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Museum-based programs for socially isolated older adults: Understanding what works

Carolyn Todd[a], Paul M. Camic[a,*], Bridget Lockyer[a], Linda J.M. Thomson[b], Helen J. Chatterjee[c]

[a] Salomons Centre for Applied Psychology, Canterbury Christ Church University, Tunbridge Wells, Kent TN1 2YG, UK
[b] UCL Culture, University College London, Gower Street London, WC1E 6BT, UK
[c] Department of Genetics, Evolution and Environment, Division of Biosciences, University College London, Gower Street London, WC1E 6BT, UK

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ABSTRACT

This paper presents research findings that help to understand how museum programs created opportunities to enhance wellbeing and health, and changed experiences of social isolation in older adults. The research conceptualized how program elements enabled both individual experiences and relational processes to occur. These components operated within a context that was enriched by the museum as a place to support wellbeing and enhance social interaction. To meaningfully support socially isolated older people as part of local public health strategies, museums need to be accessible and engaging places that purposively support social interaction by involving people *and* objects, participating in multiple sessions over time, that are facilitated by skilled and knowledgeable staff.

1. 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 focusing on activities of interest, rather than perpetuating dependence on clinical interventions such as psychological therapies, GP visits, and psychotropic medication, to improve social inclusion and wellbeing in older people. The United Kingdom, along with other countries, has developed aims for caring for older adults (Department of Health (DH), 2010), suggesting prevention as a key ingredient, involving community partners to reduce social isolation.

1.1. 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 healthcare services (Davidson and Rossall, 2015). In a meta-analysis, Pinquart and Sorensen (2001) found a U-shaped association between age and loneliness in late adulthood, with being a woman, low socioeconomic status, and low competence being associated with higher loneliness. Milligan et al. (2015) suggested that dwelling alone has tended to be largely regarded as an issue affecting older women but as the life expectancy gap is narrowing between genders, social isolation is increasing in older men. Furthermore, older men are more likely than older women to be excluded from wider social relationships (Ruxton, 2006). In addition to the number of social contacts, deficits in the quality of social contacts also correlated with higher loneliness. Likewise, Klijs et al. (2017) found that social relations buffer the effect of neighborhood deprivation on psychologically-related quality of life. These findings suggest that a complex mix of individual and social contributors are needed and for a large proportion of people, interventions that address environmental or social factors, could change their experience of loneliness.

1.2. Wellbeing

Although a definitive theory of wellbeing remains elusive (Camic et al., 2017a), the notion of psychological wellbeing has been suggested as comprising six key components, personal growth, self-acceptance, autonomy, purpose in life, positive relationships, and environmental mastery (Ryff and Singer, 2006). The role of social factors is apparent in this model, recognizing that relationships are important to wellbeing. Other components that affect psychological wellbeing, such as loneliness, life satisfaction and self-esteem, have also been identified (DH, 2014; Ryff, 1989). The 'Five Ways to Wellbeing' report (Government Office for Science, 2008) presented empirical evidence for improving wellbeing. The report focused on community resources

* Corresponding author.
E-mail address: paul.camic@canterbury.ac.uk (P.M. Camic).

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and what needs to be done to encourage and enable people's prosperity and wellbeing potential throughout their lives. How these factors interact is less well known, and likely to be multifaceted and complex. This suggests that although certain interventions appear to improve wellbeing and loneliness, it is not evident how this happens.

1.3. Social prescribing

Social prescribing interventions provide opportunities for primary care services to link with community and third sector organizations to offer services to people with emotional, social or practical needs (Chatterjee et al., 2015). The international evidence base for health and wellbeing benefits of various arts and health interventions is growing (Ander et al., 2013; Chatterjee and Camic, 2015). The scope of such interventions includes providing meaning and new opportunities to be creative and build relationships. 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). Further research is needed to explore how museum-based social prescribing can be beneficial for socially isolated older people, and help address the needs of an ageing population to live healthy and meaningful lives (Chatterjee and Thomson, 2015).

2. Research aims

Museums, working as public health partners with health and social care services (Camic and Chatterjee, 2013) are ideally suited to offer community-based programs to support the wellbeing of socially isolated older people; they are numerous, exist across different geographical areas, are often free or low cost. Unlike clinical healthcare services, museums are places where assumptions of illness or wellness are not present. They are also available to all, and relatively recently, many museums have begun addressing the relationship between social exclusion and health inequalities (Sandell, 2002) by making them more accessible and culturally relevant places to promote health and wellbeing strategies across different socioeconomic and ethnic groups (Chatterjee and Thomson, 2015; O'Neil, 2010). The present project explored the participation of museums as partners in Museums on Prescription, a large social prescribing scheme, to address the major health issues of social isolation and loneliness. Previous research reported that 10-week museum programs reduced social isolation and increased wellbeing (Camic et al., 2017c). The present study sought to understand, *how* museum-based social prescribing programs reduced social isolation for older people, by determining the specific elements and processes involved, and how these interacted to create a social and physical environment that enhanced psychological wellbeing.

3. Methods

3.1. Participants

In seeking heterogeneity, as stipulated by grounded theory methodology, a total of 20 participants (Table 1) were sampled across age, ethnicity, previous museum attendance, educational attainment, mobility levels and most recent healthcare visit. Each participant provided multiple data sources that included end of program interviews (designated as P1, P2, etc.), 3-month follow-up interviews (designated as F), and weekly "passports" (diaries). These were drawn from a larger study pool of 115 (aged 65–94), self-identifying as lonely or socially isolated who took part in programs across seven museums in central London and Kent, a semi-rural county in England (Camic et al., 2017b). Participants tended to be infrequent museum goers but this was not the case for everyone; they typically lived alone and did not regularly attend other clubs and societies. They did not work either in paid or voluntary employment. Measures of wellbeing and social isolation were recorded at baseline and across the program (Chatterjee and Thomson, 2017). Museum programs consisted of 5–12 people per group for around two-hours per week over 10 weeks. Post-program interviews (45–90 min) were conducted followed by further interviews at 3-month follow-up (20–30 min). The study received ethical approval from the ethics committee at University College London.

3.2. Intervention

As a key component of the research, each museum agreed to develop specific activities that sought to enhance opportunities for engaging and participatory experiences (e.g. Rose and Lonsdale, 2016), based on their respective collections and staff expertise and interests. These activities were not necessarily the same across museums, nor was there the intention on the part of researchers to require uniformity; this would have been an artificial stipulation imposed on museums. All sessions included information sharing components led by staff, consisting of brief lectures or introductions to the topic area of the day. This was followed by a range of activities depending on the museum, which included object handling and discussion around objects; participatory arts including creative writing, drawing, painting, sculpture and collage made in response to items in the collection; crafting items (clay pots, greeting cards, fans); singing and making music with instruments in response to exhibitions or themes in the main collection. The activities were varied across sessions and across museums; some sessions having presentations accompanied by discussion, whereas others included participatory art making, curatorial decision making, and behind the scenes tours of archives areas and storage facilities.

3.3. Design and data analysis

A qualitative study was carried out with people across 12 Museum on Prescription (MoP) programs. Grounded theory analysis was used to build a conceptual understanding of how participating in these programs might explain the processes that enabled change (Urquhart, 2013). Sampling in grounded theory is often guided by theoretical saturation; data is collected until categories are accounted for and relationships between them validated (Green and Thorogood, 2004). The present study, however, used an alternative approach, "theoretical sufficiency", described by Dey (1999, p. 257)as "seeking to reach an in-depth understanding rather than a point where nothing new emerges". In addition, the study used "conceptual depth" (Nelson, 2016, p. 6) whereby a range of evidence and subtlety in concepts shows richness in meaning, resonance with existing literature, and external validity. In order to build a comprehensive understanding, researchers used theoretical sampling (Strauss and Corbin, 1998), a key component of grounded theory. From the larger data pool, we sampled people with different end of program responses on standardized measures of loneliness and wellbeing, measured by the R-UCLA Loneliness Scale (Russell et al., 1980), Warwick Edinburgh Mental Wellbeing Scale (Stewart-Brown and Janmohamed, 2008) and UCL Museums Wellbeing Measure – Older Adult (Thomson and Chatterjee, 2015a, 2015b). All measures were administered three times during the 10-week program and the R-UCLA at follow-up. Sampling considerations such as age, gender, previous museum attendance, geographical location and group cohesion were also used to help develop the emerging grounded theory.

Audio recordings of interviews were transcribed verbatim and analyzed, along with weekly passports. In grounded theory, a process of inductive, bottom-up discovery of meaning from the data occurs, rather than the application of deductive theoretical approaches. The process started with line-by-line open coding and then moved to selective coding, identifying initial categories. Through a process of constant comparison, the categories were integrated to produce