

## **Social prescription and the role of participatory arts programmes for older people with sensory impairments**

### **Structured Abstract:**

**Purpose:** The paper describes the benefits of a social prescribing service for older people with sensory impairments experiencing social isolation. The paper draws on the findings from a 12-week programme run by Sense, a voluntary sector organisation, and illustrates how integrated services, combining arts-based participation and voluntary sector support, can create positive health and wellbeing outcomes for older people.

**Design/Methodology/Approach:** The research took a mixed-methodological approach, conducting and analysing data from interviews and dynamic observation proformas with facilitators and quantitative psychological wellbeing scores with participants throughout the course of the programme. Observations and case study data were also collected to complement and contextualise the datasets.

**Findings:** The research found that participatory arts programmes can help combat social isolation amongst older people with sensory impairments and can offer an important alliance for social care providers who are required to reach more people under increasing pecuniary pressures. The research also highlights other benefits for health and wellbeing in the group including increased self-confidence, new friendships, increased mental wellbeing and reduced social isolation.

**Research limitations/implications:** The research was based on a sample size of twelve people with sensory impairments and therefore may lack generalisability. However, similar outcomes for people engaging in participatory arts through social prescription are documented elsewhere in the literature.

**Practical implications:** The paper includes implications for existing health and social care services and argues that delivering more integrated services that combine health and social

care pathways with arts provision have the potential to create social and medical health benefits without being care/support resource heavy.

**Originality/value:** This paper fulfils a need to understand and develop services that are beneficial to older people who become sensory impaired in later life. This cohort is growing and, at present, there are very few services for this community at high risk of social isolation.

**Keywords:** Sensory impairment; Arts-health intersection; Integrated services; Social prescription; Health and wellbeing; Voluntary and community sectors

## **Abstract**

Services that integrate primary health provision with community-based intervention programmes can offer an important alliance for social care providers who are required to reach more people under increasing pecuniary pressures. The number of older people experiencing visual and auditory problems in later life is growing and this population is more likely to experience social isolation and low self-reported health and wellbeing statuses as a result of ensuing barriers to communication and mobility. The needs of this group, therefore, pose new challenges for designing and delivering community-based services. High-quality art programmes present an opportunity for meeting these needs and a social prescription model that integrates primary care with third sector support (via GP referrals) provides a way of engaging typically hard-to-reach service users with alternative forms of support. The paper focuses on a case study of a social prescription service evaluated through a translational methodology of health and wellbeing evaluation for older people with sensory impairments. Participants ( $N = 12$ ) were recruited through local GPs and prescribed regular arts-based workshop sessions over a period of 12 weeks. The outcomes for health and wellbeing included increased self-confidence, new friendships, increased mental wellbeing and reduced social isolation.

Keywords: Sensory impairment; Arts-health intersection; Integrated services; Social prescription; Health and wellbeing; Voluntary and community sectors

## **Introduction**

While reactive and care-orientated models of support have been developed quickly, through need, new models and approaches to sustain relevant support for older people with sensory impairments will be needed through better integration of care and support services. What constitutes 'integration' however is complex, meaning that consensus across and within organisations is likely to be a significant factor in delivering integrated services. Integration can be considered a continuum, representing different degrees of collaboration across different organisations (Edwards 2010) as well as across service sectors, professions, settings and types of care at a macro, mezzo and micro level (Reed 2005). Integration, in this setting, refers to a small scale collaboration between a primary health service and a community arts programme, funded by a charity sector organisation.

An ageing population presents a challenge for health and social care providers who must find more ways of sustaining support for a growing number of people. The incidence of sensory impairment and multi sensory impairment (combined vision and hearing impairment) rises exponentially with age (Jee et. al 2005). The prevalence of multi sensory impairment amongst older people, especially those with less acute cases however, is more difficult to quantify because of the varying nature of multi sensory deterioration and a lack of awareness amongst professionals and carers in identifying a problem that requires investigation and possible intervention (Roberts et al. 2007). A more recent secondary analysis study has estimated that the number of over 60s with

multi sensory impairment in the UK today is between 114,000 to 279,000 and by 2030 this is expected to double to between 223,000 and 489,000 (Robertson and Emerson, 2010). The over 70s are likely to constitute the majority (73%), presenting undoubtedly the biggest challenge for health and social care services (ibid).

Older people with sensory impairment may experience significant barriers to positive wellbeing due to decreasing social interaction and mobility. Social isolation is a significant issue for people who are both old *and* sensory impaired, for example independence, access to services and social interaction can be diminished as a result of sensory impairment, which in turn can be exacerbated by socially excluding contributing factors of old age, loss of friends and poor health (Banks et al. 2006). People with multi sensory impairment are more likely to have lower self-reported health, are more likely to be depressed and participate in fewer social interactions meaning that this group are at high risk of associated health problems (Capella-McDonnall, 2005; Crews and Campbell, 2004). The problem with delivering services to this group is twofold; health care professionals are often not aware of the existence or significance of multi sensory impairment and older people themselves may be more likely to associate this sensory deterioration with 'natural ageing' (Herman Oleson, 2012) and therefore not actively seek services or solutions to increasing isolation. This presents a significant issue for services which must better locate, identify and target this demographic. Joint-working between arts, community and health services promoting similar outcomes through different targeted approaches will be the key, we argue. Integrated care approaches such as social prescription, can function as a

preventative and health-promoting service where practical implications of current and emerging policy guidelines can come to fruition.

One such alliance operates within the field of Arts-Health intersections. This field has grown considerably in the past thirty years, and the use of creative or participatory tools in social settings is indicative of a wider public health agenda focussed on wellbeing promotion. Research indicates that interventions promoting active social contact and creativity are more likely to positively affect health and wellbeing (Greaves and Farbus 2006). An Arts-Health intersection can be defined as any program of practical arts activities that develops artistry and health wellbeing concurrently for a participant (Vogelpoel and Gattenhof 2012). This duality of intention is the notable distinction in the field of Arts-Health intersections, and as such intended wellbeing benefits are pre-determined as aspirational outcomes for participants and evaluated accordingly. The premise of the approach is to make an important distinction between interventionist creative arts therapies, and models of intersection that promote a multiplicity of outcomes.

Social prescription arts programmes, are an example of an Arts-Health intersection since they can promote positive direct and/or tangential arts and/or health outcomes for participants. Programmes, such as this, linking patients accessing primary care with non-medical support services in the community, are an example of integration across sectors and a more holistic alternative to prescription medication. Social prescription has predominantly been used in mental health settings but outcomes indicate a range of benefits for health and wellbeing (Brown et al. 2004; Lewis and Doyle 2008; Matarasso 2009; White 2004). A growing evidence base

suggests that prescribed social and *arts* engagement in predesigned programmes have the potential to improve health and wellbeing more generally (see Eakin 2003; Brown et al. 2004; Hacking et al., 2006 and Elliott et al. 2010) as well as target groups of older people who may otherwise not come into contact with arts or community services.

In this article, the findings of a social prescribing service commissioned by Voluntary Action Rotherham, and coordinated by the national charity for deafblind people, Sense are discussed.

## **Method**

A social prescribing model was designed and developed through a commission by Voluntary Action Rotherham and draws on relevant literature in the Arts-Health sector, particularly from Arts on Prescription programme models developed elsewhere (Bungay and Clift, 2010; Stickley and Hui 2013). The model comprised three important foci: participation in an arts workshop programme; ongoing individual assessments of health status; and ongoing observations of participant's health statuses.

## **Engagement and Implementation**

The three-stage referral process linked Voluntary Action Rotherham with local GPs who were asked to identify and refer 'older people experiencing social isolation and associated health problems who have single or multi sensory impairment'. It was expected that this participant group would be fairly difficult to identify if their impairment was not known to their GPs. In order to pre-empt this, a multi sensory awareness event and training toolkit, developed through recent research into the prevalence of multi sensory impairment in the ageing community was delivered to referral officers. After initial engagement and recruitment, GP referral notes providing

demographic information including age, gender and health needs, were passed to the project coordinator at Sense who then made formal contact with the participants and initiated a successful personalised recruitment process. Transportation and communication needs were discussed and negotiated at this stage. Participants were invited to the first session, and regular contact was maintained throughout; with reminders for transport arrangements and upcoming developments signposted to participants throughout the process. This aspect became an important part of the engagement and implementation phase, because it enabled participants to implement important choice-making and autonomy building processes.

The practical workshop programme was delivered at a fully accessible resource centre in central Rotherham managed by Sense. Disability and sensory adapted accessibility was ensured and both the venue and programme was promoted to potential participants at referral. Sense support staff and communicator guides assisted a visual and tactile arts facilitator, throughout the sessions.

Participants were provided travel support, and the journey to and from the resource centre was managed by a range of transport options including community transport, taxis, buses and service transport. The physical experience of travelling to and from the resource centre is factored as an important component of the programme, as the implications of reducing social isolation through physical and practical engagement are often underreported in similar programmes.

### **Programme delivery**

Local participating GPs referred or 'prescribed' 12 participants to the programme; 9 females and 3 males ranging in age from 61 – 95 years, with an average age of over 80,

all of whom had been identified as sensory impaired and socially isolated. Four of the participants were identified as having hearing impairments, seven with vision impairments, and one participant with multi sensory impairment. This was not to say that only one person had multi sensory impairment in practice, as vision and hearing loss can present on a continuum of functionality, however a single impairment was stated in their medical file. The GP notes also highlighted a range of age-related cognitive, emotional and physical impairments, as well as mobility issues, within the group. Activities and instructions required some adaptation at different times, but as all participants had acquired sensory impairments, the need for alternative interpretation of information through mediums such as Braille, audio description or British Sign Language was not highlighted. It should be noted though, that these adaptations were built into the initial design of the programme to ensure that subsequent instalments of the service could be as inclusive as possible.

### **Data collection and measures**

The research, taking a mixed method approach, combined the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS); a self-reporting measure completed at the first and last session; with accumulative qualitative analysis tools and member-checking methods such as an observation scale, case study approach and interviews with staff. The decision to undertake a mixed methodological approach to data collection was informed by a need to triangulate and contextualise the data and inform the quantitative analysis with a more in-depth and pragmatic understanding of individual circumstances (Cresswell, 2003).

An extension of Thiele and Marsden's (2003) Dynamic Observation scale was developed, consisting of 17 pre-designed factors of assessment for observing the experience of wellbeing in an arts-health intersection. The observations were conducted every three weeks to generate a case study approach to data collection and analysis. The WEMWBS scale was completed by participants in the first and last weeks of the programme and its use was informed by social prescribing programmes elsewhere (see White and Salamon, 2010; Friedli et. al., 2009).

Semi-structured interviews were conducted with the arts facilitators, support staff, and resource centre manager to ascertain observed impacts of the programme at different levels. Individual case studies were also constructed of participants' experience of the programme, to convey the complexity of their experiences of health and wellbeing improvements as impacted by participation in the social prescribing service. This incorporated the perspectives of others, such as family members, to contextualise the group observations and to offer insight into any transferable impacts or benefits of the programme outside the group; allowing for "an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project... in a 'real-life' context" (Simons 2009, 20). Because of the varied nature of experience within the group, it was important to capture a range of information in this way in order to pay attention to the "specifics of particular cases" (Denzin and Lincoln, 2005: 10) and also as a way of building effective and inclusive translational approaches to health evaluation within and outside of the social care sector. Expanding the use of multiple and translational qualitative health research methodologies is important in the context of health promotion research in the disability and social care sector and,

especially in relation to multi sensory impairment, which is a complex and multifaceted disability.

## **Results**

Data analysis highlighted common outcomes for the majority of the 12 participants involved in the programme. At the start of their involvement, dissatisfaction was wide-spread amongst the participants in relation to their perceived quality of life and personal wellbeing. Most participants highlighted the barriers they were facing in relation to access, inclusion, inter-personal relationships, physical and psychological wellbeing and autonomy, as well as receiving support for their dual-sensory impairment. At the end of the 12 week programme the findings highlighted that significant social and health-related gains had been made by the participants. Many of these improvements have the potential to be long lasting, including increased self-confidence; reduced social isolation; establishment of new friendship groups; greater group cohesion, belonging and improved mental wellbeing. A number of these outcomes are discussed below.

### ***Outcome one: increased self-confidence***

Self-belief, in art making skills as well as recognising self-potential to improve skills was a notable development for many participants. Confidence to participate in group discussions and collaboration was a particular development for at least four participants, who had expressly demonstrated uneasiness at the prospect of working with others. Through involvement in different art-making processes, these participants were able to find common points of interest to build relationships; supporting research

that friendships may emerge more easily from shared activities than in settings focussed overtly on friendship formation (Cattan et. al. 2009).

Participant C had shown initial trepidation about the prospect of attending the group. During the engagement and recruitment process, she postponed her attendance two weeks in a row, and then with encouragement from her family, attended the third session. In the first session, she insisted on holding a staff person's hand throughout the session, and was audibly distressed with heavy breathing. In the second session, Participant C was asked by the facilitator if she would like to help prepare refreshments for the group; to provide a useful distraction for Participant C and ease her into the process of taking part in the group. Within the next three weeks, Participant C began to build strong links with the group and even brought some of her personal embroidery from home in to show, and the group reciprocated the gesture with praise for her work. Their positive response, and that of the facilitators provided a notable boost to self-confidence for Participant C, and she expressed pride when describing how she had mastered the art of embroidery. In reflection, Participant C said of the group, "I can come here and be myself. Everyone here accepts me as I am. If I didn't come here, I wouldn't go anywhere because I get panic attacks and so I stay at home".

Another indication of increased confidence was that participants started to develop a willingness to articulate their communication needs and begin to be autonomous about the kinds of support they needed and how they wanted that support.

Confidence in this way has important repercussions in other areas of life, because it can lead to greater clarity and choice in navigating other aspects of support. For

example, Participant D who relied on community transport to do many things was finally able to voice her concern and frustration at the service, and find some clear and useful solutions. She describes a sense of drive and ambition when talking about the group and it is important to note that the confidence expressed by Participant D is indicative of a physical willingness to participate in social activity: “life can get so boring because I don’t go out because of my problems. I try to, but it got so hard I got to the point where I couldn’t be bothered. I love coming to this group, it motivates me to get out. As soon as the group is over, I’m looking forward to next Wednesday again.”

Building confidence, in this way, can lead to a self-driven perseverance to explore alternative health and wellbeing promoting activities in one’s life. Homework tasks set by the facilitators, where appropriate, provided a useful way of extending the reach of the service beyond the formal group setting and the majority of the group actively participated in working at home. Although it is not possible to link the social prescribing service benefits to outcomes like these, it can be argued that greater confidence in a group session with peers, professionals and strangers has the *potential* to build new approaches to making connections and voicing concern and praise in different areas of day-to-day life.

### ***Outcome two: reduced social isolation***

Most participants had acquired sensory impairments in later life and had experienced difficulty in adapting their communication, logistics, in terms of travel, social interactions and hobbies, as well as to their changing health and disability status. One of the primary intentions of the programme was to bring together a community of like-

mindful individuals experiencing similar challenges to promote group cohesiveness and indirect support from peers; something which could be pivotal in understanding, prioritising and coping with changing health and disability needs. At the beginning, many of the participants noted that they had been feeling isolated. After attending a few sessions many looked forward to the class each week and, in fact, numerous requests came from participants to extend the sessions, and to duplicate them.

When asked to describe the benefits of the sessions, Participant A highlighted that the opportunity to share weaving work with others and being with other people were the most important elements of the programme. The lack of specialist supported recreational, vocational or educational activities available for older people with sensory impairments has further amplified some of the social isolation that participants have been experiencing. As Participant A explains, the group had become a significant aspect of her social interaction, 'If the group ended, I'd only play quizzes at the centre until 4pm and then everyone goes and I'm on my own. I'd like to come all day because it makes me feel better.'

### ***Outcome three: establishing new friendships, belonging and group cohesion***

Public health research indicates that older people experience less group activity or opportunities for collaboration as they age and social isolation may result as a consequence of loss, bereavement, declining physical health and income, for example (Victor et al. 2000). Combined with this, sensory loss can create additional barriers for communicating with others, if and when the opportunity arises.

Being located in a Sense community resource centre meant that participants have become regular users of the centre outside of the programme sessions. The

relationship established between the participants and Sense staff has provided them with a direct connection to support and a greater understanding of their own sensory impairments and some of the ways they could challenge their own perceptions of their abilities.

A recent extension of the sessions beyond twelve weeks has been met with notable enthusiasm within the group and they have also lobbied to extend the length of sessions and for a final group exhibition; indicating the importance of the programme. Although some art-making could happen in isolation, as in many art classes, the facilitator of the programme worked collaboratively so that each participant's individual contribution was included in a group artwork, in this case a group mural comprising individually crafted sections.

Building new friendships has been a clear outcome for most, if not all of the participants and especially Participant E who had instigated a number of extra-curricular group activities outside of the programme, including a group excursion to a Christmas Pantomime and a local jazz night. As Participant E describes it, "Having something (the group) to look forward to keeps my spirits up. On Sundays, I think it's not long until Wednesday, and then I feel better, because otherwise life would be as dead as a dodo".

Participant B provided another example where interests had been borne out of new friendships and connections and their enthusiasm is evident:

"Before I came to the group, I didn't see anyone, and now I meet people here and take the art work home to do so I have something to occupy me at home too. [Participant A] is going to show me how to do basket weaving, and I cannot wait".

Through Dynamic Observation, the development of supportive relationships between participants was identified where skills, practical advice and mutual support were shared. Gradual, but significant development in formal communication between participants was noted during the programme and is demonstrated by the completion of the group artwork, external networks being formed, and a willingness to extend informal support to one another outside of a therapeutic framework. Although not a formal health service, the social prescribing service enabled participants to share strategies for improving health outcomes, including tips for best services to contact, best transport options, and cost-effective possibilities for engagement. The lack of personal illness narratives shared within the group further demonstrated the possibility for indirect group support to provide a different kind of platform that has similar health promotion outcomes to more formal talk-therapies.

#### ***Outcome four: mental wellbeing***

WEMWBS scores were collected at the first and last week of the programme for 8 of the participants (some were unable to attend the full programme due to illness, appointments or holidays). The impact of acquired sensory impairments on mental wellbeing is likely significant because of the impact on communication and mobility. Three members of the group had been referred by their GP with additional psychological issues, including depression and anxiety. Anecdotally, the programme had had very real impacts on the psychological wellbeing of some participants. As Participant B explains, "I feel so much better for coming. I have problems with my back so cannot stand or walk for long, and I cannot see well. I used to love taking photos and painting them, then I lost my sight and have other problems and felt useless. I told

the GP I would take all my tablets to end it I felt so bad. My wife is with me all of the time to make sure I don't. This group is fantastic! I have learnt to do art in a different way where I don't have to rely on my vision and I feel so much better"

WEMWBS is a fully validated 14-item scale containing positively worded statements covering subjective wellbeing and psychological functioning. Each statement is scored out of five, providing an overall score of between 14 and 70 for individual respondents (Stewart-Brown 2008). WEMWBS is validated to calculate *group* changes in mental wellbeing<sup>1</sup> and, although a precise measurement of what constitutes *meaningful* change remains contested, best estimates range from an increase (or decrease) of three to eight points (Putz et al. 2012).

The overall mean score for the group increased by six points, from 41 to 47 and, although encouraging, it demonstrates relative lower wellbeing compared to a general population scoring of 49.9 in Scotland (Well? What do you think? 2006). Individual scores, when ranked into 'low', 'moderate' and 'high' wellbeing<sup>2</sup>, showed that the number of participants who reported low wellbeing decreased from five to three whilst those scoring high wellbeing increased from one person to three. Although not statistically significant with so few participants, the potential of such programmes in positively impacting on the mental wellbeing of this group is highlighted.

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<sup>1</sup> WEMWBS has not yet been validated for monitoring mental wellbeing in individuals

<sup>2</sup>Low = less than 42, moderate = between 43 – 58, high = 59 and over. These figures were calculated using a template to calculate WEMWBS scores available from Stansfield et al. (2013)

Items scoring an average of '3' or more (i.e. 'some of the time, 'most of the time and 'always') increased from 8 to 12 and positive gains were made in 11 of the 14 areas by the end. The biggest positive change for the group was 'feeling more relaxed' yet, in reality, this remained a significant issue in the group as this increase moved from 'rarely' to 'some of the time'. Increased confidence, a greater interest in new things and in people were the next biggest positive shifts within the group over the 12 weeks. This largely correlates with the benefits of the programme already described in relation to harnessing self-belief and confidence, offering access to new things and new opportunities for social interaction.

Despite these advances, there was a clear difficulty within the group in relation to physical energy and, whilst the group's perception of having energy to spare increased overall, this was minimal in reality moving from having energy 'none of the time' to 'rarely'. A few aspects of wellbeing had also actually decreased, very slightly, over the programme in the areas of 'feeling optimistic', 'dealing well with problems' and 'feeling good about oneself' (0.13 decrease each). It should be noted that WEMWBS scores do not account for externally influential factors in people's lives, for example the extent to which factors such as ill health, financial worries and family issues, for example, impact on mental wellbeing. While all eight respondents qualified their more 'negative' responses by explaining that they did not feel this way *because* of the group, it is difficult to separate the two. Arts groups may be valuable in scaffolding positive wellbeing described above, but it would be unrealistic to suggest that they could improve existing health or structural conditions that impact on someone's mental wellbeing in the long term. Furthermore, WEMBWS requires

participants to report on wellbeing in a 'two-week' period, and does not aim to capture information about the impact of the group activity longer term.

***Outcome five: art-making, self-value***

Participants' relationship to their art-making and arts-skill development is an important component of the social prescribing service, and a direct outcome of the programme. For most participants, engaging with art or craft was not part of everyday routine, and many had never been involved in any kind of art class.

Participant F had a notably positive experience of art-making. He had been referred to the group following a prolonged struggle with depression instigated by acquired sensory impairment. During the first session, Participant F was unwilling to take part in the art-making activity and notably withdrawn from the group. However, when contacted the following week to make arrangements for transport, Participant F's wife explained that he had not stopped talking about the group that week and couldn't wait for the next session. She explained that his interest in art had been revived by attending the session and that they had both been searching for his art portfolio throughout the week to bring and share with the other group members. This was an unexpected outcome as wellbeing indicators, including the WEMWBS and Dynamic Observation scales demonstrated Participant F had a very low experience of personal wellbeing. It is important to note then, that although the art-making process was not the prime interest of all group members, it was certainly important for Participant F, and as a focus for engagement and personal drive to renegotiate experiences of inclusion and social participation, was highly successful.

## Discussion

Health and wellbeing promotion have gained considerable momentum in the past twenty years in line with the introduction of alternative modes of wellbeing evaluation, and a more holistic approach to public health promotion, particularly in the United Kingdom. Networks including primary health services, community care services and participatory arts programmes, we argue, provide a viable inroad into addressing social isolation and the associated health and wellbeing implications for older people with sensory impairment. Programmes such as this also enable services to be more personalised and appropriate to service users who would like better access to social support and creative development, though work will need to be done to highlight the health benefits of engaging in an activity that is not directly health-focussed, for both service users and professionals. This will be particularly pertinent for people with multi sensory impairments who may not present themselves as requiring support for isolation but, in fact, may experience the most significant barriers to positive interaction, support for health issues and a sense of belonging and meaning.

Programmes such as this could be useful and the effects long lasting; the original social prescribing service has continued further than the initial 12 week funded engagement and there are now four separate social prescribing services in Rotherham, increasing provision available to older people experiencing social isolation. Those that took part in the original programme have made links with the Sense resource centre for the first time and continue to be connected with support workers, the organisation and other people in similar situations. In terms of providing integrated care solutions, the evaluative systems in place provide health and social care services and statutory bodies up-to-date data pertaining to the needs of this group. It has been increasingly important to diversify the content, structure and management of the social prescribing services however, in response to the interests and health and wellbeing needs of the participants. These changes include alternative funding structures

(direct payments, trusts and grants, local authority subsidisation, and health and social care provision including leisure and recreation) and as such, a growing evidence base suggests that a variety of structure in delivery, engagement and dissemination is important for participants.

## **Conclusion**

Analysis of the data sets suggests that the social prescribing programme has real benefit for participants in terms of health and wellbeing promotion. A genuine sense of community was established in the group and this must be significant in combating social isolation and loneliness. In terms of promoting new art-skills, interests and a renewed sense of drive and ambition, the programme had different impacts on different individuals. This may be attributed to personal interests, but whether participants are attending the sessions for the social aspects, or for the art-making prospect, or for a combination of both, it is clear that the sessions have been important and meaningful to all involved.

There were important outcomes for participants in terms of understanding their sensory impairments and the ways in which they can access different services; sign-posting to other services is incredibly valuable for deafblind people when faced with new challenges in the social care sector, such as acquired sensory loss. This is particularly important where channels of communication are restricted by sensory loss and where older people are less likely to recognise how their impairment can isolate them from others and support services. The service was also important in the way it raised awareness amongst GPs in Rotherham of the presence, needs and specific barriers facing those with sensory impairment in the community; a condition that may often go undiagnosed (Pavey, et al. 2012) and a voice seldom heard.

Participation in arts programmes has the potential to avert crises of loneliness and isolation by enabling older people to get in touch with each other, with services, their communities and their own creativity and in a way that is not care/support resource heavy. By using and extending the existing networks of support and arts provision into a more integrated health and support system for older people, there is much to gain socially, financially and individually, for a significantly and exponentially growing cohort of people.

## References

- Banks, J., Breeze, E., Lessof, C. and Nazroo, J. (eds.) (2006) *Retirement, Health and Relationships of the Older Population in England. The 2004 English Longitudinal Study of Ageing (Wave 2)*. London: Institute for Fiscal Studies
- Brown, M., Friedli, L. and Watson, S. (2004) Prescriptions for pleasure. *Mental Health Today* June, 20-23
- Bungay, H., and Clift, S. (2010). Arts on Prescription: A review of practice in the UK. *Perspectives in Public Health*, 130(6), 277-281.
- Capella-McDonnall, M. (2005) The effects of single and dual sensory loss on symptoms of depression in the elderly. *International Journal of Geriatric Psychiatry*, 20(9): 855–861.
- Cattan, M., Bond, J., Learch, A. and White, M. (2009) Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions, *Ageing and Society*, Vol. 25 No. 1. pp. 41-67.
- Cresswell, J. (2003) *Research design: qualitative, quantitative, and mixed approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications
- Crews, J. and Campbell V. (2004) "Vision impairment and hearing loss among community-dwelling older Americans: implications for health and functioning", *American Journal of Public Health* 94(5): 823–829.

- Denzin, N. K. and Lincoln, Y. S. (2005) Introduction: The discipline and practice of qualitative research. In: N. K. Denzin and Y. S. Lincoln (eds.) *The SAGE handbook of qualitative research* (3rd ed.) London: SAGE Publications, 1-33
- Eakin, M. (2003) "Arts and health", *Journal of Public Health Medicine* 25 (1).
- Edwards, A. (2010) Working across the health and social care boundary, in J Glasby and H Dickinson (eds) *International perspectives on health and social care*, Oxford: Wiley Blackwell
- Elliott, J., Grant, D., and Morison, S. (2010) *Creative Ageing: A practical Exploration of the Arts in the Healthcare of Older People*. Report for the Changing Ageing Partnership. Belfast: Queen's University Belfast.
- Friedli, L., Jackson, C., Abernethy, H. and Stansfield, J. (2009) *Social prescribing for mental health - a guide to commissioning and delivery*. CSIP and North West Development Centre
- Greaves, C. and Farbus, L. 2006. "Effects of creative and social activity on the health and well-being of socially isolated older people: outcomes from a multi-method observational study". *The Journal of the Royal Society for the Promotion of Health*, 126: 134-142
- Hacking, S., Secker, J., Kent, L. and Shenton, J. (2006) Mental health and arts participation: the state of the art in England. *Journal of the Royal Society for the Promotion of Health* 126(3):121-7.
- Herman Oleson, H. (2012) "The challenge of progressive dual sensory loss", in Wehner, L. (ed.) *A Good Senior Life with Dual Sensory Loss*. Nordic Centre for Welfare and Social Issues
- Jee, J., Wang, J., Rose, K., Lindley, R., Landau, P., and Mitchell, P. (2005). Vision and hearing impairment in age care clients. *Ophthalmic Epidemiology*, 12, 199–205.
- Lewis, A. and D. Doyle, (Eds). (2008) *Proving the Practice: Evidencing the effects of community arts programs on mental health*. Fremantle: Optima Press.
- Matarasso, F. (2009) *The Human Factor: Experiences of arts evaluation*, Version 1.5, Available:[http://www.academia.edu/1204593/The\\_Human\\_Factor\\_Experience\\_of\\_Arts\\_Evaluation](http://www.academia.edu/1204593/The_Human_Factor_Experience_of_Arts_Evaluation). Accessed Jan 2014

- Pavey, S., Patel, M., Hodges, G., Douglas, G. and McGee, A. 2012. *The identification and assessment of the needs of older people with combined hearing and sight loss in residential homes*. University of Birmingham and Sense.
- Putz, R., O'Hara, K., Taggart, F. and Stewart-Brown, S. 2012. *Using WEMWBS to measure the impact of your work on mental wellbeing: A practice-based user guide*. Coventry wellbeing project (available from <http://www.champspublichealth.com>)
- Reed, J., Cook, G., Childs, S., and McCormack, B. (2005) A literature review to explore integrated care for older people. *International Journal of Integrated Care*, 5: Jan - Mar.
- Roberts, D., Scharf, T., Bernard, M. and Crome P. (2007) *Identification of deafblind dual sensory impairment in older people*. SCIE: Research briefing 21
- Robertson, J., & Emerson, E. (2010) *Estimating the Number of People with Co-Occurring Vision and Hearing Impairments in the UK*. Lancaster University: Centre for Disability Research
- Simons, H. (2009). *Case study research in practice*. Los Angeles; London: SAGE.
- Stansfield, J., Collins, B., Timpson, H. and Whelan, G. (2013) *Using and analysing WEMWBS to measure the impact of interventions in improving mental wellbeing*. (Available from: <http://www.champspublichealth.com/measuring-outcomes>)
- Stewart-brown, S. and Kulsumjan, M. (2008) *Warwick-Edinburgh Mental Well-being Scale (WEMWBS) User guide, version one*. Scotland: NHS Health Scotland
- Stickley, T., & Eades, M. 2013. "Arts on Prescription: a qualitative outcomes study". *Public health*, 127(8), 727-734.
- Thiele, M. and Marsden, S. (2003) *Engaging Art: The Artful Dodgers Studio*. Melbourne: Jesuit Social Services.
- Vogelpoel, N. and Gattenhof, S. (2012) "Arts-Health intersections: A model of practice for consistency in the arts-health sector", *Journal of Applied Arts & Health* 3: 3, pp. 259–274

Well? What Do You Think? (2006) *The Third National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems*. Scotland: Scottish Government Social Research

White, M. (2009) *Arts development in community health: a social tonic*. Oxford: Radcliffe Publishing

White, M. and Salamon, E. (2010) *An interim evaluation of the 'Arts For Well-being' social prescribing scheme in County Durham*. Durham: Durham University