something new and the uncertainty this created. One participant explicitly talked about concealing how they were feeling "I was feeling a bit, when I first went there because of the problems I'd had I was a bit nervous, you know what us men are like, we don't like to show it, you mustn't let anybody know*"* [P11]. However, despite this anxiety, he still felt able to go and this might have been about his expectations of gaining some benefit if he worked through his anxieties.

Participants often talked about their previous occupation, particularly in the context of the museum being a learning environment and them being entitled to take part, "I quite enjoy it yes, I think because of my background of teaching, I'm not afraid to come out with things, say things which might provoke or contribute*"* [P11].

Others presented themselves as capable, “I speak of a lot of languages” [P1]. Conversely some participants performed being less able, perhaps setting up lower expectations of what they might be able to do, “I’m no good at that sort of thing [P2], and “I cannot do craft and I’m no good at it” [P2, passport]. Ultimately this served to either inhibit participation or enable contribution and involvement. By either setting up an expectation that they are capable, or the opposite as someone who is less able, this is likely to interact with individual anxieties and expectations about the programme.

Relational Processes

The programme was aimed at people who were socially isolated and as such, the extent to which the museum created opportunity for relationships is pivotal. One of the complicating factors in this is participants judging others.

Judging others. This had a protective element that allowed people to engage without pressure to like everyone or to be liked. Judging others negatively motivated them to do something different, ensuring that they were not the same, “I think a lot of it is when they retire, they’ve got no other interests, they’ve never developed any other interests apart from work and then they retire and they find they can’t find any*”* [P6]. This is also highlighted by a participant who positioned themselves as different:

> [name] said she couldn’t come cos she didn’t feel up to it and I thought, you see something in me says if you make the effort to go, it’s going to lift you…. And I look at it that way but she didn’t…..it’s a little bit sad when they don’t [P9].

The programme enabled people to create a more positive narrative about themselves and judging others positively enabled connection more easily, *“*They all had enquiring minds it seemed, they were interesting people” [P10, 3MFU] and “they all seemed friendly and alright to talk to*”* [P2]. There was a sense that the group connected and shared in a common

experience, likely to have been influenced by an individual's outlook and judgement of others.

Influence of others. The actions or behaviours of other people, rather than judgements about them, enabled a relational process. For example, hearing other people's experiences enriched their own experience**:**

> it was interesting because everybody had a different point of view and a different history so it added variety to the experience, especially hearing about people's erm experience of things like the war….and people's experiences of travel as well. I thought the group of people made it more enjoyable [P10].

Other people's influence also created a sense of interest and connection, seen in one example of someone making tea, "we all loved tea, we were all touched, because if you live on your own, somebody to make a cup of tea for you is really nice" [P7]. Another participant described a relational process in a shared focus, "I think everybody seemed to get involved in whatever project they were on, didn't they, so nobody sort of sat back and didn't take any notice and I think everybody joined in" [P6]. The influence of the staff to the relational process was also highlighted, "the fact that the facilitator took more or less low profile role when we were together talking, that was good" [P1].

As discussed earlier, the museum programme operates within a social context, enabling change through both an individual journey and relational processes. This feeds back to interact with the social context, creating opportunities for change in both wellbeing and social isolation. Complexities of this process include individual characteristics, previous experiences, current stressors such as caring responsibilities, loss and health difficulties.

Discussion

This study offers an explanation of how a museum programme created opportunities for change in wellbeing and social isolation in older people, showing the complex interactions between individual and social processes.

Theoretical Implications

This museum programme offered a unique opportunity to enhance psychological wellbeing and tackle social isolation through addressing both self-esteem and attachment. For example, attachment theory in later life (Weiss, 1991) is relevant when thinking about social isolation and relationships. As Bowlby (1969, 1979) described, attachment behaviour is particularly evident in times of loss or poor health (Browne & Shlosberg, 2006) and it has been suggested that a relationship exists between secure attachments and psychological wellbeing. This is equally important in later life, impacting feelings of self-worth and social integration (Andersson & Stevens, 1993). The museum programme appeared to create opportunities for both connection to previous experiences and memories, thereby linking to past attachment figures, but it also provided opportunities to create new relationships, thereby enhancing feelings of connection, which also contributes to wellbeing.

Research suggests that wellbeing is enhanced by a sense of belonging and community and that ageing can limit opportunities for linking to social networks (Riger & Lavrakas, 1981). This links with self-esteem and opportunities for self-validation which can be reduced in older age (Orth et al., 2010). Emotional and behavioural components of attachment suggest that values and social attachments are as important as physical contacts (Riger & Lavrakas, 1981). Education can increase cultural exposure and connect with values, thus improving self-esteem (Krause, 1995). In this regard, museum programmes are well placed to offer access to learning opportunities and chances for people to evaluate their relational values (Orth et al., 2010).

The social and relational aspects that emerged in the current study were important both in terms of self-esteem, wellbeing and attachment. It is suggested that relationships in later life need to be both emotionally meaningful and positive. For many people, a process of social pruning precedes in mid-life, creating smaller and more intimate networks that are more beneficial to mental health (Charles & Carstensen, 2010). This means that casual relationships are less important and might explain the reluctance of some to create relationships on the museum programme. Moreover, in a bid to protect their wellbeing, people are more influenced by moral character than abilities when judging new people. They are also likely to avoid negative interactions, instead preferring positive stimuli (Hess, 2005). In this current study, the process of judging others and the value placed on the risk of forming relationships, held participants back from connecting with new people. However, for those who felt the programme was personally and emotionally meaningful, any relationships created in this context were more likely to be experienced as meaningful.

Wellbeing theories also incorporate many of the concepts discussed here and the model created in the current study provides evidence of all the elements proposed by NEF's wellbeing definition. For example, the various programme components enabled learning, connection, activity and opportunities to engage with others and share experiences. What also emerged from the temporal nature of the programme was the building of relationships and group cohesion over the 10 weeks, along with a growing familiarity with the physical space and the programme's structure. The passport data showed this development and highlighted a settling down into the pattern of the programme and familiarity with the group. Similarly, by utilising the 3MFU interviews there was a sense of participants reflecting on their experience and consolidating their learning, often by sharing the knowledge with others. The 3MFU also provided information about continued contact between participants, or not, and how the museum experience enabled subsequent connections and activities elsewhere.

Clinical Implications

With an ageing population and reduced funding for health care, public health is increasingly being utilised to provide interventions that focus on prevention of poor health and enhancing wellbeing. This offers new opportunities for clinical psychologists, as they did in the current study, to work with colleagues from museums, as well as commissioning groups, in shaping new programmes. With the link between wellbeing, social isolation and physical health being widely accepted, this research adds to the current evidence by identifying how such schemes are beneficial. By understanding the processes that are operating, interventions and programmes can be tailored and offered in a cost effective and timely manner. For example, the process of building new relationships and connections that might endure beyond the intervention, involves a complex process influenced by individual characteristics and previous experiences. Recognising these complexities in future programmes would benefit recruitment but also provides information about how the sessions could be structured, bearing in mind the individual differences of group members.

In the current study, participants widely denied being lonely, despite recognising that others were and that the programme would be beneficial to those who were lonely. This has implications for how programmes are advertised and should be considered when recruiting. The idea of people coming together for an interesting activity might be the attraction for many participants, offering benefit to those who are looking for extra richness, rather than addressing loneliness. This has implications in terms of who is targeted and who attends.

Implications for Future Research

The extent to which interventions in later life can change earlier life experiences, patterns of attachment, experiences of emotion, and physical health difficulties, is of course limited. Perhaps social programmes such as those in museums will mostly appeal to people with a stronger sense of self and existing social networks. Therefore, exploring participant

experiences in an individual context could be valuable to consider; for example, knowing about participants' previous experiences of groups, learning, and social engagement. Moreover, with an older population, a plethora of individual life stories, characteristics and experiences of attachment and loss, are all important factors that future research could consider, particularly in how these factors interact with the components of the programme.

Future research could also consider participants from other backgrounds, for example, harder to reach older people such as homeless groups or BME populations. Similarly, the current participant pool was drawn predominantly from organisations that work mostly in group formats and harder to reach participants might also include those who do not readily engage in groups or organised activities currently.

Limitations of the Study

During interviews participants often rejected the notion that they were isolated and their personal idea of wellbeing was not clearly defined. Despite being asked specifically about their wellbeing, most participants answered the question in terms of mental health or activity levels. Perhaps they had a different idea of whether the museum programme improved their wellbeing, qualitatively. By measuring and asking about something they were not familiar with, then it could be argued that the model describes changes to concepts not targeted by the research, such as increasing their knowledge or providing them with an experience of a novel activity. Moreover, the study utilised existing interview data and therefore theoretical sampling could not be extended to ask additional interview questions that could have addressed this.

Nuances found in the data were not explored as part of this study. For example, there were differences between the information some participants gave in their initial interview and the data they provided in their passport. The process of emotionally laden episodic memory (Hamann, 2001) therefore impacts the ability to reflect on, and connect to, the experience,

limiting any long lasting benefit. It might also explain some of the differences between how the programme experience was reported in later interviews, and how it was reported in passports completed directly after each session. For example, one participant was mostly positive in her passport feedback but in the interview was more negative, particularly about other participants.

The background and previous experiences of participants could also have impacted various aspects of the results. For example, expectations and experiences of education and learning may create differences in how the programme was evaluated. Similarly those who had experience in groups might have a template or expectation for what might happen, how they should interact and how others should behave. Limited information was collected about this aspect, for instance, their expectations and previous experiences of learning and groups. With this in mind, the programme may have attracted people who were likely to benefit most because of their previous experiences. For example, there were a few retired teachers in the group who held education and museums in high regard. Similarly, as a result of the exclusion criteria for the study (see table 1), people with some disabilities were not able to access the programme. Future studies need to address this by tailoring programmes to enable access for people with disabilities.

Conclusion

Social prescribing has developed in recent years and offers potential to address a range of health and social problems in various target populations. This study aimed to explore how a museum programme created opportunities for change in older participants' experiences of wellbeing and social isolation. Using a grounded theory analysis, a model was proposed suggesting elements of the museum that created opportunities for change, such as providing a new experience, the role of the facilitator, the activities, and physical space. These elements created both an individual journey that influenced emotion, health, activity levels,

expectations and how they presented themselves, but also relational processes of judging others and influencing others. The individual journey and relational processes impacted each other to enhance the experience. These elements operated within an interacting social context to influence the experience but also the museum programme impacted this social context; for example by changing how participants evaluated themselves and others or how they communicated and engaged socially. Evaluations, beliefs and experiences both predict how someone might approach social interaction, but also might be a contributing factor to social isolation prior to entering the programme. However, the museum programme provided opportunities to disprove or enhance previous beliefs. The model links to psychological concepts, such as self-esteem and attachment theory to help build understanding of individual characteristics and life stories that might be important factors in later life social interventions.

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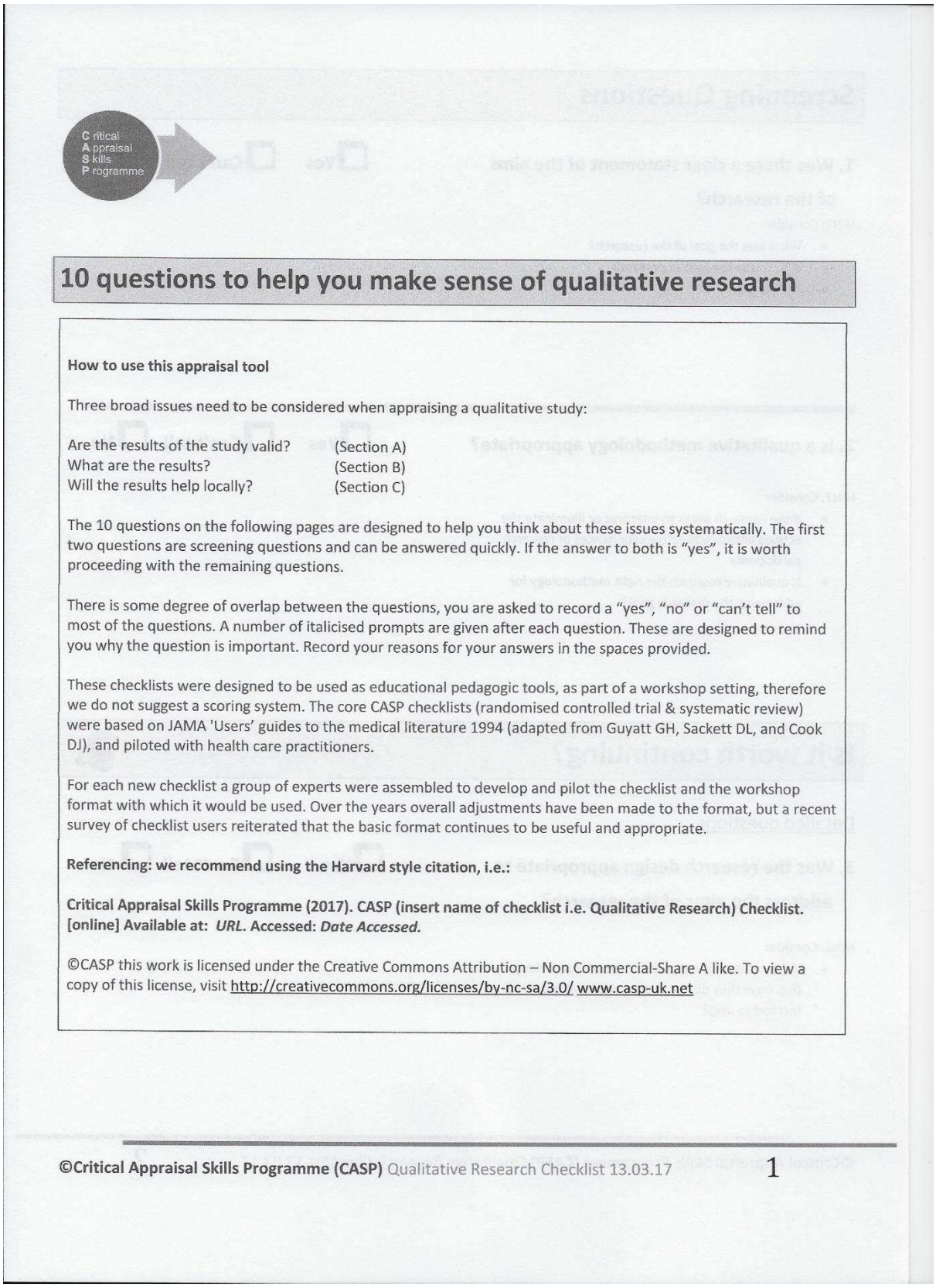
Section C: Appendices of supporting material

Appendix A: Critical Appraisal Skills Programme (CASP) tools



C ritical
A ppraisal
S kills
P rogramme

10 questions to help you make sense of qualitative research

How to use this appraisal tool

Three broad issues need to be considered when appraising a qualitative study:

Are the results of the study valid?	(Section A)
What are the results?	(Section B)
Will the results help locally?	(Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.:

Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. Qualitative Research) Checklist. [online] Available at: *URL*. Accessed: *Date Accessed.*

Screening Questions

1. Was there a clear statement of the aims of the research? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

2. Is a qualitative methodology appropriate? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?

Detailed questions

3. Was the research design appropriate to address the aims of the research? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the researcher has justified the research design (E.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- If methods were modified during the study. If so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

6. Has the relationship between researcher and participants been adequately considered? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during
  (a) Formulation of the research questions
  (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

12 questions to help you make sense of cohort study

How to use this appraisal tool

Three broad issues need to be considered when appraising a cohort study:

Are the results of the study valid?	(Section A)
What are the results?	(Section B)
Will the results help locally?	(Section C)

The 12 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.:

Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. Cohort Study) Checklist. [online] Available at: *URL*. Accessed: *Date Accessed.*

(A) Are the results of the study valid?

Screening Questions

1. Did the study address a clearly focused issue? ☐ Yes ☐ Can't tell ☐ No

HINT: A question can be 'focused' In terms of

- The population studied
- The risk factors studied
- The outcomes considered
- Is it clear whether the study tried to detect a beneficial or harmful effect?

2. Was the cohort recruited in an acceptable way? ☐ Yes ☐ Can't tell ☐ No

HINT: Look for selection bias which might compromise the generalisability of the findings:

- Was the cohort representative of a defined population?
- Was there something special about the cohort?
- Was everybody included who should have been included?

Is it worth continuing?

Detailed questions

3. Was the exposure accurately measured to minimise bias? ☐ Yes ☐ Can't tell ☐ No

HINT: Look for measurement or classification bias:

- Did they use subjective or objective measurements?
- Do the measurements truly reflect what you want them to (have they been validated)?
- Were all the subjects classified into exposure groups using the same procedure

4. Was the outcome accurately measured to ☐ Yes ☐ Can't tell ☐ No

minimise bias?

HINT: Look for measurement or classification bias:

- Did they use subjective or objective measurements?
- Do the measures truly reflect what you want them to (have they been validated)?
- Has a reliable system been established for detecting all the cases (for measuring disease occurrence)?
- Were the measurement methods similar in the different groups?
- Were the subjects and/or the outcome assessor blinded to exposure (does this matter)?

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5. (a) Have the authors identified all important confounding factors? ☐ Yes ☐ Can't tell ☐ No

List the ones you think might be important, that the author missed.

(b) Have they taken account of the confounding factors in the design and/or analysis? ☐ Yes ☐ Can't tell ☐ No

HINT: Look for restriction in design, and techniques e.g. modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors

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6. (a) Was the follow up of subjects complete enough? ☐ Yes ☐ Can't tell ☐ No

(b) Was the follow up of subjects long enough? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- The good or bad effects should have had long enough

---

to reveal themselves

- The persons that are lost to follow-up may have different outcomes than those available for assessment
- In an open or dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort?

(B) What are the results?

7. What are the results of this study?

HINT: Consider

- What are the bottom line results?
- Have they reported the rate or the proportion between the exposed/unexposed, the ratio/the rate difference?
- How strong is the association between exposure and outcome (RR,)?
- What is the absolute risk reduction (ARR)?

8. How precise are the results?

HINT: Look for the range of the confidence intervals, if given.

9. Do you believe the results?

☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- Big effect is hard to ignore!
- Can it be due to bias, chance or confounding?
- Are the design and methods of this study sufficiently flawed to make the results unreliable?
- Bradford Hills criteria (e.g. time sequence, dose-response gradient, biological plausibility, consistency)

(C) Will the results help locally?

10. Can the results be applied to the local population? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider whether

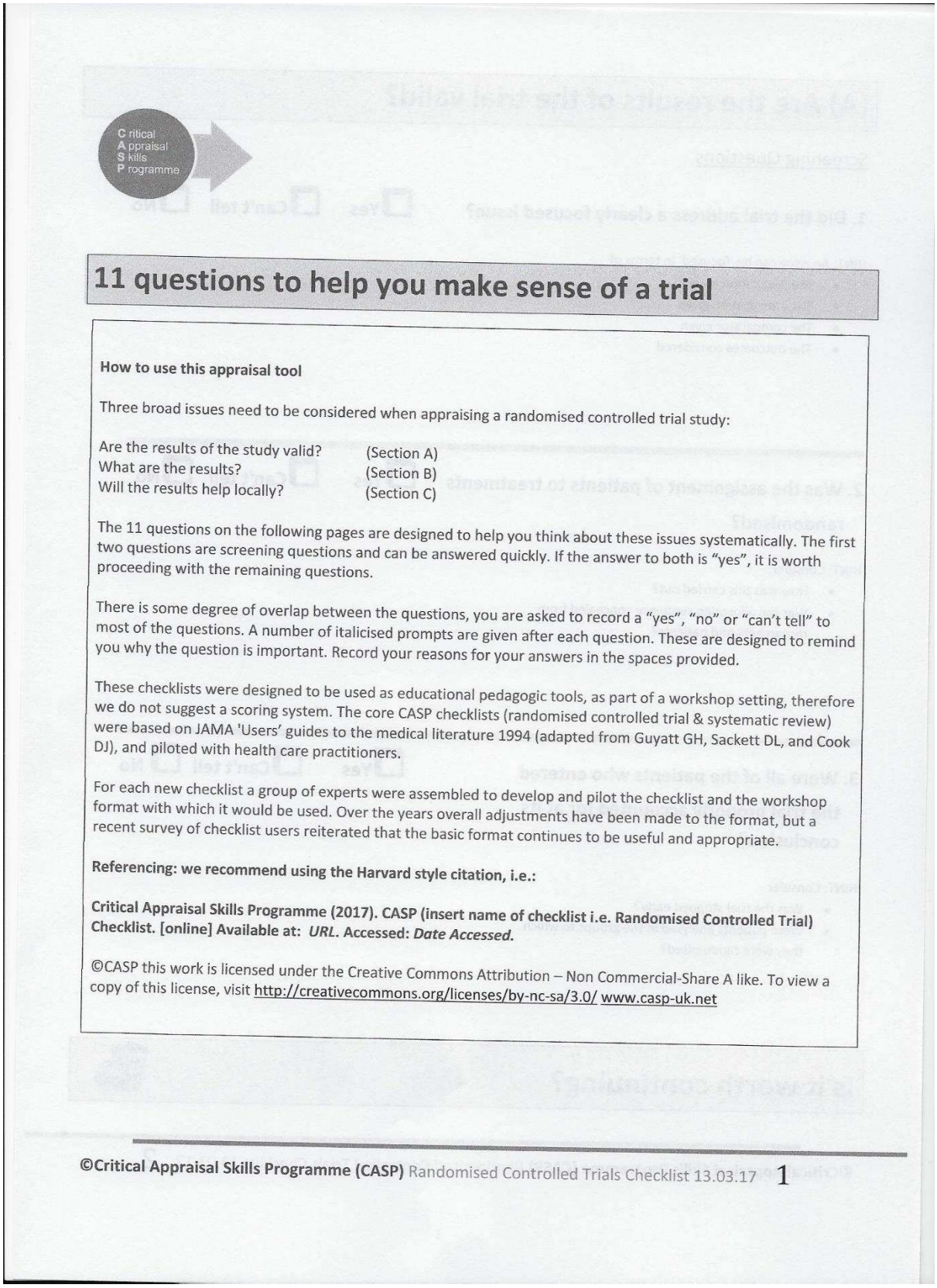
- A cohort study was the appropriate method to answer this question
- The subjects covered in this study could be sufficiently different from your population to cause concern
- Your local setting is likely to differ much from that of the study
- You can quantify the local benefits and harms

11. Do the results of this study fit with other available evidence? ☐ Yes ☐ Can't tell ☐ No

12. What are the implications of this study for practice?

HINT: Consider

- One observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making
- For certain questions observational studies provide the only evidence
- Recommendations from observational studies are always stronger when supported by other evidence



C ritical
A ppraisal
S kills
P rogramme

11 questions to help you make sense of a trial

How to use this appraisal tool

Three broad issues need to be considered when appraising a randomised controlled trial study:

Are the results of the study valid? (Section A)
What are the results? (Section B)
Will the results help locally? (Section C)

The 11 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.:

Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. Randomised Controlled Trial) Checklist. [online] Available at: *URL*. Accessed: *Date Accessed*.

(A) Are the results of the trial valid?

Screening Questions

1. Did the trial address a clearly focused issue? ☐ Yes ☐ Can't tell ☐ No

HINT: An issue can be 'focused' In terms of

- The population studied
- The intervention given
- The comparator given
- The outcomes considered

2. Was the assignment of patients to treatments randomised? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- How was this carried out?
- Was the allocation sequence concealed from researchers and patients?

3. Were all of the patients who entered the trial properly accounted for at its conclusion? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- Was the trial stopped early?
- Were patients analysed in the groups to which they were randomised?

Is it worth continuing?

Detailed questions

4. Were patients, health workers and study personnel 'blind' to treatment? ☐ Yes ☐ Can't tell ☐ No

HINT: Think about
- Patients?
- Health workers?
- Study personnel?

5. Were the groups similar at the start of the trial? ☐ Yes ☐ Can't tell ☐ No

HINT: Look at
- Other factors that might affect the outcome such as age, sex, social class

6. Aside from the experimental intervention, were the groups treated equally? ☐ Yes ☐ Can't tell ☐ No

(B) What are the results?

7. How large was the treatment effect?

HINT: Consider

- What outcomes were measured?
- Is the primary outcome clearly specified?
- What results were found for each outcome?

8. How precise was the estimate of the treatment effect?

HINT: Consider

- What are the confidence limits?

(C) Will the results help locally?

9. Can the results be applied in your context? (or to the local population?) ❑ Yes ❑ Can't tell ❑ No

HINT: Consider whether

- Do you think that the patients covered by the trial are similar enough to the patients to whom you will apply this?, if not how to they differ?

10. Were all clinically important outcomes considered? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- Is there other information you would like to have seen?
- If not, does this affect the decision?

11. Are the benefits worth the harms and costs? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- Even if this is not addressed by the trial, what do you think?

Appendix B: Ethical Approval Letter and Permission to use the Data

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Appendix C: Information Sheet for participants

MUSEUMS on Prescription

Research Project Information Leaflet

You are invited to take part in 'Museums on Prescription', a research project that is investigating the benefits of taking part in museum activities.

This leaflet explains why we are carrying out the project and what will be involved if you take part. Please feel free to ask if there is anything that is not clear or that you would like more information about.

What is 'Museums on Prescription'?

'Museums on Prescription' is a three-year research project (2014 - 2017) being carried out by University College London and Canterbury Christ Church University, which is funded by the Arts & Humanities Research Council. The project is running in Central London and across Kent.

Which museums are involved?

Museums and galleries involved in the project include the British Museum; the British Postal Museum & Archive; Islington Museum & Local History Centre; Museum and Study Collection, Central Saint Martins; UCL Museums; Beaney House of Art and Knowledge, Canterbury; Maidstone Museum and Bentlif Art Gallery; and Tunbridge Wells Museum & Art Gallery.

What is the purpose of the project?

The purpose of the project is to connect lonely older people at risk of social isolation to museums and galleries involved in the 'Museums on Prescription' project. If you are aged 65 or over, you can be referred to the project through adult health and social care services or a local charity, such as AgeUK. The project will research the value and impact of social prescribing by health and social care professionals to the arts and cultural sector, specifically to activities in museums and galleries.

What will happen in the sessions?

'Museums on Prescription' sessions will consist of museum focused activities that may include museum object handling and discussion, guided visits to permanent displays and special exhibitions, creative writing and arts and crafts led by artists and museum staff. Another adult, such as a carer, relative or friend, will be welcome to attend the museum sessions with you. There is no charge for attending.

How long will the sessions take?

Session will last for up to two hours depending on the location, usually on the same day every week for ten weeks.

Do I have to take part?

It is entirely up to you to decide whether to take part. If you do choose to take part you will be given this leaflet to keep and be asked to sign a consent form. Even after you have given consent, you are free to withdraw at any time without needing to give a reason. A decision not to take part or to withdraw will not affect the standard of any care you might receive.

What are the possible risks of taking part?

There are no risks involved with taking part in the study. You will not be liable for any damage or breakages that might occur.

Arts & Humanities Research Council | Canterbury Christ Church University | UCL

What will happen if I agree to take part?

If you agree to take part, we will explain more about the sessions and answer any questions you might have about the research project. We will ask you to fill out a questionnaire before and after three of the sessions and ask if you are willing to take part in a short interview after the whole programme has finished. We will also ask whether you agree to the sessions being recorded. If you have any further questions or comments, you will be welcome to discuss these with us. You will be asked to sign a consent form.

Will my details be kept confidential?

Yes, only members of the research team will have access to your personal details. All information collected during the course of the research will be treated in the strictest confidence. Data will be stored by University College London in a secure database and may be used for future studies. Data may be transferred with no personal identifiers to researchers or sponsors of the research.

Every effort will be made to ensure the security of this information. The results of this study may be published or used for teaching purposes however your name or other identifiers will not be used in a publication or in teaching material unless your specific permission has been sought.

For more information please contact:

Dr Linda Thomson
Lead Research Associate
Darwin Building, University College London
Gower Street, London WC1E 6BT
020 7679 2649
linda.thomson@ucl.ac.uk

Dr Bridget Lockyer
Research Associate
Canterbury Christ Church University
Broomhill Road, Tunbridge Wells
Kent TN3 0TF
03330 117 111
bridget.lockyer@canterbury.ac.uk

Prof. Helen Chatterjee
Principal Investigator
University College London
h.chatterjee@ucl.ac.uk

Prof. Paul Camic
Co-Investigator
Canterbury Christ Church University
paul.camic@canterbury.ac.uk

or visit our website:
http://www.ucl.ac.uk/museums/research/museumsonprescription

This project has been approved by the UCL Research Ethics Committee
Project ID: 4526/001: Museums on Prescription
This project is covered by the UCL Data Protection Registration
Reference No: Z6364106/2015/05/53
Section 19 Research: Social Research

Research Project Information Leaflet

Appendix D: Participant Consent Form

Arts & Humanities Research Council | Canterbury Christ Church University | UCL

Project no.	
Participant no.	

CONSENT FORM

Title of project: Museums on Prescription

This project has been approved by the UCL Research Ethics Committee
Project ID: 4526/001: Museums on Prescription
This project is covered by the UCL Data Protection Registration
Reference No: Z6364106/2015/05/53: Section 19, Research: Social Research

Thank you for your interest in taking part in this research. Before you agree to take part, the person organising the research must explain the project to you. If you have any questions arising from the Information Leaflet or the explanation already given to you, please ask the researcher about these before you decide whether to take part. You will be given a copy of the Consent Form to keep and refer to at any time.

1. I have read the notes written above and on the Information Leaflet, and understand what the study involves. ☐
2. I understand that if I decide at any time that I no longer wish to take part in the project, I can notify the researchers involved and withdraw immediately. ☐
3. I consent to the processing of my personal information for the purposes of this research project. ☐
4. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998. ☐
5. I agree to be contacted in the future by project researchers to participate in follow-up interviews as part of the project. ☐
6. I understand that from time to time my participation will be recorded and I consent to the use of recorded material as part of the project. ☐
7. I agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this project. ☐

Name of participant (please print): .....

Signed: ..... Date: .....

Name of researcher (please print): .....

Signed: ..... Date: .....

Appendix E: Initial Interview Schedule

Participant end of programme interview guide

To participant: Thank you again for participating in the Museums on Prescription programme at _____Museum. As part of our evaluation I have a few questions to ask you. There are no right or wrong answers to the questions; we want to understand about your experiences and opinions—that's what is important to us. I am going to audio record your responses to make sure I get them right. Your interview is completely confidential. I will transcribe the interview and then erase it from the machine.

To Interviewer: The following areas (in bold) will be explored with participants at the end of their 10 week session, ideally within 1-3 weeks of the programme ending. Questions can be slightly modified as needed to accommodate a particular participant's abilities and needs. If a question results in a brief answer, try and gently probe for more.

1. **Initial contact**
    a. How did you find out about the Museums on Prescription programme at _____(name of museum)?
    b. Who told you about it?
    c. Do you recall *what* they told you?
    d. What was your reaction to the suggestion of going to a museum?
    e. Why did you want to take part in the project?
    f. How would you summarise your overall health and wellbeing before starting the programme?

2. **Access and accessibility**
    a. Have you been to a museum before? (probe when it was, did they go alone or with someone? Why did they go?)
    b. In the programme at (name of museum) that you recently completed, how did you get to the museum sessions? (probe for mode of transport/by foot, geographical distance from home, physical barriers and challenges including mobility issues)
    c. How long did it take you to go get to the museum?
    d. When you arrived at the museum how did you find getting around? (probe here about physical and psychological (cognitive) barriers/challenges)

3. **The overall museum building, physical space where the activities took place, and the collections**
    a. Please tell us what you liked and disliked about the building where the museum was located? (If needed, clarify that we want to know about the *physical space* of the museum).

b. What did it feel like to be in the museum? (probe as needed but don't lead, e.g. 'When you walked into the museum, what did you notice? What did that feel like?). Did you notice any emotional responses to being in the museum? What do you think triggered them?
c. Please take a moment and think about the specific room or rooms where most of your activities took place: What was/were the room(s) like? (probe: what did you think about the room? Did the room have a particular feel to it? What made it feel like that?)
d. Museums have a lot of things in them. Were there any objects or art work that you particularly liked or disliked? What about them in particular made you feel this way?(probe)
e. On a scale of 1 to 5 with 1 being not important and 5 being very important, how would you rate the objects and art work you saw in the museum? Could you tell me a bit more about why you chose that number?

4. **Participation and their experience of the group** (Areas 4 and 5 may be interrelated but we want to get a sense of both if at all possible)
    a. Your sessions at the museum took place with a group of other people. Could you tell me what it was like for you to be part of this group?
    b. What did you think of the other people in the group?
    c. How easy/difficult was it for you to participate in the group?
    d. Did you feel any differently in the group over time as the sessions went on? (probe: Did they get on better/worse/the same?)
    e. Now that the sessions are over we want to ask you a few questions about future plans:
        1. Do you have any plans to get together with other group members?
        2. Do you think you'll come back to the museum? (explore this more)

5. **Participation and their experience of the museum activities**
    a. On a scale of 1 to 5 with 1 being poor and 5 being very good, how would you rate your overall experience of being in the museum programme? Could you tell me a bit more about why you chose that number?
    b. You were engaged in different activities at the museum whilst in this programme. Were there any activities that you particularly enjoyed or found interesting? (probe: What was it about the activity that they liked? (if the person has memory problems this question may not be answerable)
    c. Were there other activities you liked? (probe: What was it about the activity that they liked?)
    d. Were there any activities that you didn't care for? (probe: What was it about the activity that they did not like?)

e. What could we have done better or differently to make it a better experience for you? (really probe here: getting to the museum; time of programme; facilitator; length of sessions; length of programme, content of sessions)

6. **Impact on the participant**

   Interviewer: *The next few questions are about the impact of attending the museums programmes on you. .*

   a. How useful was the programme in helping you to feel more connected and engaged with other people? Do you think programmes like this can help people feel more connected and less lonely? Did it help you in this way? If yes, how do you think it did that?
   b. Often communities do not provide older people with many opportunities to socialise. The Museums on Prescription project set out to see how museums could help bring people together to socialise, learn new things and have an enjoyable experience.
      i. Thinking about your participation in the project, what was it like to be in the group? Did it provide a good experience to socialise and meet others? If NOT, what could have been done better? If YES, How so?
   c. I want you to think back to the beginning of your engagement with the Museum programme and your [health/ wellbeing/ etc. as appropriate]. If you had not been coming to the Museum, what do you think would have happened to your [health/ wellbeing/ etc. as appropriate]?
   d. Why would this have happened?
   e. Since coming to the museum programme have you changed how you use state services such as the GP, NHS, social care or local council programmes? (if participant is uncertain no need to probe).

7. **Further Cultural and Social Activities**

   a. Since coming to the programme at the museum, have you had the opportunity to attend other cultural activities including returning to the museum? (If no, probe why, looking for obstacles and barriers, both external and internal)
   b. What suggestions would you like to offer the museum about future programmes?

8. **Additional questions**

   a. I've asked you a lot of questions today and I am very grateful for the time you have taken to answer them. Are there any questions I didn't ask you that I should have? Any at all?

Appendix F: Interview Schedule – 3 Month Follow Up

Short Qs for Phone Interviews

To participant: Thank you again for participating in the Museums on Prescription programme at _____Museum. As part of our follow-up I have a few questions to ask you about what you've been doing and how you've been feeling since we last spoke. Some of these are similar questions to the ones you answered on the forms, but not as many. Then there are 4 questions at the end which require slightly longer answers. There are no right or wrong answers to the questions; we want to understand your experiences and opinions—that's what is important to us. If it is okay with you I'm going to record this phone call so I make sure I get your responses right. The phone call is completely confidential. Do you have any questions before we begin?

Short WEBWMS

Lead in: The first set of questions is about your feelings and thoughts. I'd like you to score each statement between 1 and 5, with 1 being none of the time, 2 being rarely, 3 being some of the time, 4 being often, and 5 being all of the time. For example the first statement is….

Statement	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

RCLUA-Three item loneliness scale

Lead-in and questions are read to the respondent:
The next questions are about how you feel about different aspects of your life. For each one, tell me how often you feel that way. The options are hardly ever, some of the time and often.

Question	Hardly ever	Some of the time	Often
1. First, how often do you feel that you lack companionship: Hardly ever, some of the time, or often?	1	2	3
2. How often do you feel left out: Hardly ever, some of the time, or often?	1	2	3
3. How often do you feel isolated from others? Is it hardly ever, some of the time, or often?	1	2	3

Open-ended Questions

Lead in: The next four questions are about you experiences since finishing the programme and are more open-ended.

Q1: Since finishing the Museums on Prescription programme have you been back to the museum or visited another museum?

a) If not, why not?
b) If yes, how many times? Why did you go? What did you get out of going? Did you go with anyone?

Q2: Have you taken any opportunities to do any additional social activities since the programme ended? (e.g. seeing friends more regularly, joined a social club)

a) If not, why not?
b) If yes, what? Have you enjoyed them?

Q3: When was the last time you visited the GP, nurse or had a hospital appointment? (You don't need to say why or what for, we would just like to know when you last attended an appointment).

Q4: How have you been feeling overall since the programme ended at the museum?

Thank you for your time, do you have any questions that you want to ask me?

Appendix G: Participant Passport

Welcome!

Welcome to the Museums on Prescription project! This passport is a space for you to write down some of your thoughts on each session and record your responses to the things you saw, handled and did. We'd like you to complete this after you come home from the session, or as soon as possible after. You can write what you like and feel free to do a drawing or sketch, you don't have to be an artist! Don't worry about spelling or grammar, just write what you feel able to.

We will collect this before the session in Week 6 and give you a new one for Weeks 6-10. We will give or post it back to you after all the sessions are finished.

Thank you,

Museums on Prescription Team

If you have any questions about the passport or anything else to do with the project feel free to contact Linda Thomson

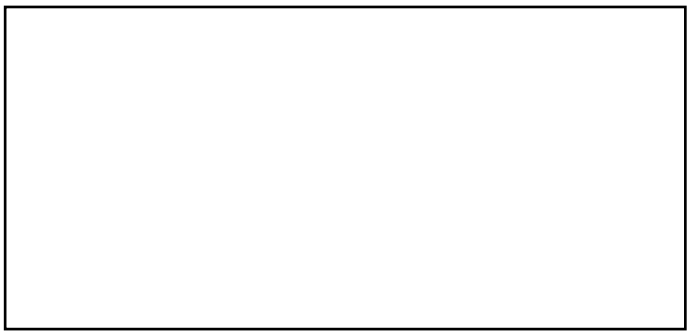
Tel: 020 7679 2649

Email: linda.thomson@ucl.ac.uk

Week One

1. If you were to use any one word to describe today's session what would it be?

2. In the space below please draw, if you would like to, any image that visually tells us how you experienced the session today.



3. How did you feel about being in the museum today?

4. What was it like for you being with this group of people today?

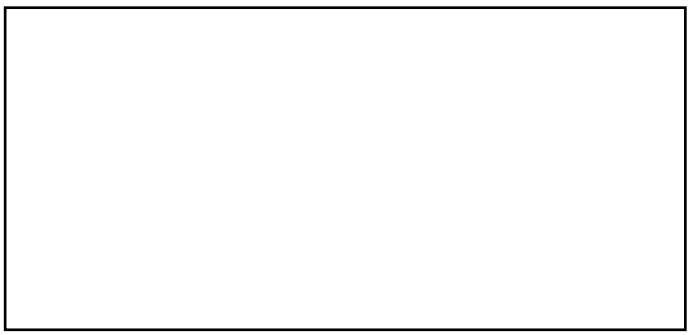
5. Was there a particular object or piece of art you saw today that you particularly liked? Can you tell us why you liked it?

6. Was there anything about today's session that you felt interested or curious about? Please explain as best you can.

Week Two

1. If you were to use any one word to describe today's session what would it be?

2. In the space below please draw, if you would like to, any image that visually tells us how you experienced the session today.



3. How did you feel about being in the museum today?

4. What was it like for you being with this group of people today?

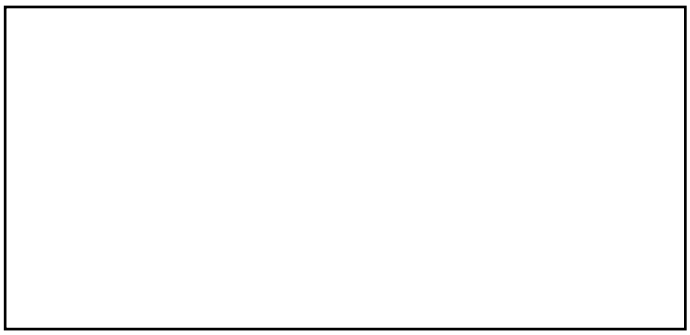
5. Was there a particular object or piece of art you saw today that you particularly liked? Can you tell us why you liked it?

6. Was there anything about today's session that you felt interested or curious about? Please explain as best you can.

Week Three

1. If you were to use any one word to describe today's session what would it be?

2. In the space below please draw, if you would like to, any image that visually tells us how you experienced the session today.



3. How did you feel about being in the museum today?

4. What was it like for you being with this group of people today?

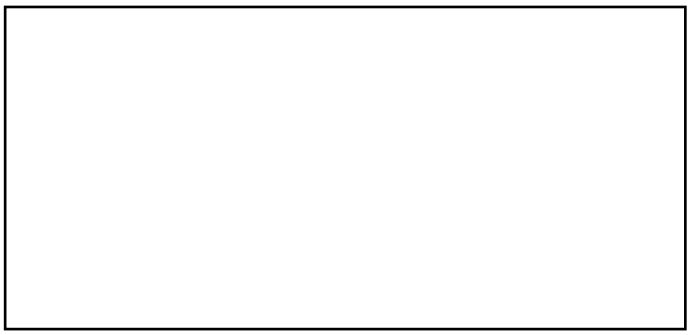
5. Was there a particular object or piece of art you saw today that you particularly liked? Can you tell us why you liked it?

6. Was there anything about today's session that you felt interested or curious about? Please explain as best you can.

Week Four

1. If you were to use any one word to describe today's session what would it be?

2. In the space below please draw, if you would like to, any image that visually tells us how you experienced the session today.



3. How did you feel about being in the museum today?

4. What was it like for you being with this group of people today?

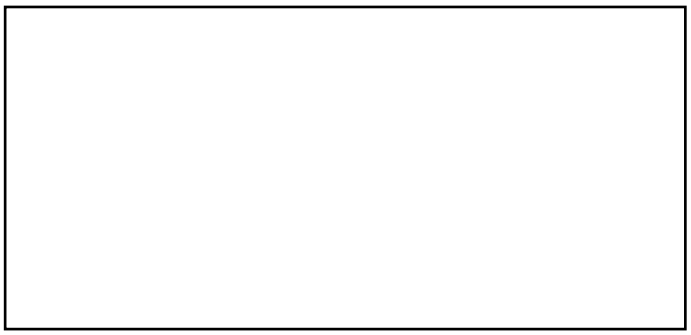
5. Was there a particular object or piece of art you saw today that you particularly liked? Can you tell us why you liked it?

6. Was there anything about today's session that you felt interested or curious about? Please explain as best you can.

Week Five

1. If you were to use any one word to describe today's session what would it be?

2. In the space below please draw, if you would like to, any image that visually tells us how you experienced the session today.



3. How did you feel about being in the museum today?

4. What was it like for you being with this group of people today?

5. Was there a particular object or piece of art you saw today that you particularly liked? Can you tell us why you liked it?

6. Was there anything about today's session that you felt interested or curious about? Please explain as best you can.

Appendix H: Example of an Open Coded Transcript

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Appendix I: Progression of Selective Code Development – Refining Initial Open Codes

Possible selective codes	Open codes	Refined open codes
Physical space	Location of objects/easiness Navigating the building Mobility/physical space Environment Positive experience of surroundings Physical space restricted Museum rooms Getting lost Location of nice objects Building Other places Finding a new place Facilities access and mobility expand the space compare to other museums liked the room size of room noisy environment spacious environment disorientated at first exhibition layout artefacts different country of origin not thought about the building not looked at building specific building features focus on exhibition content thoughts about the rooms indifferent about interiors always look at interiors interiors are a vessel	**Building** Navigating the building Museum rooms Building Other places Facilities expand the space size of room spacious environment specific building features **Contents** Location of objects/easiness Location of nice objects exhibition layout artefacts different country of origin focus on exhibition content **Meaning/experience** Positive experience of surroundings Finding a new place compare to other museums liked the room noisy environment not thought about the building not looked at building thoughts about the rooms indifferent about interiors always look at interiors **Moving around** Mobility/physical space Physical space restricted Getting lost access and mobility disorientated at first
Telling others	About museum content Sharing info about MOP Telling others Recruiting others Telling other p's about an activity Share experience	**Communicating facts** About museum content Sharing info about MOP Telling other p's about an activity Sharing exhibition detail

	Bring family Share experience with family Sharing what learned Sharing experience Encouraging others Active sharing Want to share with children Interest in others Share with others Benefit others Taking visitors from abroad (to museums) Sharing exhibition detail	**Share experience** Telling others Share experience Sharing what learned Sharing experience Active sharing **Including others** Recruiting others Bring family Share experience with family Encouraging others Want to share with children Interest in others Share with others Benefit others Taking visitors from abroad (to museums)

Judging others	Making assumptions about others Roll of others in socialising Judging what others do Ethnicity of others Negative (derogatory) judgement of another P Neutral feeling about other p's. Rejecting others/evaluating them Negative evaluation of others' ability Positive opinion of another p Age of others Judging others favourably Connecting on transport Judging others' activity Others are different Thoughts about how the others are Evaluating other group members Assuming why others might go (people who have nothing to do) judging others' health judger other older people other lonely people views about other members others with knowledge	**Difference** Ethnicity of others Others are different **Guessing and evaluating** Making assumptions about others Judging what others do Negative (derogatory) judgement of another P Negative evaluation of others' ability Positive opinion of another p Judging others favourably Judging others' activity Evaluating other group members Assuming why others might go (people who have nothing to do) judging others' health judger other older people others with knowledge wondering about their status **Characteristics** Age of others other lonely people guessing age of others volunteer status staff knowledgeable

	trying to take part wondering about their status guessing age of others holding others in high regard volunteer status staff knowledgeable	**Relational impact** Roll of others in socialising Neutral feeling about other p's. Rejecting others/evaluating them Thoughts about how the others are views about other members trying to take part holding others in high regard

Presenting/judging self	Survival mechanism Personal communication style Personal characteristic Difficulty with a task Memory Value in being active Age/decline Judging self Presenting as OK Personal characteristic Belief about self going there Physical decline Positive self evaluation ~~Personal~~ Agreeable Life stage Ability to do activity Judging self as able/adaptable Judging self as easy going Positive view of self Portraying happiness Judged by others as happy Evaluation of self Positive judgement of ability to connect Performing being 'alright' Presenting self as positive/interested Personal characteristic Rejecting loneliness Comfortable being with others Contradicting self (I've got X, Y, Z but I'm alright) Negative self judgement about ability	**Ability** Memory Ability to do activity Positive judgement of ability to connect Comfortable being with others Negative self judgement about ability Evaluating own ability Previously visited museums Age related success Knowledgeable Speaking languages **Characteristics** Survival mechanism Personal communication style Personal characteristic Personal characteristic Life stage Personal characteristic Negative experience due to internal pressures Moral duty Over involved Committed Personal values Personal characteristic Age Own characteristic (e.g. boring) **Emotion** Agreeable Positive view of self Portraying happiness Judged by others as happy Humour

	Comparing self to others negatively Negative experience due to internal pressures Evaluating own ability Judging self positively Moral duty Humour Over involved Committed Personal values Personal characteristic Exceeding age expectations Defining self as younger Recognise own limits Different to others Age Previously visited museums Own characteristic (e.g. boring) Judging self Like learning Helping others Age related defiance Age is positive Age related success Comparing self to others Knowledgeable Speaking languages Rejecting personal loneliness Loneliness is for other people Denying loneliness	**<u>Comparing & Judging</u>** Judging self Belief about self going there Judging self as able/adaptable Judging self as easy going Evaluation of self Comparing self to others negatively Judging self positively Different to others Judging self Comparing self to others **<u>Presenting Self</u>** Presenting as OK Positive self evaluation Performing being 'alright' Presenting self as positive/interested Rejecting loneliness Contradicting self (I've got X, Y, Z but I'm alright) Defining self as younger Rejecting personal loneliness Loneliness is for other people Denying loneliness Like learning Age related defiance **<u>Decline</u>** Age/decline Physical decline **<u>Difficulty</u>** Difficulty with a task **<u>Active</u>** Value in being active Exceeding age expectations Helping others Age is positive

Barriers	Barriers to engaging Mobility ~~Barrier about going~~ Physical decline Travelling	**<u>Physical</u>** Mobility Physical decline Physical barrier Barrier to going somewhere

	Avoiding answering the question Physical barrier Barrier to going somewhere Fear of being attacked Physical health barrier to connecting Barriers to going out Mobility barriers Ability impacted experience Don't have a need (to meet others) Physical health Rushing to get there Time to get there Practical reasons Age as a barrier to connecting Lack of time Health barrier to going Mood stop visits Decline Facilities Age Not enough time to visit People rushing off Making time for it Change in routine Wanting more time Time consuming Having time	Physical health barrier to connecting Mobility barriers Physical health Health barrier to going Decline Age **Mood/internal** Ability impacted experience Mood stop visits **Time** Rushing to get there Time to get there Lack of time Not enough time to visit Making time for it Change in routine Wanting more time Time consuming Having time **External** Travelling Fear of being attacked Barriers to going out Practical reasons Facilities **Relational** Avoiding answering the question Don't have a need (to meet others) Age as a barrier to connecting People rushing off

Emotion	Fear/anxiety Positive emotion experienced Negative emotion No negative emotion Positive emotional experience Personal experience ("I really like it") Personal feeling Emotion felt from activity	**Internal experience** Fear/anxiety Positive emotion experienced Negative emotion No negative emotion Positive emotional experience Personal experience ("I really like it") Personal feeling

	Enjoyment in activity Satisfied Unremarkable feeling Feeling comfortable Emotion from learning Excited Positive feelings/thoughts Very happy Enjoyment	Satisfied Unremarkable feeling Feeling comfortable Excited Positive feelings/thoughts Very happy **Externally generated** Emotion felt from activity Enjoyment in activity Emotion from learning Enjoyment

Social engagement	Ambivalent connection Enable connection to others Having friends Meeting people Connecting on transport Enabling connection Barriers to connecting Lack relationship/no lasting connection Seeing people again Other activities Other organisations Choice Social networks Connect with another participant Social connections made Lack of socialising Quality of connection Positive feeling about activity in group Confident with the group Avoid others if not connecting Another future activity with people Connection with another for activity Difficulty connection Withdrawing from the group Participating in the group Feeling able to talk to others	**Connecting with others** Enable connection to others Enabling connection Seeing people again Choice Social networks Social connections made Participating in the group Went alone Talking to others Communicating with others Other people getting together Participation in the group Evidence of relationships Positive experience of group Connecting Importance of group members Building group cohesion Group cohesion **Barriers** Ambivalent connection Barriers to connecting Lack of socialising Avoid others if not connecting Difficulty connection Withdrawing from the group Waiting for others to ask **Personal Relationships** Having friends Meeting people Lack relationship/no lasting connection

	Group changed Over time felt familiar with others No further contact No lasting connections Went alone Sharing what learned Talking to others Quality of the relationship with group Another organisation Connected to another organisation Comfortable being with strangers Familiar with being with others Communicating with others Seeing them after the programme Waiting for others to ask Other people getting together Safe way to connect Museum content helped connection Process of keeping in touch Friendships Museum as topic of conversation Participation in the group Meeting outside the group Own role in group Evidence of relationships Expectation about contact Contacting others Continued seeing group members Positive experience of group Given chance to connect Connecting Building relationships Importance of group members Feelings about the group Thoughts about the group View of others Wanting to connect Building group cohesion Group cohesion	Connect with another participant Feeling able to talk to others Friendships Contacting others Building relationships Wanting to connect **Connecting through activity** Connecting on transport Other activities Other organisations Connection with another for activity Sharing what learned Another organisation Connected to another organisation Museum content helped connection Museum as topic of conversation Given chance to connect **Lasting benefit** Another future activity with people Seeing them after the programme Process of keeping in touch Meeting outside the group Continued seeing group members **Quality** Quality of connection Group changed Over time felt familiar with others No further contact No lasting connections Quality of the relationship with group Safe way to connect **Internal Experience** Confident with the group Positive feeling about activity in group Comfortable being with strangers Familiar with being with others Own role in group Expectation about contact Feelings about the group Thoughts about the group View of others

Communication/programme information Evaluation	Expectations ~~How told/not told~~ Choice ~~Cost/availability~~ ~~Positive evaluation~~ ~~Good organisation~~ ~~Content appraisal~~ ~~Appraisal of museum content~~ Telling others about museum content ~~Evaluation of programme~~ Organisers nice ~~Good organisation~~ ~~Satisfied~~ Programme helps people connect Wellbeing means keeping busy everyday ~~Other organisation~~ ~~Getting info about MOP~~ ~~Being told about it~~ ~~Being shown~~ Evaluation of the objects ~~Positive evaluation of all topics~~ ~~Nothing to improve~~ ~~Slightly helped~~ Rejecting mental benefit Rejecting social benefit ~~Don't use other services~~ Learning helps 'people' on their own ~~Positive evaluation of learning~~ ~~Ambivalent if MOP helped~~ Might help 'others' (not me) ~~Finding out about MOP~~ ~~Other organisations~~ ~~Explanation about MOP~~ ~~Exhibitions~~ ~~Organisation of MOP~~ ~~Impressed~~ Enthusiasm for programme Enjoyment ~~Positive evaluation~~ ~~Appreciating MOP~~ Volunteers knowledgeable	**<u>Individual Experience</u>** Expectations Wellbeing means keeping busy everyday Rejecting mental benefit Rejecting social benefit Might help 'others' (not me) Enjoyment Grateful Learned new things Experience of sessions **<u>Connecting</u>** Telling others about museum content Programme helps people connect Museum content helped connecting Changing the conversation **<u>Container and provider</u>** Choice Learning helps 'people' on their own Enabled museum visits **<u>Role of museum/facilitator</u>** Organisers nice Evaluation of the objects Volunteers knowledgeable Content of exhibition valued

	Grateful ~~Genuine feedback~~ ~~Giving ideas~~ ~~Perfect~~ Learned new things Museum content helped connecting Different experience each visit ~~Positive experience~~ ~~Interested/interesting~~ Changing the conversation ~~Connecting with the interviewer~~ Content of exhibition valued Experience of sessions ~~Positive experience~~ ~~Positive evaluation~~ Enabled museum visits ~~Helped~~	

New experience	~~Return~~ Learning Outside normal experience Dislike other activities Unknown Courage to visit Reason to go Confident to go/right to be there Not been before ~~Arriving at the museum~~ Something new and exciting Not knowing what you found Experience of activity Enabled/allowed a new experience to happen ~~Coming to the UK~~ Pleasantly surprised Pre-conceived ideas Learning new information Missing out New experiences opportunities	**<u>Personal Gain</u>** Learning Courage to visit Confident to go/right to be there Experience of activity Enabled/allowed a new experience to happen Missing out New experiences Opportunities **<u>Tangible Gain</u>** Learning new information **<u>Outside Norm</u>** Outside normal experience Unknown Reason to go Something new and exciting Pleasantly surprised **<u>Different</u>** Dislike other activities Not been before Not knowing what you found Pre-conceived ideas

Health	Good for mental health Positive benefit Physical activity getting to museum Mobility Declining health Death – how and choice Follow advice Positive health outcome Health screening Health under control Health diagnosis Difficulty assessing own health Health problem controlled Take control Physical ailments ~~Health~~ Physical restriction impeding ability Barrier to activity Rejecting GP use Reluctant to talk about health Physical health barrier Physical health restricting life choices reject health difficulties physical limitation reason for being unwell deny physical problem physical health interrupting group cohesion managing personal discomfort	**Impact of physical health** Physical activity getting to museum Mobility Physical ailments Barrier to activity Physical health barrier Physical health restricting life choices physical limitation managing personal discomfort **Mental health** Good for mental health **Improve** Good for mental health Positive benefit Follow advice Positive health outcome Take control **Decline** Declining health Death – how and choice Physical restriction impeding ability reason for being unwell **Status** Health screening Health under control Health diagnosis Difficulty assessing own health Health problem controlled Rejecting GP use Reluctant to talk about health reject health difficulties deny physical problem

Expectation	"I didn't know what to expect" Limited expectation Barriers to going Satisfaction with frequency Want to do it again Passive participation Prediction about what might happen Guess why others won't come	**Unknown** "I didn't know what to expect" Prediction about what might happen Guess why others won't come Didn't know what to expect Pre-conceived ideas Positive anticipation (x3) Anticipation

	Didn't know what to expect Pre-conceived ideas Reason to go Expectation different Different expectation Exceeded expectations Expected not to stay Positive anticipation (x3) Expectation changed Reason to go (to meet people) ~~Expectation~~ Anticipation Exceed expectations	**Exceeded** Satisfaction with frequency Expectation different Exceeded expectations Exceed expectations **Limited** Limited expectation Passive participation Expected not to stay **Impact of expectation** Barriers to going Want to do it again Reason to go Reason to go (to meet people) **Different** Different expectation Expectation changed

Influence of others/on others	Translate communication as negative Someone to guide (orientation) Judging other people Judging others Split the group Irritation with others Other people's action How might impact on others ~~Given permission~~ Other people's input Thinking like others Approval from facilitator Being like others Likening self to others Facilitator role Influence of facilitator Noting benefit in others Benefit to others Views of others Influence of others Judging others	**Interaction** Approval from facilitator Noting benefit in others Benefit to others **Judging** Judging other people Judging others Thinking like others Being like others Likening self to others Views of others Judging others Staff characteristics **Negative Impact** Translate communication as negative Split the group Irritation with others How might impact on others **Others' action** Other people's action

	Role of others Staff characteristics	Other people's input Facilitator role Influence of facilitator Influence of others Role of others

Benefit	~~Reason to go~~ ~~Positive benefit~~ Good for mental health Need/desire Satisfy a need ~~Active~~ Learning ~~Other benefits/offerings~~ ~~Reason to go~~ ~~Refreshments~~ Positive feeling about activity with the group Emotional benefit felt ~~Overall benefit~~ Relaxed ~~Good overall experience~~ Difficulty assessing benefit to self Mental benefit Hard to describe WB benefit Learning benefit Building confidence ~~Interesting items~~ Personal benefit from items Finding items interesting Learning something new Artefacts Benefit of regular commitment ~~Benefit others~~ Did it for own benefit Personal benefit Learning/learned a lot ~~Perceived benefit~~ ~~Personal gain~~	**<u>Mental health</u>** Good for mental health **<u>Internal</u>** Need/desire Satisfy a need Positive feeling about activity with the group Emotional benefit felt Relaxed Building confidence Did it for own benefit Personal benefit **<u>Experience</u>** Learning Learning benefit Personal benefit from items Finding items interesting Learning something new Artefacts Benefit of regular commitment **<u>Difficulty</u>** Difficulty assessing benefit to self Hard to describe WB benefit

Activities	~~Frequency of activities~~ ~~External activities~~ Doing activities/participating	**<u>Museum</u>** Positive evaluation of objects Familiar with museums

	Enjoyment in activity Positive feeling about activity with the group Positive evaluation of objects ~~Activity task~~ Go different places Familiar with museums Frequency of visits Positive experience of objects Appraisal of objects Personal experience/thoughts of an activity Other activities Emotion felt from activity ~~Passive activity~~ Ambivalent about activities Connection with another for activity ~~Care of objects~~ ~~Activity rated good~~ Some activity easier than others Disliked activity ~~Likes artefacts/items~~ Likes particular artefact Being shown an artefact Evaluation of an artefact Learning from activities ~~Activities~~	Frequency of visits Positive experience of objects Appraisal of objects Likes particular artefact Being shown an artefact Evaluation of an artefact **Other activities** Go different places Other activities **Process** Doing activities/participating Enjoyment in activity Positive feeling about activity with the group Personal experience/thoughts of an activity Emotion felt from activity Ambivalent about activities Some activity easier than others Disliked activity Learning from activities **Social benefit** Connection with another for activity

Container and provider Wanting more/afterwards	Positive feeling about activity with the group Opening opportunities Link to life outside Cost/availability Confident to go (“allowed”) Building confidence and independence Positive confidence Enable connection to others Lead to things afterwards Built confidence Enabled future activity ~~Return~~ Enabling connection Being allowed	**Internal factor** Confident to go (“allowed”) Building confidence and independence Positive confidence Built confidence Being allowed item triggering memory feeling able to ask building confidence history fear of missing out Ending (sad) **External factor** Enough time to socialise item triggering memory

	Enough time to socialise item triggering memory link to past feeling able to ask visiting again enabling mobility building confidence transferring experience to another place visiting another museum history enabled museum visits again given chance to connect enjoyment led to carrying on fear of missing out missing out meeting outside the programme Funding Finding a new place Other places Suggesting more learning Wanting more programmes Will return to museum Do it differently next time Suggestions for future programme Wanting more to be taught Wanting a continuation Wanting more sessions Passing learning to others Continued casual contact Return to the museum Souvenir Ending (sad) Wanting more from museum Want them to continue Uncertainty about museum exhibitions in future Opening doors Passing on knowledge	Link to life outside Cost/availability link to past missing out Funding Finding a new place Do it differently next time Wanting more to be taught **<u>After the programme</u>** Opening doors Opening opportunities Lead to things afterwards Enabled future activity visiting again transferring experience to another place visiting another museum enabled museum visits again enjoyment led to carrying on Other places Wanting more programmes Will return to museum Suggestions for future programme Wanting a continuation Wanting more sessions Continued casual contact Return to the museum Souvenir Wanting more from museum Want them to continue Uncertainty about museum exhibitions in future **<u>Activity</u>** Positive feeling about activity with the group Suggesting more learning **<u>Connection to others</u>** Enough time to socialise Enable connection to others Enabling connection given chance to connect meeting outside the programme Passing learning to others Passing on knowledge **<u>Physical</u>** enabling mobility

Previous Museum Experience	~~Connecting to the expert elsewhere~~ Remembering the curator Previous museum activity/experience ~~Previous interest~~ ~~Current interest~~ Used to go to museums Museum different now ~~Previously visited~~ ~~Previously when visited~~ Compare to other museums Linking to other museums Going to another museum Experience of artefact ~~Wanting to do it again~~ ~~Visiting museums frequently/regularly~~ ~~Exhibitions~~ ~~Handling artefacts~~ ~~Explanation about MOP~~ ~~Different exhibitions~~ Memory of previous visits ~~Familiar layout~~ ~~Artefacts looked after~~ ~~Museum collection in high regard~~ Compare to museums abroad ~~Museum held in high regard~~ ~~Engaging with artefacts~~ ~~Artefacts not practical/impressive~~	**Trigger memory** Remembering the curator Previous museum activity/experience Used to go to museums Museum different now Experience of artefact Memory of previous visits **Comparison** Compare to other museums Linking to other museums Going to another museum Compare to museums abroad

Activity Levels	Physical health barrier to activity ~~Other organisation~~ ~~Attending somewhere else regularly~~ ~~Too much to do~~ Not going anywhere ~~Previous travel~~ Activities previously done Barriers to activity Change in activity level ~~Regular places attended~~ ~~No time for things~~ ~~Places visited~~ Commitment to programme increased likelihood of attending	**Barrier** Physical health barrier to activity Barriers to activity **Change** Activities previously done Change in activity level Commitment to programme increased likelihood of attending **Decline** Not going anywhere Decline in cultural activity Decline in activities recently

	~~Being active~~ ~~Overdo it~~ Decline in cultural activity ~~Previous activities~~ Decline in activities recently ~~Other organisations~~ ~~Involved in other activities~~ ~~Physical activity~~ ~~Compare own activity levels to others~~	

~~Label/performance~~	~~Carer~~ ~~Age~~ ~~Younger~~ ~~Occupation~~ ~~Good employee~~ ~~Experienced~~ ~~Knowledgeable~~ ~~Multi-lingual~~ ~~Rejecting personal loneliness~~ (moved to presenting self) ~~Loneliness is for other people~~ (moved to presenting self) ~~Denying loneliness~~ (moved to presenting self)

~~Responsibilities~~	~~Caring for others~~ ~~Volunteering~~

~~Vocation~~	~~Volunteering~~ ~~Occupation~~ ~~Previous occupation~~ ~~Defining self based on occupation~~ ~~Enjoying work~~

~~Reasons~~	~~Reasons to take part~~ ~~Reasons to go~~ ~~Not want to miss opportunity~~ ~~Personal reason~~ ~~Learning something~~ ~~Personal gain~~ ~~Reason to be at the museum~~

~~Travel~~	~~Travelling~~ ~~Physical activity getting to museum~~ ~~Public transport~~ ~~Time to get there~~ ~~Travelling home~~ ~~Enabled decision to go~~ ~~Transport to museum~~ ~~Getting there~~ ~~Distance~~ ~~getting to the museum~~

Appendix J: Progression of Selective Code Development - Memo

Refining open codes-selective codes.

Travel

Discarded this code as nothing felt relevant to SI or wellbeing in terms of HOW the MOP impacted these.

Physical space

Split between practical, tangible elements (e.g. the room, the building, location of objects) AND the emotional/meaningful element (interiors are a vessel, thoughts/feelings about the rooms/building).

Not sure if/how these contribute to wellbeing and social isolation currently?

Maybe in relation to, or as part of a process with, other elements? (e.g. feeling safe?)

Telling others

This feels like a potentially important process in reducing social isolation (maybe just a hunch at the moment) in providing subject matter for conversations with others and enthusiasm for wanting to share the experience of/knowledge gained from MOP.

Not sure that this comes out in the data currently and therefore might be more about my hunch rather than what the data says. Or have I coded some data as something else that could enhance this element more? Might come out in later coding/theory building.

Judging others

Feels like a potentially important part of a process, especially perhaps as a barrier to engaging with other socially, however, the data does not give this flavour and is not clearly telling us this.

Is there a more general code 'others' emerging?

Presenting/judging self

Didn't feel very clear-cut what the impact of this might be on WB or SI from this coding. I wonder whether more data is incorporated in a different code – e.g. enabling? To be incorporated and refined further.

Barriers

Important in terms of evaluating the programme but not sure if it tells us much about how MOP helped SI or WB. More of an intangible concept.

Emotion

Again, whilst clearly important to WB, not clear from this coding HOW. Maybe incorporated in more process related codes rather than stand-alone 'emotion' as a tangible thing. Saying that, there is something about the interplay with the activities for example, or with other people, or the building. This needs more refinement and consideration.

Social engagement

This felt like a rich and valuable set of codes that give some detail about the social element and answers the question about how it might reduce social isolation but also what some of the difficulties might be.

Communication/evaluation

Practicalities (e.g. how they were given the leaflet) – discarded as not a process that explains how SI and WB were impacted.

This category was subsequently significantly cut down by removing the evaluation components (e.g. well organised).

But what emerged was some important ideas about HOW (which is evaluative) including what helps wellbeing.

New experience

Need more exploration of how this impacts WB and SI. What is it about the 'new experience' of MOP that helps? (e.g. some data suggests, confidence, exceeded expectations – surprise and outside of the norm?)

Health

Unclear how to code this and not clear how this interacts with the MOP process and impact on SI and WB. Not a linear relationship and not an obvious interconnection from the data itself.

Expectation

Difficult to code. Feels like 'expectation' might be part of another code as in itself it doesn't add any explanation about process. Perhaps as part of the relationship between other codes – for example – expectations were a barrier/enabler to attending or affected experience/outcome????

Influence of others/on others

'Judging' arises here – could it be put with the 'judging/evaluation others' code?

Benefit

Has a feel of 'evaluation' and might not very explanatory. Some initial codes discarded for this reason, similarly to the evaluation category.

Activity

Not very explanatory and this is likely to come under a more explanatory concept – HOW does activity influence WB/SI. Is it a component itself? What IS activity?

Container and provider

Interesting data about various aspects about MOP that enabled connection (reduced SI) and built confidence (improve WB?)

Previous museum experience

Not sure of HOW this might reduce SI and improve WB in THIS programme. Quantitatively already accounted for in the questionnaires. Some codes removed and feel that remaining ones need to be incorporated elsewhere.

Activity levels

Suggest this needs to be incorporated elsewhere. Not explanatory.

Label

Remove this. The 3 that are relevant can be incorporated into 'presenting self'.

Responsibilities

Deleted as not explanatory or relevant to the research question and only mentioned by one participant.

Vocation

Deleted as not explanatory and only mentioned by one participant.

Reasons

Leave as it is – it seems like it might be relevant/interesting but is currently limited by a few examples from 1 participant.

Appendix K: Progression of Selective Code Development - Categories

Potential overarching 'process' themes – CATEGORIES (WITH SUB-CATEGORIES) (theoretical themes?):-

1. **RELATIONAL PROCESS**
   (Internal models of others, self and relationships and how the MOP programme is incorporated and becomes a component in enabling something different to happen).

   Codes include:-

   ROLE OF OTHERS = JUDGING OTHERS (difference; characteristics; evaluating others; relational impact). INFLUCE OF OTHERS (interaction; judging; negative impact; others' action)

   PRESENTING/JUDGING SELF (ability; characteristics; emotion; comparing & judging; presenting self; decline; difficulty; active).

   COMMUNICATION = SOCIAL ENGAGEMENT (connecting with others; personal relationships; barriers; connecting through activity; lasting benefit; quality; internal experience). TELLING OTHERS (communicating facts, including others, share experience)

2. **MUSEUM EXPERIENCE**
   (Museum programme experience provides a tangible benefit, interacting with individual characteristics, to provide opportunities to communicate, connect, learn and share. (NB – links with the NEF WB definition!))

   Codes include:-

   TELLING OTHERS (communicating facts; share experience; including others).

   NEW EXPERIENCE (personal gain; tangible gain; outside norm; different). BENEFIT (mental health, internal, experience, difficulty). ENABLING (internal factor, external factor, after the programme; activity; connection to others).

   BARRIERS (external, mood; internal, physical, relational, time)

   ACTIVITES (museum, other activities, process, social benefit)

   PHYSICAL SPACE (building, contents, meaning/experience, moving around)

3. **PERSONAL/INDIVIDUAL JOURNEY**

   Codes include:-

   ACTIVITY LEVELS (barrier, change, decline)

PERSONAL EXPERIENCE = EMOTION (externally generated, internal experience). HEALTH (decline, impact of physical health, improve, mental health, status)

ENABLING/WANTING MORE (activity, after the programme, connection to others, external factor, internal factor). EXPECTATION (different, exceeded, impact, limited, unknown)

4. **MUSEUMS-ON-PRESCRIPTION PROGRAMME PROCESS (Facilitator, building, artefacts – help to bring difference together and shake up the norm?)**

EVALUATION (connecting, enabling, individual experience, role of facilitator) (INCLUDE NEGATIVE EXPERIENCES)

PERSONAL EXPERIENCE = NEW EXPERIENCE (different, outside norm, personal gain, tangible gain). PREVIOUS MUSEUM EXPERIENCE (Comparison, trigger memory)

5. **WELLBEING (include NEF definition (Connect, Be Active, Take notice, Keep learning, Give)**

PRESENTING/JUDGING SELF (ability; characteristics; emotion; comparing & judging; presenting self; decline; difficulty; active).

Emotion, health, activity levels, benefit barriers?

Appendix L: Final Theory Memo

RQ: –
WHAT ARE THE COMPONENTS OF/INGREDIENTS TO A MUSEUM BASED PROGRAMME THAT SEEK TO INCREASE WELLBEING AND DECREASE SOCIAL ISOLATION?

HOW DO THESE INGREDIENTS/COMPONENTS COMBINE TO CREATE OPPORTUNITIES FOR CHANGE?

SOCIAL WORLD
Describes a two-way, ongoing process/ingredient that provides a base (background) from which the MOP (and the other components that the MOP creates) can enhance/change WB/SI but similarly these are ingredients that increase the likelihood that people will a) attend and b) have a certain kind of experience. Some individual characteristics, beliefs and previous experiences are a key component of this interaction process with the MOP. They might make it more likely that people attend because they have some previous experiences of groups or interacting that leads them to have expectations about how a group programme might be (positive and negative) but also some thoughts about other people and a desire to either get to know them/more about them or not be like them and therefore motivated to do something different or look at them negatively to increase their own wellbeing as evidence that they're 'not like that' or 'not that bad'.

The context in which the MOP is able to provide/hinder any change in relationship with individual beliefs/experiences and the extent to which the MOP provides evidence of these. And thoughts about others in the group (evaluation) enhanced/hindered the experience (communication/social engagement) but also the experience enhanced beliefs about others (sharing/social engagement).

Evaluation self and others (previously judging)
Beliefs about interaction.

Enabled people to go.

Enabled their social participation (or hindered it).

Part of an individual social template.

Positive (opportunity to build on individual template) – P11 "she was nice to talk to"; P3 "she's a lovely person".

Negative (I'm not like them (implicitly – I'm doing this so I don't get like them)). P12 "they sit there doing nothing ……. P12 Feel shy at first.

Beliefs about how self might be seen by feedback from programme denied/confirmed this:

P5 – If friendly I talk, if not, I just sit (highlights the 2-way process that might create or hinder change to SI).

Others are X (old/lonely).

I help them.
I don't want to be like them = go to MOP. MOP provides feedback that not like them.

P9 – WI. Example of types of interactions that are preferred and the role others have in that.

This might interact with/taint how they interact with group members (communication/social engagement) but also outside (and lead them to be more or less SI in the first place. But MOP might enhance/change their beliefs and increase likelihood by disconfirming their beliefs.

Communication
Experiences of communication interact with how MOP might enhance WB/SI and also how they might approach MOP and the group process (talking, companionship). This might be shaped by Evaluations of self/others. Also experiences of communication on MOP might confirm beliefs or disconfirm, therefore making it more likely/unlikely that they will engage with MOP/other activities.

P12 – embarrassed about answers – shy – speaking up.
P1 – email.
P3 – talk to people on a bus.
P1 – no-one 'took over'.
P9 – example of storytelling that arises from communication. MOP provided opportunity for these stories and the stories and interest in these make it more likely people will come and engage.

This communication is a vessel for social engagement – this is different from communication as it describes something deeper and more complex. Social engagement grows out of communication.

Social engagement
P10 – MOP – once people felt able to go (see evaluating self and others), MOP created opportunity for social engagement which fed back to increase other interactions (see sharing also).

P10 – but how long term this benefit is might be dependent on their beliefs/experiences/individual characteristics.

P7 – link with difficulties outside with a friend and re-connected her. (MOP provided evidence that she's not so bad after all (evaluation-communication-social engagement).

P4 – MOP not predominantly a social purpose (individual belief) and therefore not her focus so didn't engage socially. (this is an example of evaluation and communication leading to a decreased likelihood of social interaction).

P3 – sit on a bench – that's life (reduced likelihood of social interaction).

P2 – If they'd said meet up then I might've done (belief that others should ask, didn't communicate it to her, so didn't lead to social engagement).

P8 – passport data highlights a change in the group over time (perhaps beliefs changing through MOP process?)

P9 – provides a good example! (see quotes).

P9 – MOP provides a different opportunity for social engagement.

P8 – MOP didn't help her feel more connected and engaged (example of individual characteristics/communication not enhancing opp for social engagement).

NB – P4 AND P8 – NEGATIVES (HOW DOES THE THEORY FIT FOR THEM?)

Sharing Experiences

MOP allowed people to show their knowledge (boost SE?) but also knowledge/SE may have led to interest in museums and enabled attendance.

Led to further visits?

Provided something to share with others and enhance other social connections elsewhere.

MOP-Individual fit (see notebook for jigsaw analogy).
If there is a fit (which includes individual factors and social engagement/communication) then sharing own knowledge/experiences are more likely (facts and stories of life experiences).

P12
P1 – passing on to others.
P3
P2 – enabled connections elsewhere by telling them about what learned on MOP programme.
P9

MOP provides something for P's to share elsewhere and build connections. Vehicle for communication and connection (sharing=social engagement) and build SE (individual beliefs etc.)

PERSONAL JOURNEY
The MOP creates an experience that leads to a change, or not. By having the 10 week experience, they have something they didn't have before. The factors that create this experience, together describe a journey of learning, emotion and personal connection to something within themselves.

Activity
Not all experiences of the organised activities in the programme were positive but the impact that these negative experiences had indicate the potential impact on someone on their own emotional wellbeing and level of self-esteem.

P7 – left out – talked down to – downer.

Provided link to connect with activities they used to do and enabled people to connect with their life outside the museum (P2).

MOP provided ideas and confidence to explore museums more and find new activities.

Reminisce about activities that they used to do/stopped doing – a reflective space to consider this.
P1, P4, P5, P8.

Also highlighted what they are not good at and connected with personal performance of their abilities – suggests link to confidence and self-esteem and even if they're not good at something (and previously may have avoided having a go, the programme encouraged them to take part anyway, thus creating confidence that it's OK not to be good at things and can still do them).

Emotion
The MOP evoked some feelings that interacted with participant's current circumstances (e.g. caring, grief) and this timing and meaning created and emotional change/experience.

It also provided stimulation that seemed to offer a unique emotional experience on an individual psychological level.

P10 – confidence. Stretched.
P7 – privileged. Unloved.
P4 – cheerful.
P5 – feeling part of society. Less gloomy.
P9 – memories – connected with past and life stories created a reminiscent opportunity and link to emotional experience (part of personal journey).
P9 – MOP = something to 'make the effort for' = life you (emotional experience).
P8 – learning = happy.
P1 – learning.
P4 – something to look forward to.

Health
Activity and emotion impact physical and mental health.

Many either talked about their limitations (p2, p3) or played down problems (p4).

But MOP enabled people to take part regardless (p5, P9).

Also, didn't feel like an 'old people's' activity so didn't feel reminded of aging body and health decline. P7.

The MOP made museum accessible to those with health limitations (p1).

Some felt it would be good for their health (p3).

Learning experience provided evidence that there was no cognitive decline, despite this being a concern. P7. Therefore increased self-confidence and alleviated health anxiety.

Expectation
As part of their personal journeys participants described how they felt when the MOP was suggested, what they thought or felt about it and their experience exceeding these or not really meeting their expectations (p2).

This is likely to have been influenced by their social context, health, emotion, and activity experiences. Similarly, their expectations may have influenced their overall experience and perhaps how much they participated or what they wanted to get from it.

Some of the reasons people were attracted to the programme included P11, P7.

Some were not clear but still enjoyed their experience P5, P9 (not a big influence but….)

Some didn't know what to expect (p3, p2).

Some felt learning was predominant focus (p4).

Others were focussed on social aspect.

PASSIVE VS ACTIVE PARTICIPANTS IN THE PROGRAMME? – PERSONAL CHARACTERISTICS (SOCIAL CONTEXT).

Enabling and disabling participation
The function of performing seems to have protected people from rejection or decline but also allowed them to participate as they were presenting an able person who would be able to participate.

The process of performing allows participants to feel more equipped to take on the challenge of joining something new, in a museum, and the unknown that was involved.

By presenting oneself positively, it gives the impression that they fit in, especially in a learning environment.

P10
P8
(being a teacher).

P11
P5

Intellectual, too busy, active (p9, p3, p6) (connects to social world-evaluating self and others).

Always with people (p2), travelled, ability, volunteering (p1), P9, p7.

MUSEUM AS ENABLER
The museum provides a vessel, via various components, in which an experience is created for individual participants and creates the basis for a relational process within the programme. The social context outside of the museum programme is a key part of how individuals might

approach and engage with the museum but also interacts with individual experience and relational experiences to provide opportunity for continuing benefits.

Enabling
The museum programme enabled something to happen and without it, these things may not have happened. The containment and predictability of the 10 week structured programme, together with the opportunities for learning and meeting others, built confidence and esteem.

P13, P10, P1, P3.

Objects evoke feelings, connect to the past (P10) and provide conversation topics (literature from other studies backs this up).

P10, P4.

Connect with own personal past and evoked memories – P4, P9, P5.

Provided an opportunity to go in the museum, a reason to go, and a safe space to go.

P4 – "mentioned older people".

The idea of learning, education and the activity of doing something mentally stimulating, in an environment that is known for this, allows interest and curiosity to motivate people to give it a go, even if they were unsure at the start.

P4, P3, P1, P2, P5.

'Opening doors' to something different and new is a process participants valued.

P3, P1, P9.

There was a sense that it gave people something to go out for and they looked forward to it.

P4, P3.

The opportunity to socialise with a common focus or interest, allows for new relationships outside of the normal social circles

P4, P3, P1, P8, P5.

It showed people that they might want to continue to visit, especially at times when other activities were harder (winter).
P9, P2, P4.

It changed people's outlook and connected them to other generations.
P9

There was a sense that it occupies people, engaged them, and challenged their mind.
P8

New experience
The museum was a new, positive experience. Perhaps something previously thought to be inaccessible or not of benefit, or even just not considered before. The programme was something outside of the norm which enabled new things to be experienced.

P6, P7.

Expectations were exceeded (or not). The social context provides a template for these expectations and the actual new experience feeds back to perhaps change views or expectations about both the museum, people and individual abilities.

P2, P4.

It provided something different, outside of the norm.

P3, P8.

Changed previous thoughts, beliefs, knowledge, outlook.

P1, P8 (art), P9 (outlook on life).

Provided a new way of interacting and mixing.

P4, P9, P5, P9.

Learning opportunities. Without this programme people wouldn't have come to the museum.
It created interest.
P1, P2, P6.

Role of facilitator
Part of the museum enabling new experiences and connections is created by the facilitators, curators, organisers and volunteers. Their role is a component of the programme that provides a human element, imparting expertise and knowledge, modelling confidence and enthusiasm for learning. As with artefacts, activities, spaces and other group members, the facilitator also provides a focus for interaction with others, both in and out of the programme, enabling sharing and connection.

Personal characteristics were pivotal for role modelling and enabling confidence.

P10, P7, P9, P4, P5 (able to ask questions), P8.

Gratitude of the staff and giving their time.
P7, P2.

Positioning the 'experts' as knowledgeable and superior.
P7, P1, P8.
Privileged to have them, valued their input.
P2, P5. (therefore helping them feel worthy of such a resource – build esteem/confidence).

Interaction with experts.

P7, P4, P3.

Organisation and ability to run the programme well.
P7, P6.

Staff enabled them to go on and do other things.
P8.

Activities???? (or combine with personal journey-activities)
Activities in the museum were sometimes challenging, however, this is an important aspect of self-esteem and wellbeing if people feel supported, gain a sense of achievement and ultimately have a good experience despite any reservations or difficulties (ref).

Ability, expectations and beliefs were particularly influenced by previous experiences and evaluations of self and others in the background social context. However, the museum enabled some to 'take a chance' and have a go and the facilitators were often a part of this, as was the sense of being in the same situation as other participants and this itself was a connecting experience. This fed back into participant social worlds as something to share, connect, communicate and potentially change (or confirm) their evaluations of self and others.

Artefacts and engaging with them (ref) felt important and powerful to participant esteem, giving a sense that they were trusted with valuable and important items. Moreover, a feeling of connection to the past and the subject felt enriching to the learning experience.

P10, P2, P1, P5, P2.

Unsure what we were doing
P4, P5, P7, P9 (from physical space code).

Activity good/enjoyable
P2, P4, P1, P3.

Bonding, connecting.
P4

Connect to past
P2

Physical space
The buildings and physical spaces were a part of the experience that contributed to the experience, some had negative feelings about some rooms and spaces, highlighting the impact and potential of physical spaces on individual experiences.

Leisure space aspect enabled future meetings.
P4

Navigation of the space enables confidence and alleviates anxiety about entering spaces that are potentially daunting.
P11, P4 (familiarity), P3 (lose), P4 (nothing special), P1 (indifferent).

Comfort – P12, P2 (noise)

The relationship between the space and the artefacts, enabling connection.
P7, P9, P8 (shut away).

Inclusive
P10, P4, P6 (atmosphere).

Space
P2, P5

Exhibits, organised – P1

Building
P3, P1, P4 & P6 (extension disliked).

RELATIONAL PROCESS

The programme is aimed at people who are socially isolated and as such, the extent to which the museum programme is part of relationships is pivotal. Interacting with individual's social context as well as the museum, the role that other people have in this process is complex. One of the complicating factors is the process of individuals judging others. This has a protective element that might allow people to engage in the first place without feeling overwhelmed by pressure to like everyone and be liked. There also seems to be an element whereby judging others negatively motivated people to do something different to ensure they are not the same. The museum programme enabled this and provided the opportunity and ingredients for a personal journey that created change in some of these judgements but also fed back into individual elements such as emotions and performances as part of their interactions.

Judging others (bring quotes from previous RP category – now social world/context)

Judgements were split between positive and negative and are likely enablers of people reducing sense of social isolation and connecting, or not.

P8
P12 – strange
P3 – not punctual, rude, silly, TV,
P7 – individual lonely – appreciate diversity and commitment of the group
P1

Opinions that impacted and those that didn't
P7 – 1 odd, but not a problem
P6

Changed opinions – knows a lot (museum allowed this to emerge). Allowed opinion to change (p7).

P4 – have a philosophy about groups (expectation – personal journey). These were met.

Expectation not met – P7, P4.

Influence
The actions or behaviours of other people, rather than guessing and judging, was an enabler of relationship building and equally not if it confirmed a negative judgement.

Hearing other's stories and experiences enriched their experience. P10.

Created an emotional sense of interest and connection, often triggered by museum artefacts and activities P10, P7, P6.

Museum provided something – P7.

Influence of volunteers and staff – P3, P1, P2.

Comparing self with others
Connected with the impact that judging others has, and the relational process more generally, comparing brings the individual into this process and highlights the potential to impact confidence, esteem and connection to others.

P12, P11, P6.

Action of self, allowed others to be a certain way. Present (perform) self in a certain (positive) light.
P12
P10.

Difference was enabling.
P10.

Two way process
P1.

Activities/ability
P2 (compare and despair).
P2
P6

Appendix M: Abridged Research Diary

The following research diary excerpts are taken from various key points in the research process.

Before starting analysis	Thinking about my starting point and why I'm doing this project to highlight my biases:- • I like older people as I was close to my grandparents, I enjoy the company of older people and I have experience of working with them. I also have an ageing mother and I have my own fear of growing old and having no-one to care for me as I'm an only child. • Social isolation is an ongoing worry for me and my family as we are spread around the world, there aren't many of us and Mum is very shy and has very limited social networks (this worries me!). I also feel that older adult wellbeing and general mental health is overlooked with more resource and research focussing on dementia. • I also believe that learning and education can create changes to self-esteem and create positive social connections – something that's happened to me as I've come into education later. However, I'm also aware due to reaction of people around me that many people are intimidated by institutions such as universities and I wonder if museums might be the same. However, I'm also anti-medication generally and if a social programme can help people's health and wellbeing rather than medication then I would be happy. This has shown me that I might have biases in my analysis and need to be aware of that. I'm also petrified of starting!! I've not done grounded theory before and I'm terrified of getting it all wrong. I'm anxious, excited and don't know where to start!
After transcribing first interview	Wow! This participant had so much to say. It was fabulous. I found it hard to think analytically while transcribing as I just enjoyed transcribing and listening to the interview and information. I'll obviously have to go over it all again during the coding process. Some initial thoughts are:- - There seemed to be a stigma to saying he was lonely - He had mixed views on the other participants - The learning aspect increased his confidence - Wouldn't have gone in the museum alone

	I wonder if the museum is a vessel or a way to externalise conversations about things such as loneliness or difficulties? Also wondering about individual characteristics. A bit like the 'drug, set, setting' theory of Zinberg.
After transcribing 10th interview	I start to get a feel for some common themes but I've found some of the interviews quite boring. I also get quite annoyed by the constant judging of other people – some of it feels a bit bitchy. This taps into my feelings about mum being critical and judgemental and is why it's hitting a nerve! The role of the facilitator and of learning per se seems important to some as they talk about it but I'm not sure what the meaning of this is or the action. Thinking about my research question, I think I need to be closer to the data to understand the mechanisms and relationships. I do feel that judging and performing seem to play a role though. I got the sense that some interviewees were being more genuine and honest than others and this might be a limitation – can only analyse what we're given and can't make inferences that they're not being genuine in their answers.
After the first line by line coding	That was intense! Feel totally overwhelmed by the amount of codes. I also feel really unsure. Is there too much overlap? Are there too many? There are lots of interesting codes, some expected (activity, connectivity, and place to go) and some less expected (personal characteristics, outcome to self, choices, expectations). I've really enjoyed this process so far though and it feels like I'm finally doing something with all the data. I wonder if I need to be holding my research question in mind as I do the open coding? I'm not sure that I did today so there's a danger of ending up with irrelevant codes. Arranged a meeting with supervisors to discuss. Also having NVivo nightmare! I need to understand it more to make proper use of it. I've no idea if I'm doing it right! Overall I'm tentative, uncertain, anxious and excited. Why? What can I do about it? I'm interested to see if I feel differently tomorrow with fresh eyes.
Moving into selective coding	Started to refine codes in Nvivo as per previous hand coding done in December. Using Nvivo and word to combine and compare 3

	participants with each other and combine their initial codes into combined categories (comparison and asking questions). In comparing these and finding similarities/differences, some of my thoughts are:- There is crossover which suggests some relationships to me. For example, I'm wondering about the relationship between how people judge themselves/others and their subsequent template for how they might relate/connect to others in the museum. As part of this process, I wonder whether previous experiences/expectations about museums then also have a role in how they might connect with other people on the programme. Separately or maybe part of the same process is how this translates to what happens after the programme has finished. Does anything change for them? And is this dependent on their template for relating and how this interacted with the programme? In terms of answering my RQ I'm wondering what the process is of relationships intertwined with presentation of self/belief about self and judging others/belief about others. Relational processes seem key in perception of loneliness and ability to connect. Current levels of activity and connection seem important to portray (eg going to other clubs and meeting other people). MOP appeal to those who are active and connected? Is this another group they can do or does it offer something else (e.g. learning, vehicle for different type of relationship?). Similarly, beliefs about the museum, artefacts, experts etc. will impact the experience of the programme to WB and social engagement. NB the concept of wellbeing is mostly rejected/not taken on by participants. Similarly the idea of loneliness is often rejected. <u>Codes put to one side</u> as they don't feel relevant to the 'process' of 'how MOP impacts WB/SI'. These more tangible ideas may be better picked up in another project that is more interested in environment or physical space. - Physical space - Barriers - Emotion (picked up in other codes such as 'social engagement') - Evaluation - Health - Expectation - Activities - Previous museum experience

	- Activity levels The way that people present themselves in interviews seems to portray people who are interested, interesting, learners, busy, active, not lonely, intelligent. This interplays with judgements about others (what they need, why they're there, what they bring/don't bring). Q - Psychological process of self-other interaction?
After showing the theoretical model to supervisors	Well I'm relieved that it didn't all seem totally ridiculous! It was received quite well although there's also still some refinement needed and explanation. I got a bit tongue tied about how to explain my model, even though it makes complete sense in my head! Agreed that the next step is theoretical coding to build on this model and see if anything new emerges. Also need to clarify some things, especially visuals as it wasn't clear what was impacting what. Also need to start linking to psychological concepts. Overall I feel positive and more confident.
Theoretical coding	Revisiting the data, codes, categories and comparing and listening to the participants to see whether my initial theoretical model is meaningful. Coding the remaining interviews and passports in line with the theoretical model. Check for saturation! Is there anything new coming up? Explanations with examples of emerging theory:- NB – despite some negative judgements about others and the programme maybe this ALLOWED (as defended against anxiety) connection and tolerance over time. The programme gave a focus and meaning to the group – less pressure on the group to 'get along' and therefore not a meaningless group interaction. Group dynamic changed over time. SE – "I'm the sort of person that……". MOP provides confirmation evidence. **SEE DIAGRAM** <u>Psychological concepts to build/explain theory:-</u> Attachment (defend against rejection – JUDGING/PRESENTING) Templates – social interaction, previous experiences with groups/people/learning Self-esteem Life stage and current stressors Group process (storming, norming, forming, etc.)

	I feel happy with my model BUT I'm still so anxious that I've missed something or it's just my projection. I think the write up process will help bring it all together, with quotes, and hopefully alleviate some of this anxiety! Here goes!

Appendix N: Example of a Coding Memo

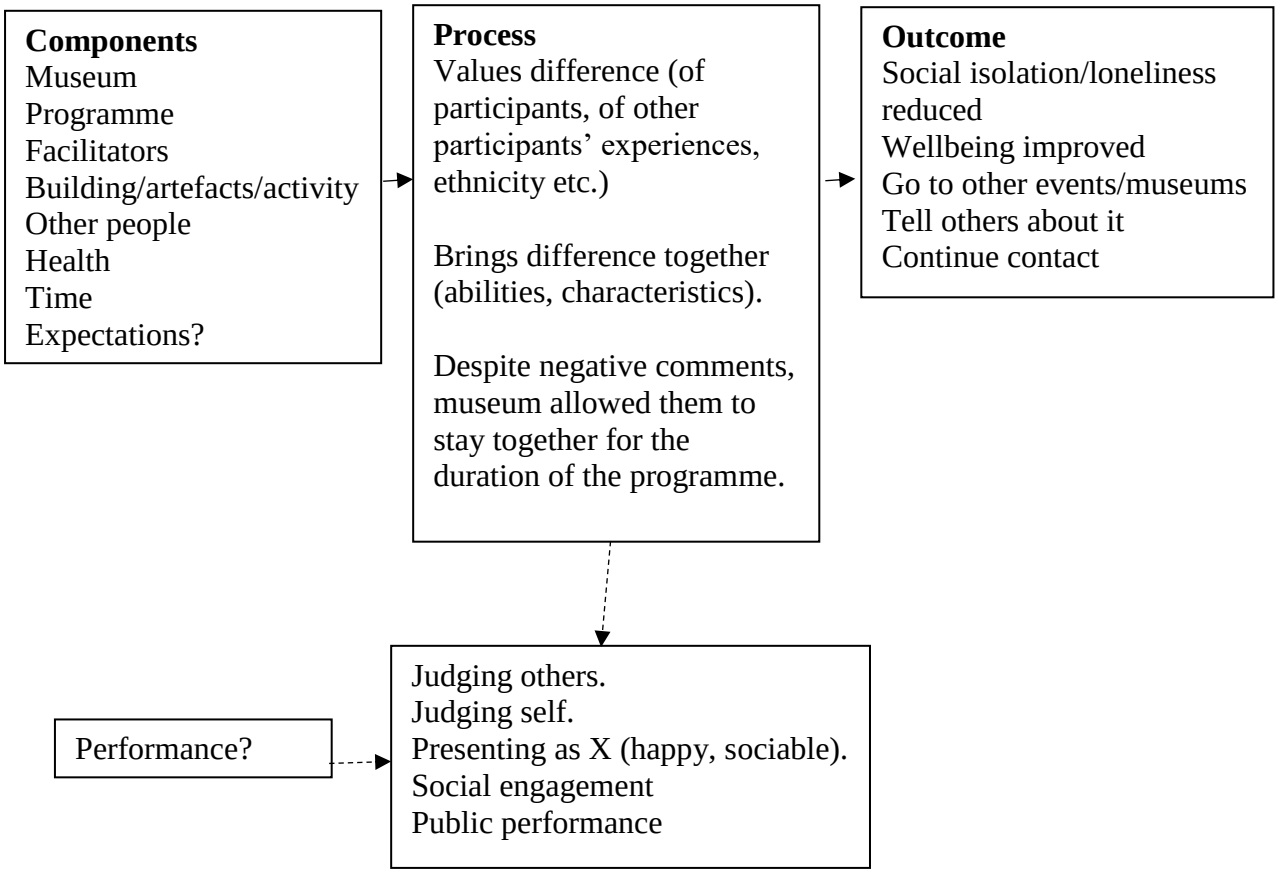
119-2-9 coding memo

Round 1

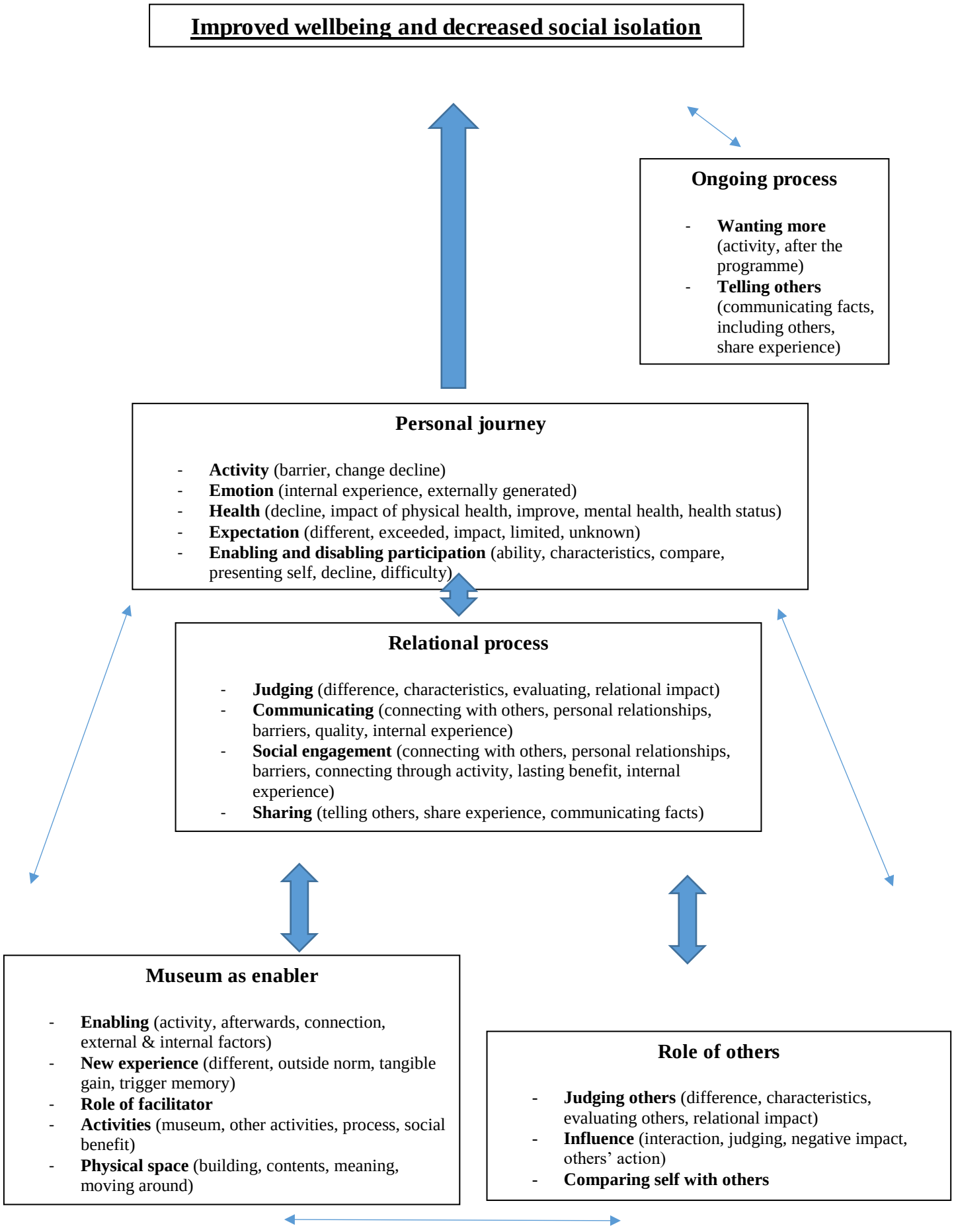
- Coding details relevant to psychological question, rather than purely evaluation of the programme.
- There are however overlaps (for instance, enjoyment from an activity – possibility link to wellbeing but also evaluation of the programme).
- Pure evaluation or information about artefacts not coded (e.g. the skeleton had so many teeth).
- "I like everything here" – evaluation AND personal experience. Hence included.
- Concrete views/opinions about actual things vs process vs experience vs social processes (judgements/assumptions) – emerging differences in coding?
- Difference in quality of social connections? (e.g. couldn't remember the name of Chinese man but immediately commented on the Irish lady's name).
- Don't code detail/information about future events outside the programme (unless it's about process and benefit or enabling because of this programme). EG not coded object detail about an event in the future – Egyptian buildings).
- Descriptions of objects not coded
- But do these demonstrate the knowledge that people acquired? Connect to wellbeing?
- Activity descriptions included if an evaluation of the activity is given (wellbeing theory – be active?)
- When asked how useful the programme was in helping her feel more connected and engaged, she said she was a talker and adaptable. Didn't answer the question.
- So, coding these nuances and direction in conversation might add rich information?
- Asked 3 times about whether the programme helped her feel connected to others. Avoided answering, but 2nd time, did mention death.
- Had to ask about health and wellbeing again?
- ?what do participants think wellbeing is?
- Prompted and asked again about wellbeing and participant equated it to 'mentally well/unwell'.

- Unsure whether to code general chat about other people, general activities, opinions (not related to the programme, loneliness/SI or wellbeing). This might be a bit inconsistent in my initial coding.

Appendix O: Developing Theory Diagrams



Components come together and contribute to the process that influences an outcome.


Improved wellbeing and decreased social isolation
Ongoing process
- Wanting more (activity, after the programme)
- Telling others (communicating facts, including others, share experience)
Personal journey
- Activity (barrier, change decline)
- Emotion (internal experience, externally generated)
- Health (decline, impact of physical health, improve, mental health, health status)
- Expectation (different, exceeded, impact, limited, unknown)
- Enabling and disabling participation (ability, characteristics, compare, presenting self, decline, difficulty)
Relational process
- Judging (difference, characteristics, evaluating, relational impact)
- Communicating (connecting with others, personal relationships, barriers, quality, internal experience)
- Social engagement (connecting with others, personal relationships, barriers, connecting through activity, lasting benefit, internal experience)
- Sharing (telling others, share experience, communicating facts)
Museum as enabler
- Enabling (activity, afterwards, connection, external & internal factors)
- New experience (different, outside norm, tangible gain, trigger memory)
- Role of facilitator
- Activities (museum, other activities, process, social benefit)
- Physical space (building, contents, meaning, moving around)
Role of others
- Judging others (difference, characteristics, evaluating others, relational impact)
- Influence (interaction, judging, negative impact, others' action)
- Comparing self with others

Appendix P: Author Guidance Notes for Chosen Journals

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements. For general guidance on the publication process at Taylor & Francis please visit our Author Services website.

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Manuscript preparation

1. General guidelines

PLEASE NOTE: The main text should be formatted according to the Taylor & Francis layout guidelines. These guidelines include information on section headings, table and figure formatting, and other essential main text elements. The references should be formatted in APA style. Links to both the Taylor & Francis layout guidelines and the APA references guidelines can be found below.

- Manuscripts are accepted in English. Any consistent spelling and punctuation styles may be used. Please use single quotation marks, except where 'a quotation is "within" a quotation'. Long quotations of words or more should be indented without quotation marks.

Research and policy manuscripts
A typical manuscript will not exceed 6500 words including tables, references, captions, footnotes and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.

- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- Abstracts of 150 words are required for all manuscripts submitted. The abstract must be divided into the following sections: Background, Methods, Results, Conclusions.
- Each manuscript should have 3 to 5 keywords.

- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance here.
- Section headings should be concise and follow the Taylor & Francis guidelines on hierarchy.
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- Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:
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    - For multiple agency grants: "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."
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- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

Additional guidelines for original research papers

While these guidelines are not intended to be prescriptive it is important that authors of original research also take into consideration the following points:

Title page:
The title of the article should convey something specific about the topic
e.g. The role of service user participation in a community based visual arts and health programme: an ethnographic case study.
Main part of manuscript:
Background. This should establish the context and rationale for the research and provide an overview of the paper. It should also provide a critical account of current relevant research, showing how evaluation of its strengths, limitations and gaps supports the rationale for the current study.
Research approach and methodology. This should begin with a statement of the research aims

and objectives. As well as informing the reader about the rationale for the approach taken this section should provide a critical account of the methods used. It should address the responses by the researcher/s to any methodological or ethical challenges they faced during the study.
Results. This should outline the main findings from the research.
Discussion/conclusions and implications. This should situate the research findings within the broader context of current knowledge as well as addressing the implications of the study for research, policy and practice.
References
Contact information

Systematic and Literature Review

The journal welcomes systematic reviews and literature reviews that are deemed to make a substantial contribution to the field. Systematic reviews should follow internationally recognised guidelines (e.g. Cochran Reviews) for the development, organisation and reporting of reviews. Literature reviews should present a clear rationale for the review, be well organised into coherent subsections that are appropriately titled, and present well-defined conclusions and recommendations for future research. The length for systematic and literature reviews is 8000 words including tables, figures and references. Longer submissions will be considered but we urge authors only to do this in exceptional circumstances. Similar to research and policy manuscripts, literature reviews require a structured abstract.

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Each issue will publish one or two articles focusing on programmes that demonstrate 'best practice' in the arts and health field. Programmes can be delivered in any venue (e.g. hospital, clinic, community centre, museum, etc.) but must address an issue or problem broadly related to healthcare. Practice-oriented articles are meant to inform the reader about innovative, groundbreaking, emerging and/or longstanding programmes from around the globe. A typical article will be between 2000-3000 words. Abstracts should be approximately 100 words in length and are not required to be structured.
While these guidelines are not intended to be prescriptive it is important that authors take into consideration the following points:
Title page:
The title of the article should convey something specific about the programme
a. Story telling and poetry in a children's cancer unit
Main part of manuscript:
Abstract: Not to exceed 100 words.
Introduction: A description of the programme, it's history, how it is funded, location, and population served
Programme rationale and goals
How the programme is evaluated. This is a key area and authors should describe the evaluative aspects of the programme in detail. Please include any data the programme has collected if possible. Include a discussion of any challenges relating to evaluation, e.g. methodological issues, ethical issues, resource issues
Future plans for creative activity
References (if relevant)
Recommended reading (if relevant)
Contact information

- Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.
- Figures must be saved separate to text. Please do not embed figures in the manuscript file.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

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Journal of Applied Gerontology

Journal of Applied Gerontology is the official journal of the Southern Gerontological Society. It features articles that focus on research applications intended to improve the health and quality of life of older persons or to enhance our understanding of age-related issues that will eventually lead to such outcomes. We construe application to include original investigations or meta-analyses/systematic reviews that have significant clinical, policy, and/or practice implications. Studies of theoretical, conceptual, or methodological issues pertaining to research application are also welcome.

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Appendix Q: Feedback Report to Ethics Panel

Dear Research Ethics Committee

Study Title: Museum-based programmes for self-identified socially isolated older people: Understanding what works for enhancing psychological wellbeing and social isolation

I am writing to inform you that the above study has now been completed. Please find attached a brief summary of the findings of this research. Please do not hesitate to contact me if you require any further information.

Yours sincerely

Carolyn Todd
Trainee clinical psychologist

Summary of Research

Study Title
Museum-based programmes for self-identified socially isolated older people: Understanding what works for enhancing psychological wellbeing and social isolation

Research Context
Social prescribing schemes have been developing in recent years, with potential benefits for various target populations. With an increasingly ageing population and reduced funding in health and social care, schemes targeting older people are growing in importance and research is starting to show the benefit to wellbeing and social isolation. However, despite research showing that there is a change, no research has so far explored what the components are that create opportunities for change, or how they operate.

Research Aims
This study used qualitative interviews and participant diaries to explore the components of a museum programme that provided opportunities for change in participant wellbeing and social isolation. The aim of the research was to build on current research that addresses if schemes reduce social isolation and improve wellbeing and using a grounded theory analysis addressed the theoretical gap to ask how. More specifically, what are the elements and processes of the programme and how do they interact to create opportunities for individual change.

Method
Twelve participants from a 10-week Museums-on-Prescription programme that took place in different museums in London and Kent were interviewed about their experiences of the programme. Weekly museum passports completed after each session were also analysed along with follow up interviews three months after completing the programme. The data were analysed using a grounded theory approach.

Results
A proposed theoretical model highlighted the museum enabled both an individual journey and a relationship process which also interacted with each other. These processes operated within an interacting social context that both influenced how the museum programme was experienced for each participant but in addition the programme enhanced their social context.

Implications
The components identified and the process that created opportunity for change identified the role of previous experiences, attachment styles and self-esteem. The museum offered a unique opportunity to connect participants to these individual components and a reflective, relational process allowed them to have a new experience that had the potential to change previous beliefs, or confirm them. It also connected them to memories and life stories which was a vehicle for communication and connection. Implications for clinical practice include understanding how group programmes can enhance individual experiences and how they can best connect with individual differences of the group to unite the group and create change.

Future research could further explore the connection with participant early life experiences and attachments and how they experience group cultural programmes in later life. Moreover, future research could explore how such programmes might help harder to reach groups, for example people who are not familiar with educational or group settings.

Appendix R: End of Study Report for Participants

Museum-based programmes for self-identified socially isolated older people: Understanding what works for enhancing psychological wellbeing and social isolation.

Introduction

Social prescribing schemes are becoming more popular and include activities such as exercise, gardening and singing. It's thought that they can help people feel more connected to their community, provide support when needed and improve general health and wellbeing. These schemes are backed by research that shows good evidence for helping various people, including older people, who might be socially isolated. However, research has not yet told us how such schemes might be helpful. This study was done to explore what the helpful components were of a 10-week museum programme.

How the study was done

We analysed interviews from 12 people who had taken part in different museums-on-prescription programmes across London and Kent, about their experiences of the programme. We also looked at their museum passports and interviewed them again three months after they had finished the programme. The analysis looked for common issues and experiences using a method of data analysis called grounded theory.

What the study found

We found that there were various processes that helped improve wellbeing and feelings of social isolation. These included the museum itself (such as the physical space and the artefacts) creating individual experiences for people such as improving their health, helping them feel more able to connect with people, and increasing their confidence. The museum also created the opportunity for building relationships. All these components were affected by people's individual stories and expectations, which often helped them come along in the first place.

What the implications are for the future

This study could be used to help future programmes make the most of the group experience, perhaps taking into account some of the things that were harder for people such as not having enough time to socialise, or having too much time in a classroom. Future research might also look at how programmes like this could help other older people who are not familiar with going to group activities or wouldn't normally join things like this.