THE EXPERIENCE OF COMMUNITY FOR SENIORS INVOLVED IN COMMUNITY-ENGAGED ARTS

by

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B.Sc.N., St. Francis Xavier University, 2003

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

September 2008

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ABSTRACT

Social isolation is a concern for the health of older adults in Canada. Community-engaged arts (CEA) programs are thought to support social inclusion but how such programs contribute to building community connections for older adults at risk of social isolation is poorly understood. This study, therefore, is aimed to explore the experience of community for this population in the context of a CEA program as well as the role the program plays in that experience. A qualitative study using ethnographic methods was conducted to answer two research questions: (1) What does community mean to seniors in the Arts, Health and Seniors program? (2) What is the role of the Arts, Health and Seniors program in the participants' experience of community?

Data were collected over a six week period using participant observation, semi-structured interviews and document analysis. The sample was a group of 20 urban-dwelling seniors at risk for social isolation who participated in a CEA program once a week. Regular group art sessions were observed by the researcher and extensive field notes were recorded. Interviews were conducted with five senior participants and four other key informants (including two artists, a senior worker, and an administrators), and documents related to the community were reviewed.

Data were analysed throughout the data collection process and interpretations were noted. Through immersion in the data and a movement between the data and interpretations, themes were developed. Connections between themes were explored and taken back to the data. Findings were presented as a detailed description of the participants' experience of community. Community for the participants focused around

the Seniors Centre where the program was held. The participants expressed that the meaningful relationships at the centre made it ‘another home’ and was a place they could find resources to adapt to challenges. The CEA program provided a unique experience of community through working together as a group and making new social connections. For health professionals working with older people at risk for social isolation, this research will add to the understanding of how community is experienced by older adults and how community is supported by CEA programs.

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ACKNOWLEDGEMENTS

It is my pleasure to acknowledge **my** community – those who have provided me with the support and means to complete this process.

I would first like to thank my supervisor, Dr. Alison Phinney, for her dedication, knowledge and encouragement in completing this thesis. Also, I would like to acknowledge the support of my supervisory committee, Drs. Sabrina Wong and Loren Lovegreen, for their guidance and insight.

I am grateful to my family for their support; especially my sister, Allison, who has been a great resource at every turn, and to my grandparents, who led me to this field.

I am indebted to the School of Nursing at UBC, including the faculty, staff and my fellow students, for the stimulating and positive community I was part of. A special thank you to the graduate secretary, Peggy Faulkner, for her commitment to graduate students and for all she has done for me.

To the older adults I have worked with, thank you for providing the motivation for my work. To the faculty at St. Francis Xavier University, thank you for giving me my first exposure to nursing research. To all the nurses I have worked with over the years, thank you.

Finally, I would like to acknowledge and thank the participants of this study for their time, openness, and most of all, for their lessons.

CHAPTER ONE: INTRODUCTION

Problem

The older adult population of Canada has unique and varying health needs, many of which cannot be adequately addressed by the traditional health care system. There is increasing recognition that it is important for health care practitioners to be able to support the health needs of older adults in the context of their communities. With this shift toward what one might call "community gerontology", an issue that has come to the foreground is that of social isolation. There are growing numbers of older people who are at risk for social isolation and the significant negative health consequences that result. The question of how communities can be more inclusive and supportive of their older citizens has become a matter of particular concern for health care practitioners working with this population. This research study is an attempt to address one component of this overall issue.

For the purpose of this study, social isolation has been defined as the exclusion of an individual or a group from the goals, values, and practices of society (Barry, 2002). Those who are socially isolated are excluded from consideration in social processes and are systematically limited in their ability to participate in social activities (Health Canada, 2002). This type of isolation has been associated with a variety of negative health outcomes. House (2001) has suggested the negative health outcomes associated with social isolation are comparable to those of smoking and other major lifestyle factors. Indeed, social isolation has been associated with increased mortality, as well as increases in the severity of chronic health conditions such as high blood pressure and heart disease

(Bower, 1997; Knox & Uvnas-Moberg, 1998). There is also evidence to show that social isolation leads to depression and other mental health concerns (Kawachi & Berkman, 2001).

Negative health consequences associated with social isolation are observed across populations, but are known to be more significant for some populations than for others. Older adults (defined as those over the age of 65) may be particularly at risk for the negative health outcomes associated with social isolation. In large part this is because older adults are more likely than younger people to experience social isolation. A study done in London, England found that 15% of those over 65 had levels of social interaction which put them at risk for social isolation. This study also found that this percentage increased with age; up to 31.8% of those over 85 years were at risk for social isolation (Iliffe, Kharicha, Harari, Swift, Gillmann, & Stuck, 2007). Other social determinants of health compound the risk of experiencing social isolation including female gender, low socioeconomic status, fewer years of education, unemployment, and aboriginal and immigrant status (Wilkinson & Marmot, 2003). According to demographic statistics, many older adults also face these compounding factors. Seven percent of seniors are below the low-income cut-off (a measure used to describe low income) and the percentage is higher for those who live alone and for women, those who have disabilities, immigrants, and those from visible minorities (National Advisory Council on Aging, 2005). Education rates are also lower in those over 65 and employment rates for seniors are less than 10% (Statistics Canada, 2006).

This demographic picture shows that older adults are at greater risk for social isolation due to the intersection of many social factors, which speaks to the complexity of

how to best address social isolation in this population. Practitioners working with older people in health care and community environments recognize the benefit of greater community connection on the health of seniors (McElhaney, Shaw & Ho, 2008). To achieve this, it is important for health professionals working with older people in the community to be especially aware of ways to combat socially isolating factors and support social inclusion for the population.

Social Inclusion

Social inclusion is the term used to describe the state of being included in a society and is the language that is used to discuss the opposite of social isolation. The concept of social inclusion has been promoted by organizations such as the World Health Organization, the Canadian Nurses Association and the Public Health Agency of Canada as a means to promote health for populations (Wilkinson & Marmot, 2003; Canadian Nurses Association, 2005; Public Health Agency of Canada, 2004). Social inclusion occurs when individuals are included in a social network and have a respected place in a community. When someone is socially included they have resources with which to solve problems and deal with stressors (Public Health Agency of Canada).

Statistics Canada reports that feeling a sense of connection or inclusion within a community positively influences the health of seniors in Canada (Statistics Canada, 2004). This sense of community may come from interactions with family, friends, community and broader society (Guildford, 2000). However, as people age, they tend to have fewer social ties and less family interaction than in their earlier life. This results in changing patterns of social inclusion. For example, a Statistics Canada survey from 2003 shows that Canadians over 65 have a lower average number of friends than those

between 20 and 65. Many older people have significant relationships with their spouses (54% of Canadians between 65 and 74) but there is also a high level of single older people who live alone (22% of Canadians between 65-74 years) (Statistics Canada, 2006). These statistics suggest that as people age, they have fewer supports among family and friends. It is important then, to look to sources outside these traditional relationships to provide social connection for older people.

The Role of Community in Supporting Social Inclusion

As health professionals seek to support social inclusion for older people, they are increasingly looking to community resources to meet the social and related health needs of individuals. These are resources that emerge out of the social connections between people who are not necessarily family members or close friends, but who have a meaningful place in each others' lives (as opposed to defining community in terms of a geographic location). More and more practitioners in fields ranging from emergency nursing to geriatrics to public health are embracing the idea that being engaged in the community is critical to the health of older adults (McElhaney, Shaw & Ho, 2008). One way communities can support the social inclusion of older adults is through activity programming. The Age Friendly Cities Program, a World Health Organization initiative focusing on making cities more supportive and aware of the needs of older people, suggests that community programming oriented to older people is one way to foster social inclusion (WHO, 2007). Community activity programs that provide older people with opportunities to interact with peers as well as participate in activity may also be helpful in promoting social inclusion.

One area that has received recent attention and is viewed as a possible means for communities to foster social inclusion amongst older people is community-engaged arts programming (CEA). CEA programs provide an environment where professional artists collaborate with participants to create an aesthetic product or performance which addresses a relevant community issue. This performance or work of art is ultimately presented in a public presentation to further engage with and be appreciated by the larger community. The skills, abilities, and expertise of the artist, along with the individual knowledge, creativity and life experience of participants are all valued in the art making process. The arts have long been used as a means of personal expression and the therapeutic nature of art has been used in art therapy with various populations, including older people in the community (Flood & Phillips, 2007). However, the idea of using community-engaged art programs to foster social inclusion for older adults is relatively new. There is some anecdotal evidence to support this idea, and as a result CEA programs are increasingly being implemented and evaluated. However, to date there has been little formal research done. An example of this is the recently implemented Arts, Health and Seniors program (AHS) in Vancouver, Canada. While there is research being conducted to explore specific health outcomes of the AHS program, there remains a need to explore the potential contribution of CEA programming in the inclusion of older adults in communities.

Purpose

One of the key goals of the AHS program is to promote the social inclusion of urban-dwelling older adults. Therefore, the purpose of this study is to explore the experience of community for seniors participating in the AHS program, developing a

description of how they perceive community and how engagement in the community is supported or not supported by the AHS program.

Research Questions

This research seeks to answer two questions:

1) What does community mean to seniors in the AHS program?
2) What is the role of the AHS program in the participants' experience of community?

Having a greater understanding of what community means and how being part of a program such as the AHS program impacts the experience of community will provide practitioners with information they can use to support community building and social inclusion for older people in other areas.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The following literature review will focus on the intersection of artistic activity and community in healthy aging. First, I will discuss the current theoretical understanding of healthy aging and the importance of activity and social inclusion in these theories. I will then discuss some of the research that has focused on community as a means of supporting individual health. Finally, I will present the current understanding of the social impacts of artistic activity.

Gerontological Theory

In order to place this research within the current literature, I will begin with a discussion of the current and historical understanding of aging and what is known about how to age well. I will briefly describe how an understanding of healthy aging came about, including a discussion of theories on activity in aging. I will then look at some components of healthy aging discourse which form the basis for this research. Scholars have been exploring the aging process for centuries and have developed theories which attempt to explain how individuals can best navigate the aging process. This literature review will not go into the history of gerontological theory in depth, but it is important to point out key theories which have influenced the understanding of the significance of social connection and activity in the aging process, and which in turn, have informed this research.

Disengagement theory was first developed in the 1960s and suggested that older people and society distance themselves from each other as individuals prepare for death

(Cumming & Henry, 1961). From this perspective, older people normally become less involved in activity and decrease their social connections as they get older. This theory was popular amongst gerontologists for some time, but more recently has been replaced by the understanding that activity and social connection are important for older people.

This research project is based on theories which recognize the importance of activity and social connections to aging well. Theories such as Activity Theory and Continuity Theory attempt to describe the relationship between social connections, activity and aging. Activity Theory suggests that as people age they continue to be integrated in society by adapting to changing roles and finding new roles that are also valued in society (Havighurst, 1963). Aging well, from this view, is continuing to maintain social contacts and a place in society as social roles change with age (Bengtson & Schaie, 1999). Those who age well seek to maintain their social ties through choosing activities which substitute those which they were involved in during their middle years.

Continuity Theory suggests that older people remain interested in similar activities to those they participated in earlier in life and will remain involved in activities similar to those they participated in during mid-life (Atchley, 1989; 1993). This theory also suggests that individuals use knowledge gained in previous experiences to guide decision making surrounding activity selection and participation (Atchley, 1993). Older adults will continue to make choices based on experiences earlier in life which were positively reinforced (Atchley, 1993). This theory outlines the importance of being able to express that which is important to the previously defined self in old age.

Healthy aging as a current model guiding gerontological nursing practice can be defined as the adaptation to age-related changes directed toward maintaining optimal

health and involvement in life (Hansen-Kyle, 2005). The concept of healthy aging serves to describe how individuals can take an active part in ensuring that they age well. This model has developed based on successful aging theories. These theories moved away from the view of older adults as passive and dependant to acknowledge their agency and adaptability to the processes of aging (Rowe and Kahn, 1998). Successful aging theories suggest that older people can take an active part in their lives to have the most positive aging experience (Rowe & Kahn, 1987; 1998; Kahana & Kahana, 1996; 2003). Successful aging theories maintain the importance of remaining engaged in meaningful social connections and proactive in life choices in order to age well (Rowe & Kahn, 1987; 1998; Kahana & Kahana, 1996; 2003).

Together, these theories of aging have influenced the orientation of the current research. It is evident that social connections and activity make a significant contribution to the aging process. Being engaged in activity and having meaningful social connections are recognized as being important to aging well. Activity Theory describes activity as providing a role in society and this research is exploring the role of CEA in the participant's experience of community. Continuity Theory suggests older people will choose activity which maintains their sense of self and has aspects which are familiar to them. Successful aging theories point to the adaptive nature of choices that older adults make in order to age well.

Community Membership as Social Inclusion

In discussing the contributions of various gerontological theories to our understanding of healthy aging, it has become clear that social interactions play an important role in the lives of older people. The previous discussion of social isolation

showed the impact this may have on the health of older adults, including increased mortality (Bower, 1997), increased severity of chronic health problems such as heart disease (Knox & Uvnas-Moberg, 1998), and increased incidence of depression Kawachi & Berkman, 2001). It is therefore particularly important for older adults to experience inclusion in a social group that can provide support and resources for overcoming health related challenges (Public Health Agency of Canada, 2004). As individuals age, there are inevitable changes in their social contacts, which means that community connections may come to play a more significant role in supporting social inclusion for older people. Therefore, in what follows I will explore some of the empirical and theoretical literature on community (as defined earlier in terms of social connections rather than geographic location), as well as what is known about the role of community in the experience of aging.

Community

In the nursing literature, community can be viewed in a number of ways, most notably as: (1) a context in which individuals live; (2) as a resource for health; or (3) as the social connections that constitute part of the individual (Sheilds & Lindsey, 1998). These three perspectives can be found as threads in much of the current research about the meaning of community.

Community as a context implies that individuals live in a community that is often geographically based; it is the environment where a person lives. In nursing practice, which is often institutionally based, this is a common perspective, and individuals are seen as coming from, and returning to, their communities (Sheilds & Lindsey, 1998). In a

US study of a community health centre serving a low-income neighbourhood, researchers found that the board members and staff of the centre primarily adhered to a view of community as context, expressed in terms of demographics and epidemiological information (Drevhahl, 1999). Community for them was a place where people lived. Similarly, in a survey of 115 participants in a community-based participatory research project, researchers found that the physical space, or locus, of a community was an important part of how these participants defined community (MacQueen, McLellan, Metzger, Kegeles, Strauss, Scotti, Blanchard, & Trotter, 2001)

The second common view of community in nursing is community as a resource. This is a view of community as fluid and ever changing, and as interacting with individuals at various levels (Sheilds & Lindsey, 1998). In this perspective, the nurse's role is to help individuals navigate the community and to make use of its resources to support optimum health (Sheilds & Lindsey). In Drevhahl's (1999) study, the users of the health centre had quite a different perspective from the centre's board and staff. For them, community meant the provision and receiving of support. The users of the health centre spoke of being active in the community as a way to support their overall health.

Finally, community can be viewed as part of an individual. Expanding on John McKnight's idea that community is fundamentally about relationships, Sheilds & Lindsey (1998), explore how community is being part of those relationships; a person is a part of their community rather than separate from their community. This same idea emerged from the findings of the study by MacQueen et al. (2001), who described how social ties were seen as the foundation of community, and were often unspoken, simple to upkeep and provided significant support. Similar themes are apparent in the seminal

work by MacMillan and Chavis (1986) who outlined a theory and definition of sense of community developed though an examination of the theoretical and empirical evidence available to them. This theory suggests that sense of community involves having a sense of importance to other members of the group and an understanding that each individual will have their needs met through their links within the community.

The ideas that have been presented here about different perspectives of community are important to this current research, but do not provide an adequate account of the experience of community, especially for those who are not traditionally included in large quantitative research such as older adults at risk for social isolation. While these studies present perspectives of community from various groups, there is little about the experience of community for older people.

Community for Older Adults

It is known that seniors prefer to remain in their own homes and their own communities as they age and face functional and health challenges (Cutchin, 2003). The concept of "aging in place" has been developed to describe this concept of assisting seniors to live relatively independently in the community (Cutchin, 2003). However, not enough is known about how older adults in the community get support from informal community connections while they are aging in place. Large quantitative studies, such as those done by Statistic Canada, have found that older adults have more frequent social ties with neighbours in their community than do younger adults. They report that 14% of those over 75 reported having social ties with neighbours as compared to 9% of those 25-54 (Statistics Canada, 2006). It is clear that community connections are important for

older people living in the community. However, more needs to be known about how communities support healthy aging.

Benefits of the Arts

Activity has long been acknowledged as a part of healthy aging, as is evident in the previous discussion of gerontological theory. There is emerging evidence to suggest that art-related activities in particular may play an important role in healthy aging, possibly through their support of social inclusion and experience of community for older adults.

Art and Healthy Aging

While the body of empirical evidence is not extensive, existing research does suggest that the arts can play a positive role in healthy aging. It has been demonstrated that artistic activity influences physical and mental health for older adults who are independent in the community (Cohen, 2006); increases quality of life in those with a disability (Got & Cheng, 2008); and prevents decline associated with nursing home placement (Hanna, 2006). Art therapy, a form of treatment using art to express and explore psychological and emotional issues, has been used in various settings to promote mental health and well-being in older adults (Ginn, 1999; Johnson & Sullivan-Marx, 2006). However, most of the work done with art therapy has focused on individuals with a medical diagnosis, and has not explored the social benefits of art (Madden & Bloom, 2004). Community-engaged arts (CEA), as the focus of this current study, are arts that are produced with others, thereby having an important social component. As such, CEA

is conceptually quite distinct from art therapy, and the research findings from studies of art therapy are not necessarily transferable.

Two recent studies have provided evidence that there may be unique advantages to artistic involvement that happens in a group environment. Wikstorm (2002) in a controlled intervention study found that older women who took part in a discussion group about art had more positive social interactions over time than those who participated in a regular group discussion. Moreover, Noice, Noice & Staines (2004) found that older adults who made art experienced better outcomes in terms of their cognition and well-being than those who participated in discussions about art. Community Arts Programs

While the empirical studies described above suggest that there are positive outcomes of group participation in the arts, they do not address how the arts may play a role in the experience of community. The literature on community-engaged arts and its social impacts is relatively new; it is generally accepted that publication of material in this field started in the early 1990s (White & Rentschler, 2005). Therefore, there are some limitations with the literature in this field. There has been little formal research on the impact of community arts on social interaction, and that which has been done is criticized for its lack of scientific rigor (Newman, Curtis and Stephens, 2003). Nevertheless, the few published case studies that address the impact of community arts programs on social factors, while not following traditional methods, consistently show positive social outcomes and provide valuable information about how researchers view the role of the arts in social interactions.

The seminal work on the social impact of arts is Matarasso's study done through the Comedia group (1997). This research was done in the United Kingdom with two

additional research sites in other countries, specifically the United States and Finland. Although this study has significant issues in terms of methodological rigor, it is considered a significant work in the field due to its use in forming policy (Merli, 2002). The study used various qualitative and quantitative methods to examine the impact of arts on social factors. While the study findings are broad ranging, of particular significance are the findings related to the social impacts. The author describes how involvement in the arts decreased social isolation, developed community networks, and helped to bring groups of people together who otherwise would not have had the opportunity.

A report by Jermyn (2004) discusses research done on the role of arts in social inclusion in England. This project was a case study design in which the researchers interviewed various participants and informants in arts programs, and reviewed pertinent documents. Fifteen art programs (e.g. writing, theatre, photography, etc.) were included in the study. Again, amongst the findings was the observation that participants in the arts programs experienced increased social contact and social skills.

While no research has examined how CEA supports these kinds of outcomes, a recent analysis of two case studies suggests that CEA make it easier for people to adapt to changes in health and to provide social connection for individuals (White, 2006). This finding, along with the results of the other case studies, makes a strong case for more closely examining the social benefits of CEA.

In summary, although there is some evidence to suggest that community-engaged arts programs will support social inclusion, there is a need for further research in this area. Many have noted the significant gap that exists in the evidence base on the social impacts of community-engaged arts programs (White, 2006, Cooley, 2003; Newman,

Curtis and Stephens, 2003; Merli, 2002). Given the focus of the current study, it is important to note also that none of these studies have focused on older adults. Furthermore, much of the research on the role of the arts in the experience of community has been done in fields such as art, community development, leisure studies, and others, but little is available from the health care sector, including nursing.

Summary

From this literature, it is clear that there is a need to explore the role of the arts in the experience of community for older adults. Theories of aging outline the importance of activity and social interaction to the experience of aging. However, the application of these theories to situations where involvement in the arts may play a role in the experience of social interaction, have not been explored. Community has been studied from multiple points of view and there is some understanding about how people become part of a community, and how community members perceive the meaning of community. However, there is little literature focused on the experience of community for older adults, a group that has unique experiences and challenges which may well influence their experience of community. The arts have been linked to healthy aging and there is some support for using arts in group settings to influence well-being and promote social interaction. However, studying community-engaged arts (CEA) is relatively new and there is still very little rigorous research on the topic. The work that has been done suggests that CEA programs have positive implications for the social connections of participants..

This study will address the role of the arts in the experience of community in the context of healthy aging where there is currently a gap in the literature. The research will

explore what community means to urban-dwelling older adults who are at risk for social isolation and will explore how participation in a CEA program helps shape the experience of community for these individuals.

CHAPTER THREE: METHODOLOGY

Introduction

In order to explore the experience of community for older people involved in the Arts, Health and Seniors Program (AHS) a qualitative study using ethnographic methods was conducted. This chapter outlines how I conducted the research. First, I will explain and justify the design of the study. As is important with this type of research, I will discuss my assumptions and their potential influence on data collection and analysis. I will then describe the Arts Health and Seniors Program as the context for the study, and then proceed to explain the study procedures including the study site, participants, data collection, ethical considerations, and method of analysis.

Design

A qualitative design using ethnographic methods was employed to investigate the research questions identified for this study. This was done for three main reasons. First, this was an exploratory study about a phenomenon that is poorly understood. Using an ethnographic approach allowed me, the researcher, to immerse myself in the field for a period of time to discover and explore new concepts as they emerged, and integrate these insights into the analysis and results (Polit & Beck, 2008). Second, qualitative research allows a concept to be explored within its context and for relationships to be taken into account (Polit & Beck, 2008). Community is often studied from a positivist approach, which necessarily breaks a concept into parts and takes it out of its natural environment. An ethnographic approach on the other hand, takes a holistic, contextualized, approach which in this case, allowed new insights into the concept of community to be explored (Hammersley & Atkinson, 1995). Finally, arts and cultural activities are composed of

complex creative and social processes that are not easily broken down into parts (Cooley, 2003). Using ethnographic methods allowed me, the researcher, to join in the activities of the group, watch interactions and make connections between these phenomena over time (Hammersley & Atkinson, 1995).

For this research project several ethnographic methods of data collection were used. This included **participant observation** as the main data collection strategy. Participant observation uses observations of actions and informal interactions to provide data about the concept being studied (Hammersley & Atkinson, 1995). **Interviews** were used to support data collected from participant observation. The interviews with the participants allowed for insider accounts of the experience of community (Hammersley & Atkinson, 1995). Interviews with key informants other than the participants gave information about the context of the phenomena being studied as well as interpretations from those who had close interactions with the participants (Hammersley & Atkinson, 1995). I examined available **documents** from the centre and from the community that provided information about the context of the centre as well as some of the formal structure of the centre (Hammersley & Atkinson, 1995). These data collection strategies were used to inform each other and, in the end, to develop a detailed description of the experience of community for participants.

Clarifying Assumptions

Prior to entering the field, I sought to prepare myself, the researcher, for the research process. While some qualitative methodologies require the researcher to remove all knowledge and assumptions prior to beginning the research, that was not the case in this study. For this research, I have acknowledged my location as a member of a

community, as well as a person with prior knowledge of community so I can use this location and knowledge as a means to understand the experience of others. I first looked at what is currently understood about community in the literature and some of the main components of programs that support community engagement from other studies. This theoretical and empirical understanding I have summarized in the previous chapter. I also came to this research with particular assumptions about community and the role the AHS program may play in the experience of community. While conducting this research, even as I remained open to concepts emerging in the field, I continued to examine my prior assumptions about community, particularly in light of how they were potentially impacting the research process. In what follows, I will present an overview of my experience with community, as well as my related assumptions.

Assumptions

My assumptions about community and social inclusion come from experience being part of communities, my formal education and my professional experience. Together, these experiences have helped guide my inquiry and the analytical process.

For most of my life I can identify the communities I belonged to and the factors which brought us together. My earliest experience of community was as part of a traditional neighbourhood. The community shared geographic location and social ties formed through shared values and backgrounds over a long period of time. As a nursing student, I lived in a small university town, renowned for its strong sense of community. My experience of community in this environment came from shared experiences, challenges and achievements with other students and residents of the community. My

most recent experience of community was moving to a large city where I learned that recurring and reciprocal interaction is important to community.

During my nursing education, I learned about community though class work and a research project. Through course work in my undergraduate degree I learned how community can be a resource for health and well-being, but cannot necessarily be understood by outsiders. Also at this time, I completed a research project about life satisfaction in older, rural-dwelling seniors and the relationship of life satisfaction to social and volunteer activity. During my master's education, I took a course from the School of Community and Regional Planning with other students interested in community. We each participated in a social learning project with a unique community. This experience taught me about developing community through planned programs and how to evaluate community engagement.

As a practicing nurse I learned a great deal about community both as a member of a practice community and working with individuals in the community. As a member of a practice community, I found sharing concerns and challenges, and working to solve problems with others, led to connection with other staff. Travel nursing provided an opportunity where being on a different floor each day, I had to quickly become part of a group. I found that sharing my interests and background as well as feelings and concerns helped me connect to others.

Finally, work experience I have had in the community has taught me about the experience of others in their communities. I worked for a period as a home support worker in home care where the majority of my clients were older adults, and most with chronic health issues. Many of these individuals experienced difficulty being engaged in

their communities because of their functional ability or other health concerns that led to challenges in transportation. Also, I worked for a time in a small Aboriginal Community in Western Australia. Through this experience I learned that being in the same geographical area does not make a community and that community is influenced by shared values and culture.

The Arts, Health and Seniors Program

The AHS program in Vancouver, BC has been developed through collaboration between the local health authority and the Board of Parks and Recreation to provide arts programming for seniors at risk for social isolation. The AHS program provides cultural and artistic experiences to groups of older people of diverse backgrounds and life experiences to encourage community engagement in those at risk for social isolation and its associated negative health outcomes. The programs are being offered in four self-identified communities and are embedded in local neighbourhoods with artists and senior workers associated with each site. The Renfrew-Collingwood project was one of four programs offered. The AHS program has been funded for a three year period, and this research was conducted in the second year of funding.

The program is being evaluated to better understand the process of providing a CEA project as well as to identify the health outcomes for the participants. This research project is one part of the larger evaluation of the AHS project. It is focused on exploring the experience of community for the participants of one of the study sites, namely the Renfrew-Collingwood community.

Study Procedures

Study Site

The study site was the Renfrew-Collingwood Senior's Centre (RCSC) where a weekly AHS session was held. There was a group of approximately 20 older people who attended the centre twice a week for a regular program supported by the centre staff. The AHS program was incorporated as part of the regular programming on Tuesday mornings for two hours from September to May. At the time this study was initiated, the AHS program was in place for one and half years. The AHS program was run by two artists and was supported by the centre's regular staff, including senior workers and volunteers.

Study Participants

AHS Population

The AHS program was designed to focus on urban-dwelling seniors at risk for social isolation and the associated negative health outcomes. The four AHS groups were formed by recruiting community organizations who were interested in providing an arts program, and then finding participants for the projects. Approximately 60 older adults participate in the four groups that are part of the AHS program. This population is mainly female and Caucasian (although there is one group of Chinese participants). The participants range in age from 50 to over 90 years, and many suffer from chronic or recurring health issues. The method of recruitment into each group varied, but included asking regular members of community centres, community outreach, word of mouth and advertising.

Renfrew-Collingwood Seniors Centre Members

Given the limited scope of this proposed research, participants were sampled from only one AHS group. The RCSC site was selected for this study in collaboration with the AHS program coordinators and the research team because it was believed that this group might provide rich data about community in the context of the program due to historical circumstances and the structure of the program. Specifically, the RCSC site reportedly had difficulty making collaborative connections with other community serves and the program organizers felt the older adults at this centre had more significant challenges maintaining social connections than those in the other three groups.

Of those members of the RCSC who participate regularly in the seniors programming (had a scheduled mode of transportation to the centre or consistently came to the programming each week), all were given the option of participating in the AHS program. There was also one person from a nearby seniors' residence who was brought to the sessions by a community senior worker. Each week seventeen to twenty regular attendees participated in the AHS programming during the research period. The group was mainly female (only two men attended the program). The sample was mainly Caucasian, and had English as a first language. There was one person who spoke only Cantonese and three others whose first language was not English. Participants ranged in age from approximately 65 to 94.

From the AHS group, a range of participants were sampled to participate in individual interviews. Participants were eligible to be included in the interviews if they spoke English and were willing and able to participate in interviews. Approximately twelve participants were eligible. Recruiting stopped at five participants due to time

limitations and the fact that one quarter of participants (five) chose not to participate in interviews. This number of interviews provided significant data to complement participant observation and other data collection strategies.

The final interview sample consisted of women who spoke English as a first language. These women had been involved with the RCSC from 3 to 10 years. Three of the participants lived in the Renfrew-Collingwood neighbourhood, while the other two lived in adjoining neighbourhoods. Some of the participants chose not to give their age so an age range cannot be provided.

Key Informants

In order to explore the context of the AHS program, four key informants were also interviewed. The informants were individuals who have a close relationship with the AHS program and the participants of the program. During each AHS session, there was regular staff in attendance including two artists, one volunteer with the AHS program, two senior workers, and one volunteer with the centre. The executive director, cook and administrator were also in the centre for most of the sessions, but were not significantly involved in the programming. All of these individuals were eligible for participation in interviews. The sample was selected based on their willingness to participate as well as the amount they were involved with the AHS program either directly or as an organizer. Those interviewed included the two artists, the executive director and the community senior worker who was involved in the implementation of the AHS program at the RCSC. These participants were felt to be able to give a range of opinions as they ranged in their level of participation in the program as well as their role.

Ethics

Research with Human Subjects Approval was sought from the University of British Columbia prior to conducting the research. After gaining access to the site and getting support from the artists and executive director, I presented the seniors and staff with what I was proposing to do for the research study. I explained to them what I would be doing and the type of phenomena I was interested in and assured confidentiality. Assent was obtained from the group to conduct observations. At this time the executive director also told the seniors that I would be interested in conducting interviews with individuals and that they might be approached to participate in the future.

The sample for the individual interviews was recruited in collaboration with the executive director and the senior workers at the centre. I asked the staff who they thought would be willing to participate and asked them to inform the participants of my interest in doing interviews. I spoke to the interested individuals about the research study, explaining what would be expected of them if they chose to participate. Participants were not included if they were unable or unwilling to provide informed consent. Prior to conducting interviews, I asked participants to explain their understanding of participation in the research to ensure they understood the process. A consent form (attached as Appendix C) was presented to the participants during the initial discussion of the research. This was done at the senior's centre in a quiet location away from the other participants. Participation in the interviews was completely voluntary and did not affect their participation in the overall program.

Those who participated in the informant interviews were recruited from those who organized or participated in delivery of the AHS programming. These individuals

were also chosen in collaboration with the executive director and AHS program coordinator. Once identified, I approached potential interviewees to discuss the research and determine if they would be willing to participate. They were also given the opportunity to refuse and were made aware that their participation would not affect their role in the program. These individuals also completed the consent form prior to the interviews. They were given an option of where they would like to have the interview done; they chose either quiet areas in offices or public locations such as coffee shops.

Research material was kept in secure areas with limited access. Digital recordings of interviews, transcripts of interviews, field notes and research notes were kept on a password protected research computer only accessible to me. Paper documents were kept in a locked office in a locked filing cabinet. Particular attention was paid to keeping the participants' identity anonymous by not putting their real name on any data, using pseudonyms in written work and changing key characteristic which may make the participants recognizable.

Data Collection

Data collection took place over a period of two months just prior to the program ending for the summer break. This provided time to carry out participant observation as well as conduct interviews and review relevant documents. The data collection took place in the second year of the larger AHS program when the majority of participants had been enrolled in the program for the first year and five months of the second year.

The primary means of data collection was participant observation which served to address both research questions. In order to gain access, I used connections I had

previously made through an internship with the AHS program. I had been working with the AHS program coordinator who was able to introduce me to the artists in the RCSC project. In a meeting with the artists and the coordinator, it was decided that I would help with the program by providing support to the participants and artists while I conducted the observation. I helped set up materials for the sessions, helped participants with their projects and helped in the clean up of the sessions. Working with the program gave me a reason to be at the sessions and a way to interact with participants and staff. I was also able to be introduced to the staff at the centre as part of the AHS program as well as a researcher. I was present for seven sessions for a total of approximately 16 hours of observation.

I observed the sessions from when the participants first arrived, through their morning tea, and then during the arts programming until they left for lunch. Observation was of the seniors, the staff at the centre, and those working with the AHS program. Specifically, I observed verbal and non-verbal interactions between the participants and between the participants and workers. I also observed interactions between the staff. As I was also participating in the program as an assistant, I was able to have informal discussions and interactions with participants and staff.

While the sessions were happening, I took notes of things that I felt were relevant and that I wanted to expand on later. I had explained to the participants that I would be taking notes periodically and had a clipboard on a chair where I would jot down significant observations and things I wanted to remember later. After the sessions I would go to the library across the street and elaborate on the notes I had taken in the field and add other information I had acquired. The field notes I wrote were rich with description

of my observations as I attempted to capture as much information as possible. The field notes took a rough chronological format and described what the participants were doing as well as conversations I was part of or had overheard. Although most of the notes were descriptive I also included some of my initial interpretation of events.

Participant observation was augmented with participant and key informant interviews and document analysis. The participant interviews provided insider accounts of the experience of community and the AHS program. As this research was done in partnership with a community group, there were restrictions from the centre on how researchers could approach participants for interviews. It was important that the interviews be done within the centre rather than at participant's homes for security reasons and to ensure the participants had support from staff. It was also decided that interviews would be limited in length so that participants would not be over exerted. Therefore, interviews were conducted at the seniors centre during scheduled programming. The participants were given an option of where they would like to sit; quiet locations away from the other participants were chosen. Participant interviews varied in length from 15 to 45 minutes. Interviews ended when participants were not providing new information with questioning or appear tired or disengaged in discussion. There were also some instances where interviews were stopped due to the programming schedule at the centre (lunch being served for example). One interview was done with each of the five participants, and each interview was tape recorded with the participant's consent.

Interviews were semi-structured and participants were asked about their experience of community as well as the role of the AHS program in that experience. The

interview questions evolved with the research process. Interviews and field notes were reviewed as data collection progressed and interview questions were adjusted based on new information and emerging concepts. Some of the research questions are provided in Appendix A. The interviews were not expected to follow a predetermined progression; rather, they were guided by interview questions but were flexible to follow participant's ideas.

Interviews were also conducted with key informants. The purpose of these interviews was to address the second research question regarding the context of the AHS program and to validate other data collection. Interviews were conducted with two artists, the executive director of the centre and the senior worker from the community centre. These interviews were approximately one hour in length and were digitally recorded. They were scheduled with the informant at their convenience and held in a location of their choice. These interviews focused on the structural mechanisms in place for the development of community in the groups, as well as insights into the history of the program and the community. Again, the research questions developed with the research process. Sample questions can be found in Appendix B.

To further understand the context of the AHS program in the community, an analysis of relevant documents was conducted. In order to better understand the neighbourhood where the program was offered, I reviewed some publicly available statistical documents on the neighbourhood which provided information about the demographics of the community available from the official Vancouver city website and a document available from the local Health Authority which outlined some population statistics including income and education information. Other relevant documents which

informed the research included monthly newsletters put out by the senior's centre, a newsletter from the community centre located across the street from the RCSC, and the AHS Overview and Evaluation Framework. The RCSC newsletter was used to gain insight into other programs at the centre. The community newsletter was used to compare what other resources the seniors had access to in the community. Finally, the AHS Overview and Evaluation Framework was used to better understand the purpose and organization of the program. Documents were considered data and were analysed with field notes and interview transcripts.

Data Quality Management

Data included field notes from participant observation, recordings of interviews and the transcripts of those interviews, notes about the research process and interpretation, and pertinent documents as discussed above. The interviews were transcribed by a trained transcriptionist. Field notes from participant observation were written directly after the session to ensure significant events were included and details were not lost. The field notes were typed and stored with interview transcripts. The transcripts were cleaned by comparison with the actual tape recorded interview to ensure accuracy. The names of the participants, along with any identifying characteristics or details were removed from the data to ensure anonymity.

Data Analysis

This research was conducted to provide a description of the experience of community for participants in the AHS program. While I conducted participant observation in the environment and conducted interviews with relevant participants, I

was continually analyzing what I discovered. As principle investigator, I immersed myself in the data by listening to taped interviews, reading and re-reading field notes and transcripts, and reviewing initial interpretations. The data were coded into manageable parts and initial impressions and interpretations were recorded. Themes of similarities and common experiences were organized using tables. Themes emerged in various ways. Some concepts first arose from formal and informal discussions about community and were validated with observation. Other concepts arose from observation, including what created reactions from the participants during the art sessions and what I heard participants speak about during the programming. I reflected on emerging themes to consider my assumptions as well as the validity of the themes to the entire group. Using methods similar to other qualitative methodologies, I went back and forth from the interview text and field notes to interpretations, thus, the analysis was an iterative process (Polit & Beck, 2008). I looked for ways that themes from the data were connected and attempted to identify relationships between themes. Participant observation and interviews with seniors were used to describe the experience of community, while participant observation, informant interviews, and document analysis addressed the context of the experience including the wider community and the AHS program. The final product from this research is a detailed description of the seniors' experience of community in the context of the AHS project.

Scientific Rigor

Trustworthiness

Trustworthiness of this qualitative research was addressed at each step of the research process. Field notes and interviews were reviewed by my research committee chair to ensure they had adequate depth and were addressing the research questions. Coding and interpretations from data were also checked with my committee chair to ensure they were accurate and came from the data and not my personal assumptions. I kept a research journal where I reflected on the decision making as well as methodological challenges. These journals also provided an opportunity to reflect on my assumptions and potential biases during data collection and analysis. Journals helped to clarify the research and analytic process and also provide an audit trail (Lincoln & Guba, 1985). The majority of interpretation was done by me, but through in depth discussion with my supervisor, the interpretations were clarified and extended.

Transferability

Information is provided in the written results of the research to help others determine if the findings of the research can be transferred to other populations or environments (Polit & Beck, 2008). There is a detailed description of the participants of the AHS program including demographic factors, living conditions and their environment. There is also a detailed description of the AHS project including the organizational structure, the personnel involved and participants' role in the project. The setting where the program is conducted as well as the routine of the program is presented

in as much detail as possible. These descriptions allow those who read the results of the research to determine to what extent they can be transferred to other contexts.

CHAPTER FOUR: FINDINGS

Introduction

The findings from this ethnographic study are presented as a detailed description of the experience of community for seniors involved in a Community-Engaged Art program (CEA) intended to address the following two research questions: (1) What does community mean to seniors in the Arts Health and Seniors program? and (2) What is the role of this program in the participants' experience of community?

. As is important in all qualitative research, I will begin with a discussion of the context of the participant's experience including the location of the program within a neighbourhood as well as within a seniors centre. I will provide an overview of the program itself, and will present a description of the participants in the program. To address the first research question, a description of community from the perspective of the participants will be presented. As the findings show that the meaning of community for the participants is exemplified in their experience at the Renfrew-Collingwood Seniors Centre (RCSC), I will focus on meaningful relationships developed through the RCSC and how the centre is able to support the seniors through everyday challenges. To address the second research question, I will discuss the role of the Arts, Health and Seniors program (AHS) in the participants' experience of community and specifically how it provides meaning and opportunities to make new social connections.

Context

One of the strengths of conducting work in the qualitative paradigm is the value placed on understanding the context and environment of study participants. Individuals are not independent of their environment (Polit & Beck, 2008). People are influenced by

their environment and the people in their environment in such a way that it is impossible to take a person out of their context and fully understand their situation. I will begin, therefore, with a presentation of the physical and social environment of the Renfrew-Collingwood neighbourhood and the RCSC.

The Neighbourhood

The neighbourhood of Renfrew-Collingwood is located in the eastern part of the city of Vancouver, Canada. It is a fairly typical urban area, with grid pattern streets and modest, single family dwellings (Vancouver Coastal Health, 2005). The neighbourhood covers about 820 hectares of rolling hills between other urban areas (City of Vancouver, 2005). There are parks and forested areas mixed with residential areas. As the area is between the city centre and large suburban populations, there are main transportation lines running though the neighbourhood. This includes five train stops and several main bus lines. Along the train line is a large commercial area with several chain stores, restaurants and service providers.

The neighbourhood was first populated in the 1890s when a main road from Vancouver to New Westminster was constructed through the area (City of Vancouver, 2005). Over the last fifty years, there has been an influx of immigrants from Asia (mostly from China), with approximately 55% of the population having immigrated to the area since 1961 (Vancouver Coastal Health, 2005). As a result, only 27.3% of Renfrew-Collingwood residents speak English as a first language, with the most common language spoken in the area (43.6%) being one of the Chinese dialects (City of Vancouver, 2005). These factors make the Renfrew-Collingwood neighbourhood significantly different than

the rest of the City of Vancouver, which has proportionally fewer recent immigrants and 49.4% with English as a first language (City of Vancouver, 2005).

The neighbourhood is home to about 45 000 people in almost 15 000 households for an average of 3.1 people per household. The average income for the community is about $50 807 compared with the average for the city of Vancouver at $57 916. The number of seniors (those over 65) is almost 13% and is about the same as the rest of Vancouver (City of Vancouver, 2005). The majority of seniors live with their spouse or an adult child (69%) or they live alone (17%) (Vancouver Coastal Health, 2005).

The Seniors Centre

Within this neighbourhood, the RCSC provides programming such as the AHS program, to urban-dwelling older adults. The RCSC is located in the centre of the community, at the intersection of two main streets in an area rich in community resources. The two streets that intersect provide access to the area through major bus routes and a steady stream of traffic. The centre is located midway up a hill at the bottom of which there is a Sky Train stop and a commercial area. Hanging from the lamp posts on the way up the street are banners created by members of the neighbourhood in vibrant colours and patterns. The area around the intersection is full of open, green landscape, flower beds and trees as well as buildings that serve the community.

Near this intersection are several buildings that provide services and programs for the community. On the way up the hill to the intersection there is an elementary school and playing field. At the intersection there is an assisted living residence and a long-term care facility. The RCSC is next to the long-term care facility and on the other side of the

RCSC building is a group of shops including a convenience store, a beauty salon, and a pizza shop. Across the street from the seniors' centre is a community centre attached to a public library. The community centre has a pool and offers programs for all ages in recreational, social and physical activities. On the other side of the community centre is the local Fire Hall.

The seniors centre fits well with the surrounding brick and glass buildings. The building that houses the seniors centre is two stories, but the seniors centre is only on the ground level. The front of the building is all ground level windows and the entrance is at the west side of the building and is also at ground level so there are no steps to enter the building. There are, however, flower beds and a table and chairs at the entrance. Inside the building is a large open area divided by half height, moveable shelves. The centre is nicely decorated with rich colours and traditional prints; there are flowers on the tables and pictures hanging on the walls. The area is divided into three main areas: a sitting area with comfortable armchairs, a dining area with three round tables and an activity area which is an open space with moveable chairs and tables. Along the sides of this main area are staff offices, the kitchen and bathrooms.

The seniors centre serves a distinct population of older people in the community. While the community centre across the street provides programming for all ages (including seniors), it serves very independent and active older people. The assisted living facility and long-term care centre next door serve their residents who need significant functional support. The RCSC serves an older population who is living independently in the community but who may have functional or physical limitations that require modifications in activity programs. A non-profit society, the Renfrew-

Collingwood Seniors Society, runs two programs at the centre. One is an Adult Day Centre, funded by the health authority, and serving older adults being cared for in their homes to provide them with social and meaningful activity. The second is referred to as 'community days' and serves to provide programming to older adults in the community who are living independently in their homes. This program is funded by the city of Vancouver and incorporates the AHS program on one day a week.

Overall, the centre provides programming to 60-65 seniors who are involved with either program. Some people come to the centre a couple times a week and others will come a couple times a month. The seniors are mainly women (75%) and range in age from 60 to over 100. About a third of the seniors are in their 80's and almost one-quarter are in their 70s.

The 'community days' programming at the centre follows a general routine that is structured by the staff. The staff includes two senior programmers, a nurse who works one day a week and the cook. They have all been involved with the centre for several years and know the seniors well. The day begins with the seniors sitting at the dining tables to have tea and socialize. After tea, the staff will have organized a morning program that might be a game, physical exercise, a video, a current event and news discussion or other such activity. After this programming the seniors return to the dining area for a warm lunch prepared by the cook. Again, after lunch the staff will have organized a program such as bingo, a presentation by a health care professional or a musical concert. Before the seniors leave, they again have tea in the dining area. Some days, about twice a month, the staff organizes an outing where the seniors will be taken

to a park, museum, presentation, garden, or other location outside of the centre. These trips are optional and the seniors who chose not to participate can stay at the centre.

The Arts, Health and Seniors Program

The RCSC supported the AHS program from the beginning of the program and this research was conducted in the second year of the program. The RCSC came to be involved with the AHS program through the local community centre and the previous executive director. When this research was completed, the AHS program was offered to participants of the community days on Tuesday morning, between morning tea and lunch.

When everyone had tea and a chance to socialize, the artists asked the participants to go to the activity area where tables and chairs were set up as well as the needed materials for the days' work. During the two hour period, the artists led the seniors in their art program, which, over the time I was present, included two projects that were progressive; work done one week led to work the next week and sample projects were completed so that the participants could practice the processes. The program finished when the cook rang a bell to signify that lunch was ready and that the seniors should make their way back to the dining area.

There were two main projects during the time I observed the group. The first was making scarves with a water theme and involved indigo dying, doing photo transfers of words or pictures with a water theme to the scarves and stamping the scarves with water related images. The project developed over several weeks and also involved watching a video about indigo dying, making practice scarves and doing writing exercises to discover memories of water. The second project was making memory boxes. This was

done with a grade three class from the elementary school across the street. The students had interviewed the seniors and made portraits of them. The interview was turned into a story and put with the portrait in a box which the students decorated with the help of the seniors. One week, the program diverged from the two projects somewhat and the students who worked with making the memory boxes and the students who had worked with the seniors the year prior, came to the centre and sang for the seniors.

The final goal of the program was to have the scarves and memory boxes available for a public exhibit and presentation. The exhibit and presentation was an opportunity for the four groups of seniors from the different communities to come together to present their art work. The presentation happened in June at a downtown community centre. The seniors were taken on a bus to the centre where they were able to watch a performance by another group, have lunch and look at the exhibits from the other groups.

AHS Senior Participants

The AHS program was offered to all the seniors who attended the RCSC on the day it is provided, as well as two seniors who were involved with the program the first year and who lived at the assisted living facility near by. The centre had funding to support 20 seniors on the day the AHS session was held and generally all of the participants who were at the centre participated. Although some of the seniors missed sessions, there was a group of approximately 20 people who participated on a regular basis. Regular participants were considered those who had arranged transportation to the centre or who came to the centre on their own each week. Several of the participants missed sessions but were considered regular attendees if they consistently came to the

centre when able. Unlike the Renfrew-Collingwood community in general, the majority of those who attended the seniors centre spoke English, and similarly the participants of the AHS program were mostly Caucasian and spoke English. There was one person of Chinese background who did not speak English and three other people who came to the sessions regularly who had first languages other than English. As with many of the older people living in the Renfrew-Collingwood community, many of those who attended the seniors centre lived with family members including adult children, grandchildren and spouses.

The individuals who were part of the AHS program were at risk of social isolation. Many of the participants were dealing with changes associated with aging such as health problems and functional declines. The participants often had difficulties with transportation. The seniors of the AHS program also faced general challenges maintaining social connections from the past. Many experienced the death of a spouse or had family members who moved away. Many participants themselves had relocated from a home they had lived in for many years to a different location and social connections had as a result been disrupted. Many of the participants described situations where health care professionals had noticed their social isolation and had referred them to the seniors centre.

The Experience of Community at the Renfrew-Collingwood Seniors Centre

The first research question focused on the meaning of community for participants of the AHS program. Findings show that for the participants of the AHS program, community is strongly tied to the RCSC. Community means social connections and having support for daily life challenges. The RCSC was able to provide an opportunity

for the participants to maintain social connections and to access supports with daily life. Therefore, in what follows, I will discuss how the centre provides opportunities to make meaningful social connections. Then, I will discuss how the centre offers support and resources for the participants to cope and adapt to changes and challenges associated with aging.

It's Another Home

For many of the participants, their involvement in the RCSC was a catalyst for maintaining social connections. When asked why she kept coming to the centre, one participant responded "it's another home". She continued to explain that it was a place where she was around people who were important to her. This sentiment was repeated in my formal and informal discussions with the seniors and staff at the centre; participants came because they liked the people. When asked why she came to the centre, another participant replied "meeting new people and friends, socializing". There was a feeling of relaxed fun at the centre. The participants were able to sit and chat over tea or be comfortable with silence, but there was a lot of laughter as well. The staff and the participants were often engaged in some sort of banter and would have a whole group of people laughing. After spending time with the participants and staff at the centre it was clear they felt comfortable and enjoyed their time there.

The relationships at the centre were very important, not only amongst the seniors themselves, but also between the staff and seniors. The staff was there to provide services to the group, but they offered much more to the people that came. All of the staff including the senior workers who provided programming, the cook who made nutritious

meals, and the executive director who ensured the centre ran smoothly, made time to interact personally with participants. During tea times and at lunch, the staff sat with the seniors and chatted about their own lives and the seniors' lives.

I saw many examples of how the staff knew about each person and what was happening in their lives. One example was the interaction between a staff member and a senior about an afternoon outing that was supposed to be paid in advance so transportation could be arranged. Mary had not been at the centre the week before so had not paid. Although I did not know the reason Mary had not been at the centre the week before, it was clear the staff member did as he added her name to the list of people going and made an exception for her. It was not so much the staff member's actions that showed me the importance of their relationship, but the way they interacted. There was an unspoken understanding, not only of the woman's situation, but that she would want to participate in the outing and needed to be included. Another example is the cook. She had been a part of the Senior's Society that runs the RCSC in various roles since its inception and had worked closely with many of the participants of the centre over the years. During an interview with one of the seniors, the cook was called over to answer questions about the history of the centre. It was clear that the staff was not there just to do their jobs but because they genuinely cared for the people they worked with.

The seniors at the centre have significant relationships with each other. Most of the people who participated in the AHS program had been coming to the centre for over three years, and many of them had known each other before coming to the centre through other community organizations. Of the relationships I witnessed at the centre, some of the relationships between the seniors were the deepest; they extended beyond the centre.

It was evident the relationships were important because of small interactions during the day. People would seek another out to discuss a shared interest, they would save chairs for a close friend, and they would seek advice from friends about health issues. A woman crossed the room to ask another about how a particular plant was doing. One woman asked another about a man who had been at the centre until he moved to a long term care facility. The woman had been to visit him and passed on his news. Someone told me how she had accepted her doctor's advice to join a specific health program because she had heard about it from a trusted friend at the centre.

It is clear that the participants of the AHS program find significant social interaction at the RCSC. People enjoy the time they spend at the centre and have come to have relationships with others that are meaningful to them. These connections are part of the experience of community for the participants.

It's One of the Things I Need in Order to Adapt

Along with the social interaction the centre provides, the seniors have access to people, programs and other resources that can help them through challenges in their daily lives. In a discussion with one of the participants, she told me how important the exercise program at the centre was. She said "it's one of the things I really need in coming here" and went on to explain that the regular exercise she participated in at the centre kept her chronic health issues at bay and that she did not like to miss the program. For many of the participants, functional and physical decline is a reality and they must accommodate to the challenges they face. When asked why she came to the centre, Paula said "the meals- I don't have to cook". For Paula, the centre provided support in meal preparation.

The RCSC provides some key services that make everyday challenges easier to deal with. In this section, I will outline some of the ways I observed the centre providing support for individual needs. This will include a discussion around transportation and community resources.

As I noted above, many of the seniors who participated in the AHS program had difficulty with transportation. Paula was one of the more independent participants. While she walked a lot and was active in other community activities, she also described how she is not able to take public transportation because her ‘balance is bad’ and the sudden movements from buses would cause her to fall. Other people had mobility challenges and used canes or a walker, and some had oxygen tanks that make transportation more difficult. Kathleen told how she lived only a mile away from the centre and for years had walked to participate in the programming until she suffered an acute illness that left her with chronic pain. She then had to get a bus that met her special needs, to pick her up and bring her to the centre. It was clear that those who were at the centre had found access to transportation that met their needs; otherwise, they would not have been there. The staff at the centre helped the participants find supports for transportation and continued to mediate between their needs and the services they used.

Many of the seniors used HandyDart. This is a public bus service for individuals with physical or cognitive challenges that provides transportation in specially equipped buses that give door to door serve. The service is booked in advance or on a regular basis and costs a regular public transportation fee. Staff at the centre served as mediators between the bus service and the seniors by arranging pick ups and collecting the fares. The centre had also been able to provide direct support with transportation. They had a

bus which picked up participants from their homes prior to the program and took them home after. One of the staff members drove the bus and ensured the seniors made the trip safely. Some of the seniors I spoke to described finding transportation resources in the community through connections at the RCSC. Pat described using taxi vouchers that are available for those who are eligible for HandyDart services and which cover 50% of a taxi fare. When I asked Pat how she had found out about this service she told me a previous executive director at the centre had told her about them. These transportation services are essential to the seniors keeping connection with their community, but they are also important for seniors to remain independent in the community. Having options for transportation allowed the seniors to continue to be independent when going to appointments, getting groceries, and other activities that are necessary in daily life.

The RCSC also offered support through serving as a connection to community resources. The centre was a place where people had informal discussions and sometimes formal discussions about resources in the community that could help them cope with challenges they faced. It was a network of people who shared information. Maureen found an optician who had very reasonable prices on eye glasses and brought business cards to give to other participants who needed glasses. Several of the other seniors asked for cards and were intent on contacting the optician when they needed new glasses. When having an informal discussion with the nurse who works at the centre, she told me part of her role was to advocate for the seniors to members of the community and health care professionals. She would call the community health nurse or a physician to make appointments or get referrals.

In summary, for the seniors who participated in the AHS program at the RCSC, community was both enjoying social interactions and having access to many people who could link them to resources they needed either formally, through the staff, or informally, in discussions with other seniors.

The Role of the AHS Program in the Experience of Community

There was much that happened in the AHS program that was very similar to the regular seniors centre programming and that supported and maintained what was cherished by those who attended the RCSC. Like the regular programming at the centre, the AHS program provided an opportunity to interact with others and to socialize. There was time to spend chatting and joking. It also provided opportunities to seek and receive support with daily life. Often during the AHS programming I overheard participants talking about daily life concerns like housing, mutual friends, and family. However, there were important differences from the regular programming that influence the experience of community for the seniors.

In order to address the second research question I will discuss the unique role of the AHS program in the experience of community for the participants. Two things stand out as being important parts of the AHS program to the experience of community for seniors. The first is that it provided an opportunity to be part of a group, both in experiencing novel situations and in experiencing a shared accountability. The second is that it provided new ways of interacting with others. Although the programming at the RCSC provided opportunities to socialize as part of a group, the AHS program provided opportunities to make deeper more meaningful connections within that group.

A Group Effort

The AHS program provided an opportunity to work together as part of a group. While talking with one of the informants, she told me all about how she had developed an interest in crafts earlier in life. She had become very involved in her work and found much gratification in what she did. I asked if her participation in the AHS project was anything like what she had done at home. She replied "no, no, this is a group effort, and I really like it". The AHS program provided experiences to the seniors that brought them together as a community. Also, the program had expectations of the seniors which, through group commitment and effort, were met.

The AHS program provided novel experiences which the group members experienced together. The artists brought new, innovative and creative ideas to the participants. During the first formal interview I conducted, Paula said that although she did not always participate in the art projects she thought the artists' 'ideas are wonderful'. As I observed her during the sessions she may not have been participating by creating art, but she sat with other members of the group and was interested in what the artists presented. Paula's experience was shared by a few others who chose not to participate in doing the art work. The participants still wanted to be with the others as they learned new skills and progressed through the project. An example of this is the sessions that were spent decorating the dyed scarves. A few of the seniors chose not to dye a scarf but chose to observe the others. Later when the group was decorating the scarves with stamps or photo transfers, the same individuals were present and made suggestions about what to put on the scarves. Although individuals did not participate in the arts program in a

hands-on way by making art, they continued to be part of the group, being exposed to and contributing to novel ideas and experiences.

Another way the participants experienced community through the AHS program was through being accountable as a group to meet expectations from the program. The expectations the seniors faced stemmed from the fact that their creations were going to be shared with a larger community at the end of the year exhibit. In order to meet the expectations, the group needed to work together to complete the project. Individuals had to compose written work, decide what to use in memory boxes and choose the design for stamping on their scarves. This individual work was not easy for many of the participants, but they completed their tasks as part of a group. As they were asked to write about their experiences with water, the seniors talked with each other about childhood memories and experiences with water but were reluctant to write anything down. Some said that they had never been good at writing; others thought their ideas were just silly. At one point the artist reminded everyone that the words would be used on the scarves and presented at the end of the year. I watched as one particular woman put her head down and wrote a few lines. In the end, most of the seniors had writing they put on their scarves that were presented at the end of the year. There was a level of commitment from the group to have something to present at the end of the year.

Through working together as a group the participants of the AHS program were able to deepen their experience of community. Working as a group was an experience that was new for many of the participants and gave them experiences that were different than other activities they had participated in. Although some of the participants did not always participate in making the art, they were part of the group which together was

learning new skills and having new experiences. The final exhibit for the program meant that the participants were expected to complete a project and the group shared a commitment to meet those expectations.

New Connections

As was described earlier, community for the participants is about having meaningful social connections. The AHS program provided opportunities for the participants to enrich the connections they have with those already in their community, and to make new connections with others.

The AHS program provided opportunities for the seniors to enrich and strengthen connections with members of their existing social networks. For many participants, whose families were often their closest social network, having something to share with their families was a new and significant event. The program was a way for the seniors to bridge a gap between themselves and their family members. An example of this is Vivian. On the last day of the program the seniors were able to take their art home. Vivian was anxiously looking for her memory box because she knew her grandson "would get a kick out of it". The portrait that the grade three student had drawn was very well done but was probably humorous for an older child. Vivian was able to bring part of the project, something she was part of, to her grandson to make a connection with him she had not had before.

Another example of how the AHS program strengthened existing ties was evidenced in how the AHS program influenced the connection between the staff and the seniors at the RCSC. Although there had been art programming at the centre prior to the

AHS program starting, it was generally small individual projects that were completed in a couple hours. One of the staff members is very creative and enjoyed the new ideas from the artists for her creative work. She often participated in the programming and asked to borrow some of the materials the artists use. Towards the end of my time at the centre this staff member discussed a program she is running with the Adult Day Centre group that comes to the centre on alternating days during the week. The program had many similarities to the project that was done with the AHS group. This staff member had changed the way she connected with the participants at the centre because of the AHS program.

Participation in the AHS program also allowed the seniors to build new connections. Part of the AHS program at RCSC was having a grade three class from the local elementary school come to the centre and do art with the seniors. Before this study began, the students had come to the centre to interview and create portraits of the seniors. The stories and pictures were then used to make memory boxes that the seniors and students together created and decorated. Although the school is less then a block from the RCSC, these groups do not normally meet. From talking with the artists and watching a video presentation at the final exhibit, I learned that the students and the seniors shared stories about games they played, their family life and life in general. The seniors had an opportunity to tell stories about their youth to children who knew nothing about life years ago. The seniors seemed to enjoy this part of the program. When asked by the main artist what they wanted to do next year, the majority of the seniors vocalized that they would like to have the students return. In my interviews as well, the seniors said they thought

having the students involved was fun. Having students come to the centre to work with the seniors provided new connections for both the seniors and the students.

Another example of the seniors building broader community ties through their involvement in the AHS program was seen when the seniors from RCSC attended the final public exhibit of the AHS projects. Participants from all four groups came to the exhibit and had an opportunity to see what the other groups had done through presentations and a display of the art. The seniors from RCSC could not see all of the presentations at the exhibit because of remaining transportation issues, but they were able to see a presentation by a Gay, Lesbian, Bi-Sexual and Transgender (GLBT) group. While this exhibit was on the surface quite different than what the RCSC group presented, it was clear from their comments afterwards that they had connected in an important way with the seniors from the GLBT group through this exhibit. One participant said “I felt it was courageous of them to put it on for the seniors because I found most of the people around my age are pretty close minded”. Others commented that they felt it was “okay” for the other group of seniors to present what they did.

Through participating in the AHS program, the older adults at the RCSC were able to make new connections with others. They were able to connect in new ways with those currently part of their social networks, specifically family and staff at the centre. Participants were also able to make new connections with those who they would otherwise not meet. This included working with grade three students from a local school and connecting with other seniors who participated in the AHS program at other centres.

In summary, the AHS program added depth to the experience of community for the participants. This was done through an exposure as a group to new experiences and through making new connections with social contacts.

Summary

The findings from this research study provide a description of community for the participants of the AHS program. After discussing the context of the program and the participants in the program, community, for the participants was discussed. For those who took part in the AHS program, the RCSC was an important part of their community. Specifically, the centre enabled participants to form and maintain meaningful relationships and provided resources to help the seniors adapt to challenges as they aged. The AHS program contributed to the experience of community by providing an opportunity for the participants to work together as a group through new experiences. The program also provided opportunities to make new connections with others.

CHAPTER FIVE: DISCUSSION

Introduction

While small in scale, this study has revealed some potentially important findings that will inform understanding of how urban-dwelling seniors who are at risk for social isolation experience community in light of their involvement in a community-engaged arts program. In the following discussion, I will situate the study findings in the context of current literature in this area, focusing specifically on ideas of healthy aging and aging in place. I will go on to take a critical look at the limitations of the study, while also highlighting how this research is relevant to nursing and to community gerontology. Finally, I will conclude by identifying the issues that have emerged from this study that require further investigation.

Summary of Findings

The findings from this study show that urban-dwelling seniors at risk for social isolation who are involved in regular programming offered through a seniors centre experienced community first and foremost in terms of their connections with others, including the staff and other seniors in the program. These relationships between the seniors and between the staff and seniors displayed deep and meaningful connections; members of the RCSC community were involved in each others' lives and cared about each other, the centre was seen as another home. Community also meant having access to resources to support the seniors through challenges associated with aging. Through the relationships that occurred at the centre, the seniors received support in their daily lives that went beyond their time at the centre. As these individuals aged and were increasingly faced with physical and functional challenges, they required new ways of adapting and

coping with changes. Their involvement with the RCSC provided for them a community that helped support these adaptations.

While the participants experienced these two important aspects of community (connections and support) through their involvement in the RCSC, the findings clearly show that community-engaged arts (CEA) have the potential to deepen this experience of community for participants. Through their involvement in the AHS program, the senior participants were able to be together while learning and experiencing new things. Also, they were part of a group that had a shared commitment to complete the projects. Through the AHS program, the seniors were able to create new connections with people and communities they otherwise would not have met, such as the grade three students from a local school and seniors from another centre, The AHS program also allowed them to strengthen existing connections with those in their social networks such as their families and the staff at the centre.

The Role of the AHS Program in Building Community

Like other inquiries into the role of community-engaged arts programming, this research has shown that being involved in group art making helps create community connections (Jermyn, 2004; Matasarro, Wenger, Cesbiens, Teno, Hamel, Liu, Carliff, Connors, Lynn & Oye, 1997).

The findings of this study support this earlier research by showing that the participants have the potential to make deeper connections with other group members through shared experiences in novel situations and working together to produce art work for a presentation. For the participants, being expected to create art and working to meet those expectations as a group impacted their community connections. This provides

evidence to support conceptual and empirical claims that have been made about the importance of group members undertaking action together that is based on their shared commitment to common goals in order to develop of a sense of place or community (Cutchin, 2001; MacMillan & Chavis, 1986; MacQueen, McLellan, Metzger, Kegeles, Strauss, Scotti, Blanchard, & Trotter, 2001)

Understanding the Role of Community in Healthy Aging

Healthy Aging models are used to inform current nursing practice with older adults in the community (Hansen-Kyle, 2005). This model has been strongly influenced by successful aging theories which show that meaningful social connections and adaptation to change are important to aging well (Rowe & Kahn, 1987; 1998; Kahana & Kahana, 1996; 2003). While the role of community in healthy aging has been acknowledged, it has not been fully developed (Hansen-Kyle, 2005). Findings from this current study have expanded and clarified the role of community in healthy aging models by providing evidence about how involvement in community-based programs such as the RCSC can provide important social connections for the participants.

Existing research shows that healthy aging for older people is being able to continue to do what they want to while adapting to changes due to aging (Hansen-Kyle, 2005; Bryant, Corbett & Kutner, 2001). One important aspect of healthy aging is being involved in meaningful relationships that are important and valued by the individual (Bryant et al., 2001.). This is often family and friend relationships but may also be connections in the community (Hansen-Kyle). This research study provides further support for this claim, showing how the connections that older adults made through the RCSC were meaningful and potentially contributed to healthy aging. In particular, as

suggested by MacMillan & Chavis (1986), this research has shown that community is comprised of caring relationships. The participants in this study cared about each other and the staff also cared about the seniors they worked with. The findings support that being involved in a community such as the RCSC, is one way to build and maintain meaningful relationships. The findings also show that the seniors at the RCSC face significant challenges with maintaining meaningful relationships as they age. However, RCSC is a place that provides a reliable social network. The community at the RCSC is a part of the social connection which the seniors enjoy as part of healthy aging.

Like the other programs offered at the RCSC, the AHS program provided opportunities to make connections with other members of the RCSC thereby influencing healthy aging. The AHS program was an opportunity for seniors to participate in social interactions that are important to healthy aging, however, the AHS program also provided unique contributions to healthy aging through its provision of 'meaningful activity'.

In healthy aging, there is an importance placed on participation in meaningful activity (Hansen-Kyle, 2005). Meaningful activity can be that which is personally significant, but it is also suggested that activity that is meaningful to others or to society is also important to aging well (Rowe & Kahn, 1998). Being part of a community provides opportunities to engage in activity that is meaningful in this way. Through the AHS program, the participants were able to work together on a shared project. Through the commitment of others in the group, the seniors were part of an activity that was valued by the group. Thus, the activity was validated by the group and became more meaningful. Similarly, the participants of the AHS program were able to share their experiences in the program with their families and with the public through a presentation.

By having something they could take away from the centre, to their family and to members of other communities, there was added validation that the activity as part of the AHS program was meaningful.

Understanding the Role of Community in Aging in Place

Older adults prefer to age in place (Wagnild, 2001). Maintenance of social ties with others (family, friends, and neighbours) and participation in meaningful activities facilitate the ability and desire to 'age in place' (Berkman, Glass, Brissette & Seeman, 2000). The concept of Aging in Place has been adopted by policy makers in North America as a means to keep older people out of costly long-term and other care facilities (Cutchin, 2003). In response, there has been an increased effort to create supports for older people to age in their homes and their neighbourhoods as long as possible. The findings of this study contribute to a better understanding of the important role that community, and in particular community engaged arts, plays in supporting aging in place.

The findings demonstrate that community, as experienced through involvement in a seniors centre such as the RCSC, can support older people as they face challenges with daily life. This in turn may allow them to maintain their place in their homes and in their neighbourhoods. It is clear that the seniors involved in this study faced challenges related to aging which affected their everyday lives. Through involvement with the RCSC, the participants had access to supports and resources that helped them adapt to the challenges they faced. Seniors gave each other advice about health issues, and the staff provided advocacy in relation to other community resources. These findings are similar to those of other research which have shown community is a means to support individuals through

challenges (Sheilds & Lindsey, 1998; Drevdahl, 1999). Being part of the RCSC enabled older people to adapt to changes and challenges associated with aging and they were therefore better able to ‘age in place’.

Pivotal to the concept of Aging in Place is the notion that individuals have an informal network of social resources that can be called on to adapt to challenges (Morris & Morris, 1992). Having informal community connections provide opportunities for older people to ask and receive help when they are faced with changes due to aging. The AHS program provided opportunities to develop new connections with the broader community. In particular, the seniors were able to interact with the grade three students who came to work with them, and the GLBT seniors who presented at the end of the year exhibit. As Matarasso (1997) also found, CEA are a way to bring people together who otherwise would not have met. These new connections provide the participants with a wider social network; they have more resources to call on in times of need.

Limitations

This research was completed to explore the experience of community for those in a CEA program. The ethnographic methods resulted in substantial amounts of data for analysis. However, the participants who chose to not participate in an interview may have had significantly different perspectives than the women I spoke with. Similarly, the interviews with the key informants were all conducted with individuals who had a strong positive connection with the AHS project. Although I spoke with a group who varied in their involvement with the planning and implementation of the program, those with whom I did not speak could have provided different perspectives.

I am a novice researcher with very little experience with ethnographic methods. Although significant time was spent reviewing the methods of data collection and practicing field skills, it was my first experience conducting field work. Even though I collaborated with my research supervisor on my interpretations, ultimately it was my interpretations that were developed. However, completing journals and discussing the procedures with my supervisor provided a check for my methods and findings.

There were issues in gaining access to the study site and limitations placed on my interaction with the participants, notably in the interview process. The interviews with participants were all conducted at the centre during normal programming when the regular activities of the centre may have been a distraction from our conversation. To help prevent this, the interviews were conducted in a quiet area away from the other activity at times where there were no other conflicting activities. Although the recorder may have made people uncomfortable at the beginning of the interview, as the interview continued they became more comfortable with the recorder and spoke freely. Interviews were relatively brief as they were limited by the routine of the centre, but provided significant data to complement field work and informal conversations.

Implications for Practice

As social isolation can have a significant impact on the health of individuals and is of particular concern for the older adult population (Iliffe, Kharicha, Harari, Swift, Gillmann, & Stuck, 2007), it is important for those working with older people in the community to address challenges individuals have in meeting their social needs. This is true for health professionals as well as others who work with seniors in the community.

The findings of this study suggest possible directions for future community-based practice with this population.

The extent to which the RCSC helped support seniors' experience of community serves as a reminder to health care professionals to consider the role a community senior's centre can play in the lives of the seniors they work with, and to consider how to increase individual access to such programs. The findings show that being involved in the seniors centre provides social interaction as part of a community. More significantly perhaps, this research shows that being involved with the RCSC community gave seniors access to resources which help them in other parts of their lives. Although this research does not provide evidence to support claims about how senior centres affect individual health, it does suggest that community centres may support individuals as they face challenges and need access to community resources.

The findings from this research exploring the role of the AHS program in seniors' experience of community suggest that more importance should be placed on the role of the arts in aging from a policy perspective. The seniors who participated in the AHS program had experiences in the program that deepened their existing social ties and also allowed them to make connections with people in other communities. Being involved with community art projects such as the one in this study provide opportunities to interact more significantly with existing social contacts such as family members, but also create opportunities to interact with communities that are new to the seniors. These experiences create a larger social network for seniors, potentially impacting their ability to 'age in place'. As social inclusion has been associated with significant positive health outcomes (Statistics Canada, 2004) it is important to support this type of activity for seniors. Public

policy in Canada should reflect this important part of social health as other countries have begun to do (White & Rentschler, 2005).

Directions for Future Research

The findings from this research suggest that there are further questions to be examined around CEA and its impact on community for older people. This research provides support for previous work that suggests a link between CEA and social connection; however, there is a need for a systematic evaluation of community arts for seniors. Further research is not only needed to examine the social impact of involvement in CEA, but the health outcomes as well. This study provides support for the idea that CEA could be beneficial to health for older participants.

This research did not examine ethnocultural, socioeconomic or health status factors in the experience of community. The neighbourhood where the community centre was located was populated by a large percentage of immigrants, but the participants in the AHS program did not reflect the same diversity. As those who have immigrated are at higher risk for social isolation (Wilkinson & Marmot, 2003), research about the experience of community for those who have immigrated should be conducted. Having English as a second language may have significant implications for becoming part of a community. It is noted that all of the services provided at the RCSC are provided in English and many of the residents of the neighbourhood have English as a second language. Although there are services provided at the community centre in languages other than English, there is a need to explore providing an environment such as the RCSC for those who do not have English as a first language. Although some of the participants did have chronic health issues or functional challenges, this aspect was not part of the

sampling procedures and was not systematically addressed. Although there may have been differences in socioeconomic status for the participants, again this was not taken into consideration when sampling or while conducting field work. It is important to explore how these factors influenced the experience of community as well.

This study was done with seniors who were already part of a seniors centre and who had already developed relationships with others at the RCSC. There is a need to examine the experience of community for those who choose not to be involved in a seniors centre. The seniors at the centre were able to access the RCSC and continue to come to the centre and be involved with the programming. The seniors were able to develop relationships with others at the center. It is important to understand how those who do not have the same access or ability to make social connections experience community. The study was done with a group of people who were already interacting together and already part of a social group. Research is needed to explore how individuals who do not have this base of social connections develop community and how CEA may influence this process.

Conclusion

The aim of this study was to explore the experience of community for urban-dwelling seniors from the Renfrew-Collingwood Seniors Centre (RCSC) who were participating in the Arts Health and Seniors (AHS) program. A qualitative study was done using ethnographic methods to explore this phenomenon. Through the analysis of data obtained from several hours of participant observation, participant and stakeholder interviews, as well as document analysis, a description of community was developed. The findings show that the seniors have developed a community at the RCSC consisting

of meaningful relationships that provide support to the members. The AHS provides further depth to these experiences of community by creating an environment where participants experience novel ideas and activities while working together to meet expectations of the group. These findings relate to other research that has been conducted exploring the social impact of community-engaged arts, and support the claim that programs like the AHS play a significant role in the experience of community for seniors, potentially contributing to their healthy aging and ability to age in place. This would suggest that professionals, in practice and policy, should support the implementation of community-engaged arts as one way of promoting social inclusion for seniors. However, further research is needed to explore these programs and how they can be used to develop these kinds of practices and policy.

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APPENDIX A – INTERVIEW GUIDE FOR SENIORS

<u>General</u>

What is your birthday?
What neighbourhood do you live in?
For how long?

How did you get involved with the RCSC?
Why do you come here?

<u>AHS</u>

Were you involved with the AHS program last year?
Can you tell me a bit about what you did?
What do you think of the program?
Have you learned anything new? What?
What do you like about it? Dislike?
What would you like to be doing with the program?

<u>Community</u>

What would you be doing if you weren't coming here?
How do you get here?
How do you get places generally?
What do you tell your family and friends about coming here?

Is there anything else you would like to add?

APPENDIX B – INTERVIEW GUIDE FOR KEY INFORMANTS

<u>Artists</u>

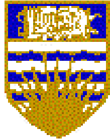
What is your role with the program?
How did you get started with the program?
Can you give me some background to the project at Ren-Coll?
    How did you get matched with the Ren-Coll?
    Can you tell me a bit about the community?
How is this year different that last?
What are your goals for the program?
    Are they being met?

<u>Senior Worker and Executive Director</u>

What is your role?
    What is your part in the AHS program?
Can you give me some background to the community? Community centre?
    The relationship between the two centres?
What population do you serve?
How did the community get involved with the AHS program?
How is it going?
What are your goals for the program?
    Are they being met?
What are some differences from last year?

APPENDIX C – CONSENT FORM

THE UNIVERSITY OF BRITISH COLUMBIA



School of Nursing
T201- 2211 Wesbrook Mall
Vancouver, B.C. Canada V6T 2B5

Tel: (604) 822-7417
Fax: (604) 822-7466

CONSENT FORM

PROMOTING HEALTHY AGING

THROUGH COMMUNITY ARTS INVOLVEMENT

Principal Investigator: Alison Phinney, RN, Ph.D., Assistant Professor

Co-Investigators: Jeff Small, Ph.D., Associate Professor
Student Investigator: Elaine Moody, RN, BN, Masters Student

Background: Community arts for seniors involves artists and seniors participating together in artistic activities that express cultural meanings within their community. We believe that being involved in these types of activities improves seniors' health and well-being. We want to conduct a research study to find out if this is true.

Purpose: The purpose of this study is to explore the experiences of people who are involved in community arts, as visual or performing artists, as senior workers, or as senior participants. In particular, the purpose is to find out if involvement in community arts is associated with improved health for the senior participants. You are being asked to take part in this study because you are involved in a community arts program.

Study Procedures: If you take part in this study, a researcher will interview you on one occasion for one to two hours. This visit will take place in a location of your choice and will be scheduled at a time that is best for you.

The interview will be in the form of a conversation. Everything you say will be tape-recorded. The focus of these interviews will be on your experiences with community arts, specifically what types of activity you do and how you perceive the benefits.

The researcher may also be present at the art sessions where she will observe what goes on. She will observe the **interactions** between all the people in the room (including the senior participants, the senior workers and the artists), and their **communication** (both verbal and non-verbal). She will also observe the **activities** that people are involved in. After each session, she will write down what she has observed.

Risks: There are two main risks to taking part in this research. First, it is possible that <u>you may feel upset, embarrassed or tired</u> by thinking or talking about your experiences. If you become upset or embarrassed or tired, you may choose to stop the interview, or you may withdraw from the study completely.

Second, by taking part in this research <u>you will experience a loss of privacy</u>. To help ensure that information obtained from you will remain as anonymous as possible, no identifying information or names will appear in any document or report about this research. All documents and recordings will be identified by a code number and will be kept in a locked filing cabinet inside a locked office. The recordings will be stored on a computer hard drive, which is password protected and accessible only to Dr. Phinney and her assistant. The co-investigators and students who are involved with this research will also have access to the information for purposes of analysis.

Information obtained from you (with identifying information and names removed) may be used for educational purposes or for presentations at professional conferences.

Contact: If you have any questions or you want further information about this study, you may contact Dr. Phinney at 604-822-7484.

If you have any concerns about your treatment or rights as a research subject, you may contact the Director of Research Services at the University of British Columbia at 604-822-8598.

Consent: I understand that my consent to take part in this study is entirely voluntary. I may refuse to participate or withdraw from the study without jeopardy to my access to services from the facility sponsoring the community arts program or to my involvement in the program.

I have received a copy of this consent form for my own records.

I consent to participate in this study.

____
Printed Name

______________________________ ________________________
Subject Signature Date

APPENDIX D – UBC REB CERTIFICATE OF APPROVAL

The University of British Columbia
Office of Research Services
Behavioural Research Ethics Board
Suite 102, 6190 Agronomy Road,
Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - MINIMAL RISK AMENDMENT

PRINCIPAL INVESTIGATOR:	**DEPARTMENT:**	**UBC BREB NUMBER:**
Alison Phinney	UBC/Applied Science/Nursing	H06-80366

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

Institution	Site
UBC	Vancouver (excludes UBC Hospital)

Other locations where the research will be conducted:

Participant observation will take place in settings where community arts groups take place (e.g. activity rooms of community centers)

CO-INVESTIGATOR(S):
Jeffrey A. Small

SPONSORING AGENCIES:
N/A

PROJECT TITLE:
Promoting Healthy Aging through Community Arts Involvement

Expiry Date - Approval of an amendment does not change the expiry date on the current UBC BREB approval of this study. An application for renewal is required on or before: June 27, 2008

AMENDMENT(S):

AMENDMENT APPROVAL DATE:
April 29, 2008

Document Name	Version	Date
Consent Forms:		
Consent Form	2	March 26, 2008
Other Documents:		
Letter of Support	N/A	March 26, 2008

The amendment(s) and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board
and signed electronically by one of the following: