MuseumsForward

Museums on prescription: Incorporating museum staff perspectives

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Abstract

At the intersection of social prescribing and museums in health is museums on prescription, a project in which the museum is viewed as a viable community service provider for social prescriptions. Although museums on prescription has gained considerable attention by museum practitioners and healthcare professionals in various countries, it is understudied and there is a need for more rigorous research that incorporates a broader scope of stakeholder perspectives. This study responds to this research gap by richly describing museums on prescription models from the perspectives of the museum practitioners involved in them. This study utilized a descriptive case study approach where data was acquired through document analysis and facilitated interviews with six museum staff from five museums in two countries where museums on prescription is most prevalent, the UK and Canada. Findings suggest that museums on prescription is commonly associated with social prescribing *light* models, requires a verbal or written referral, and adopts one of two program formats that is heavily dependent on partnership—customized programming or ticket distribution. Although museums on prescription was viewed by museum staff as a means to increase the well-being value of the museum, limited stakeholder capacity was a considerable constraint. This study also found that while there is shared concern for the impact of Covid-19 on future programming, museum staff are majorly optimistic of the possibilities. This study lays the groundwork for further research connecting museum staff experiences to social prescribing.

Keywords

social prescribing; museums; prescription; staff

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Introduction

Never has it been more important to explore novel and unconventional solutions to the growing health crisis in America. Before Covid-19 arrived in early 2020, nearly one in five Americans had some form of mental illness (“Quick Facts,” 2021). One year later, researchers report that Covid-19 has had a “profound” impact on mental health in our country, as evidenced by the serious influx in cases of anxiety, depression, loneliness, and psychosis across America (Reinert & Nguyen, 2021, p. 5). The problem is compounded by the reality that poor mental health has long-established ties to multimorbidity, or the presence of multiple, physical, chronic ailments, and polypharmacy (Pryke, 2020). This article describes results from an international research study that examined the role that museums outside of the US can play in promoting positive mental health.

Mental health crisis

There are multiple factors that contribute to poor mental health. For example, loneliness and isolation can have an enduring impact on an individual’s state of health and well-being (Pescheny, Randhawa, and Pappas, 2020). Other predominant examples of psychosocial factors include housing insecurity, financial strain, and bereavement. Moreover, fundamental inequities in income, power, and wealth means psychosocial problems and resulting illness will disproportionately affect those from a poorer socioeconomic background (Chatterjee & Noble, 2016; Mercer, Fitzpatrick, Grant, Chng, McConnachie, Bakhshi, James-Rae, O'Donnell, & Wyke, 2019). This “social gradient” also means that individuals who reside within poor communities typically have less access to care and prevention resources (Mercer et al., 2019), potentially accounting for the 24% who are unable to acquire mental health treatment (Reinert, Nguyen, & Fritze, 2021).

Even more problematic is the lack of infrastructure to address mental health issues in America. Broadly speaking, “many of the issues facing mental health treatment infrastructure and adequacy are related to the implementation of federal laws, or are state level issues that are common across the states” (“Regional Policy Council,” 2021, para. 4). At the state level, lack of behavioral health services integration, workforce capacity, and access to community resources are significant barriers to

offering sufficient mental health care and treatment. The additional strain placed on healthcare employees during the pandemic has further exacerbated these shortfalls. Not only are 58% of primary care physicians feeling burnt out, overworked, and overextended as a result of the pandemic (The Physicians Foundation, Part 2, 2020), but as a result of the economic crisis created by the pandemic, 1.4 million healthcare employees are out of work (The Physicians Foundation, Part 1, 2020).

Mental Health America, a community-based nonprofit devoted to mental health awareness and advocacy, has composed a list of position statements and recommendations based on what they believe to be the most outstanding policy issues facing our country ("Public Policy," 2021). One of these statements emphasizes the need for a renewed commitment to the psychosocial needs of people through increased linkages to community services and community-based intervention ("Position Statement 16," 2017). This approach is particularly redolent of the asset-based health model. The asset model deviates from deficit models, which are predominantly focused on the origins of disease, to models that are grounded in the theory of *salutogenesis* (Morgan & Ziglio, 2007). Salutogenesis is centered on the belief that we can generate health by identifying the origins of health. Accordingly, asset models leverage the existing capacities of the community to create health and reduce health inequities by meeting the wider set of determinants for mental health. Asset models have the potential to increase the sense of empowerment and resourcefulness among individuals to sustain their own health, strengthen local experts' appreciation for community resources, and bolster the responsibility felt among community organizations as co-producer of health. One pathway to accomplishing such integrated, community-based solutions has become common practice in the United Kingdom.

Social prescribing

Given the critical role of psychosocial factors and sociality in our overall health and well-being, there is a growing interest in bridging the gap between primary care services and patients' social needs in the UK (Pescheny et al., 2020). In the UK, social needs account for 20% of patient visits and the number of long-term conditions linked to psychosocial issues and health inequities are increasing at a rapid pace (Bertotti, Frostick, Hutt, Sohanpal & Carnes, 2018). Physicians are inundated with multimorbidity cases, health disparities, and insufficient resources and time, making it exceedingly difficult to address the social

needs of patients. Social prescribing, a model first introduced in the 1990s, emerged as a promising solution to the challenges facing their health sector (Polley, Fleming, Anfilogoff, & Carpenter, 2017). Early studies also revealed its potential to reduce inpatient and outpatient admissions, emergency visits, improve patient well-being, and enable community organizations to access NHS funding (Dayson & Bashir, 2014). It has since been regarded as one of the ten high impact actions to relieve pressure on primary care and has officially become a core component of the NHS Long Term Plan (Thomson, Morse, Elsden, & Chatterjee, 2020). Outside of the UK, social prescribing is also part of a growing conversation taking place in Canada. Regional pilots such as Rx: Community have made noteworthy strides in starting a dialogue around social prescribing as an appropriate and effective form of health intervention in Canada (Mulligan, Hsiung, Bhatti, Rehel, & Rayner, 2020).

Social prescribing can be understood as a "formal means of enabling primary care services to refer patients with social, emotional, or practical needs to a variety of holistic, local non-clinical services" (Kimberlee, 2015, p. 105). Social prescriptions are written by primary physicians to then be filled by an array of community organizations that could include libraries, museums, fitness centers, art centers, gardens, community centers, and schools. Therefore, prescriptions can take the form of anything ranging from financial advising and ecotherapy to cooking classes and museum visitation. In most cases in the UK, a referred individual is directed to a "link worker," a non-clinically trained person who has knowledge of the community services available and builds a rapport with the individual in order to customize their prescription according to their needs and goals (Polley et al., 2017, p. 16). By providing access to services centered on community services and sociality rather than traditional treatment—medication, cognitive behavioral therapy, and counselling (Pescheny, Pappas, & Randhawa, 2018)— social prescribing is understood as a more salutogenic approach to health (Dayson, Painter, & Bennett, 2020; Howarth, Griffiths, Da Silva, & Green, 2020) which is characteristic of its asset model design (Morgan & Ziglio, 2007).

Social prescribing follows an asset health model. As such, there is no singular and correct way to establish a social prescribing program as it is entirely dependent on locality. Social prescribing models reflect the challenges, resources, and abilities associated with their geography because health and well-being is heavily dependent on the social context in which a person lives (Chatterjee, Camic, Lockyer, & Thomson, 2018). Four model types have been identified by researchers, however,

which distinguish social prescribing schemes by their perceived complexity and overall involvement in care (Kimberlee, 2015). The most common model type is categorically understood as social prescribing *light*. Social prescribing *light* takes community-based intervention one step above the model type *signposting* in terms of general practitioner or link worker involvement by connecting individuals considered to be at-risk and vulnerable with programming that meets their specific needs and motivates them to accomplish a particular goal. Social prescribing *light* is often associated with social prescribing services such as museums on prescription, exercise on prescription, and arts on prescription.

Regardless of model type, however, reviews of social prescribing have promising implications for the betterment of individual health. Several research studies have indicated that clients find a sense of empowerment and control when afforded the opportunity to take on a more proactive role in developing their own treatment (Chatterjee et al., 2018; Wildman, Mofatt, Steer, Laing, Penn, & O'Brien, 2019). Furthermore, a client's initial responsiveness opens the door to a wide spectrum of health and well-being outcomes. A systemized review of literature examining eighty-six social non-clinical interventions connected to social prescribing demonstrated the various positive impacts on referred individuals (Chatterjee et al., 2018). In addition to fostering a sense of empowerment, social prescribing can yield increases in confidence, self-esteem, sociability, communication, and social connections; improvements in physical health, psychological well-being, mood, and meaning of life; reductions in loneliness, isolation, and primary care visits; and the acquisition of new skills.

Museums on prescription

Museums become catalysts for change when uniquely positioned at the intersection between collective impact and social well-being (Dowdell & Norton, 2016). Typically, museums do not carry as much clout as an "anchor" institution such as a university or hospital because they do not, generally, employ as many people as an anchor institution. However, they make for extraordinary community assets because they are embedded in communities, have a public service mission, and are perceived as trustworthy organizations. When united with anchor institutions to implement social well-being initiatives, museums play a vital role in the collective impact that ensures the "betterment and improved quality of life of the community as a whole" (Dowdell & Norton, 2016, p. 11).

Over the course of the last decade, museums have increasingly begun to embrace their role within the public health sector (Chatterjee & Noble, 2016). Museums are an ideal home for health and well-being programming in that they can facilitate self-reflection, introspection, and exploration into other cultures and viewpoints (Chatterjee & Camic, 2013). They are also less stigmatizing than health facilities and promote access and social inclusion by waiving fees. A year-long study conducted in 2011 revealed over fifty instances of museums involved in health and well-being programming (Chatterjee & Noble, 2016). Well-being programs were hosted by a wide swath of museum types—art, history, natural science, science, libraries, and historic sites— and targeted a broad range of audience types that included mental health service users, older adults, individuals with specific health and well-being challenges, and vulnerable populations. Furthermore, The American Alliance of Museums (AAM) shared the "Museums, Health, and Wellness Compendium," documenting over one hundred American museums that deliver health and well-being programming ("Museums, Health, and Wellness Compendium," n.d.). The compelling body of evidence that has materialized from these museums in health initiatives has merited further investigation into museums' role in the healthcare landscape; the success of museums in health has become the impetus for museums on prescription (Thomson, Lockyer, Camic, & Chatterjee, 2018). What distinguishes museums on prescription, specifically, from other forms of museums in health is that it authorizes museums to accommodate referrals and physical prescriptions from healthcare providers.

Studies performed on museums on prescription demonstrate possible program outcomes for referred individuals. One UK study discovered through pre- and post-session surveys using the Museum Wellbeing Measure for Older Adults (MWM-OA) that museums on prescription improves the psychological well-being of older adults with significant improvement to major six emotions— absorbed, active, cheerful, encouraged, enlightened, and inspired (Thomson et al, 2018). Another study designed to assess the biopsychosocial effects of participation in an arts and nature-based museum intervention found that adult mental health users experienced improved self-esteem, decreased social isolation, sense of community, and overall physiological well-being (Thomson et al., 2020).

Although museums have gained a lot of traction as a viable form of health intervention, social prescribing is largely understudied and there is a significant gap in the amount of rich data supporting it (Chatterjee et al., 2018; Husk, Blockley, Lovell, Bethel, Lang, Byng, & Garside, 2020;

Kilgariff-Foster & O'Cathain, 2015; Pescheny et al., 2020; Pescheny et al., 2018; Skivington, Smith, Chng, Mackenzie, Wyke, & Mercer, 2018). There is a need for more rigorous research that assesses a broader scope of stakeholder perspectives (Chatterjee et al., 2018), particularly from those in the community and voluntary sector who are involved in the co-production process (Fixsen et al., 2020). In consequence, there is a surprisingly diminutive list of meaningful research on museums on prescription and even less research on the roles and perspectives of those who offer the service. Although we know that museums on prescription can contribute to enhanced well-being for the referred individual, we do not know much about the input required by the museum in order to offer museums on prescription services or the experiences of those who develop and implement the programming. Few studies have been done on social prescribing programs that incorporate the views of personnel within community organizations (Koebner, Fishman, Paterniti, Sommer, Ward, & Joseph, 2018; Pescheny et al., 2018; Skivington et al., 2018) and only one refers to the distinct views of museum staff (Koebner et al., 2018).

Koebner et al. is qualitative evaluative study of Art Rx, a pilot social prescribing partnership between the Crocker Art Museum and the UC Davis Center for Pain Medicine (2018). The pilot was a social prescribing hybrid where outreach was conducted by both the pain center and the museum. In other words, the museum accommodated referred individuals from the pain center, but people who heard about the program on their website or through association were also welcome to register for the program. Individuals from the UC Davis health system as well as museum staff were asked to participate in semi-structured interviews as part of the evaluation process. Responses by museum staff were wholly positive with expressions of appreciation for their highly valued and transparent partnership, and statements of the program's innovativeness, inclusivity, and heartening impact on participants.

However, one study that incorporates the museum perspective, even if the result was majorly positive, is simply insufficient. This lack of research concerning, especially with the influx of recent studies showing that two recurring barriers to the sustainability of social prescribing is the lack of financial support for services provided by participating community organizations (Bertotti et al., 2018; Dayson et al., 2020; Pescheny et al., 2018; Polley, Whiteside, Elnaschie, & Fixsen, 2020; Skivington et al., 2018) and staff capacity (Kilgariff-Foster & O'Cathain, 2015; Pescheny et al., 2018; Skivington et al., 2018). Challenges communicated by personnel involved in various museums

in health schemes also indicate that staff capacity is a common constraint to health and well-being programming (Chatterjee & Noble, 2016). This presents a huge problem because in the situation that community organizations like museums no longer have the means to support the rising number of referrals, especially self-referrals, an overabundance of work and responsibility will fall on link workers (Skivington et al., 2018) and referred individuals do not receive adequate care and attention. In essence, without the appropriate support to community organizations, social prescribing fails to meet its overarching objective which is to holistically meet the social needs of people while mitigating pressure on the healthcare sector.

Study purpose

This study richly describes the nature of museums on prescription models from the perspectives of museum practitioners involved in them. The study explores the following research questions:

1) What are the defining characteristics of museums on prescription models?

2) From the museum practitioner's perspective, what are the affordances and constraints associated with museums on prescription work?

3) In what ways has Covid-19 impacted museums' ability to participate in social prescribing programs?

Methodology

This investigation into museums on prescription used a descriptive case study design. This was the most appropriate design method, as it permits the study of multiple cases in order to describe *what* the phenomenon is and *how* it operates in practice (Yin, 2002). In alignment with case study design, in order to yield a more holistic view of the phenomenon in question, data were derived from a diverse collection of source material (Yin, 1998). Specifically, data were acquired from a series of facilitated interviews with museum professionals and through documentation analysis.

Sampling

Five case study sites were selected using a purposive sampling methodology that accounted for museums on prescription involvement

and presence within the social prescribing community. Museums designated as sites for research met the following inclusion criteria:

- Has an established prescription-based program, organized and implemented their own museums on prescription pilot, or participated in region-wide social prescribing project
- Involvement with their local social prescribing network has been documented in published research studies and/or media released by organizations affiliated with social prescribing

Museum programming of this nature is largely unadvertised, so broad inclusion criteria and a multi-pronged recruitment strategy was used to acquire sites for research. Prospective sites that were identified in published literature were emailed directly. Frontline staff directed the researcher to professionals who developed the prescription-based programming at their institution. Additional recruitment methods included exploring the Museology program's personal network and posting a call for participants on the Culture Health and Wellbeing Alliance website (see Appendix A). Ultimately, six individuals from five museums agreed to participate in the research study. Position titles for the six participants were as follows: Acting Manager of Inclusion, Assistant Curator Community Programs, Education Officer, Collections Officer, Audience Development Officer, and Education Programs Officer, Arts Therapist. Although all information has been anonymized, the cases are broadly described below.

Site One

Site One is a council-led museum located in the United Kingdom with a diverse, international collection of fine art, culture, and natural history. They were one of seven museums to participate in the UCL and Canterbury Christ Church University research study, *Museum-based programs for socially isolated older adults: Understanding what works* (Todd, Camic, Lockyer, Thomson, & Chatterjee, 2017). Their predominant motivation for launching a prescription-based program was to support the growing body of research that recognizes museums as a space for wellness, to engage new audiences, and to increase access to their museum's collections.

Site Two

Site Two is a regional council-led museum located in the United Kingdom with a concentration in local art, culture, and natural history.

Similar to Site One, their prescribing program emerged from the 2016 social prescribing study conducted by UCL and Canterbury Christ Church University researchers (Todd, Camic, Lockyer, Thomson, & Chatterjee, 2017). Their participation resulted from positive experiences with previous well-being programming as well as their desire to leverage their museums on prescription experiences to secure funding for future well-being programming.

Site Three

Site Three is a large fine art museum located in Canada. They launched their museum on prescription pilot independently from other social prescribing initiatives and in partnership with a local doctors association. Their museums on prescription pilot program was an extension of pre-existing programming that has allowed the museum to develop and nurture their well-being perspective and to build on practices that welcome diverse audiences for over two decades.

Site Four

Site Four is a large fine art museum located in Canada. Their museums on prescriptions program materialized following a request by a local advocacy group for the museum to connect with their local community health center and participate in a region-wide social prescribing pilot. Their commitment to maintaining a well-being lens and increasing access to their museum motivated them to participate in the pilot.

Site Five

Site Five is a large government fine art, culture, and natural history museum located in Canada. Site Five took part in the same region-wide social prescribing pilot as Site 4 and later went on to officialize their museums on prescription programming. For their museum, their involvement was motivated by the opportunity to act on their growing interest in social prescribing.

Data collection

Data were collected through a series of semi-structured interviews and document analysis. Interviews lasted approximately 45 minutes and were recorded and transcribed to ensure data validity. To ensure the safety of all involved during the global health crisis, interviews were

conducted remotely on the video conferencing platform, Zoom. An interview guide (see Appendix B) was used throughout the study in order to guide responses and further elucidate the nature of museums on prescription in art museums and how they were impacted by Covid-19. Whenever available, relevant documentation was also provided by the interviewees. Documentation collected for research included website content, two final reports (Mulligan et al., 2020; Todd et al., 2017), one program session plan, and one program overview. They were analyzed to supplement interview data and to further contextualize their museums on prescription approach.

Data analysis

All data obtained from interviews transcripts were analyzed comparatively, to illuminate the ways in which programming can vary while achieving a common purpose, while the data pulled from relevant documentation supplemented interview responses. Qualitative data from the interview transcripts and relevant documentation were assessed using emergent coding strategies to identify key themes.

Results

What are the defining characteristics of MoP models?

Six explanatory components were identified that describe the key characteristics of the museum on prescription model, including: i) museum-patient relationship; ii) partnership and collaboration; iii) referrals; iv) past well-being programming experience; v) confidentiality; and vi) staff and training.

Museum-patient relationship

Data analysis revealed two primary approaches to museums on prescription. This included museums on prescription in the form of highly customized programming (Sites 1 and 2) and ticket distribution (Sites 3, 4, and 5).

Sites 1 and 2 were invited to participate in a social prescribing study developed by University College London and Canterbury Christ Church University researchers in order to assess the impact of museum experiences on the well-being of older individuals that self-identified as being lonely or socially isolated (Todd et al., 2017). Their approaches varied slightly, but in both cases, the museum developed an entirely

new line of programming tailor fit to older adults. The program at both sites ran for two cycles. Each cycle comprised ten sessions of approximately an hour and a half held on a weekly basis.

Participant recruitment was performed by university researchers who afterwards would provide the museum with a participant list. In some instances, recruitment took “convincing” because many of the referred individuals were not museum goers and naturally, were skeptical of the program’s ability to be a healing and pleasurable experience (Site 2). Those same researchers who had established those connections to healthcare partners were present throughout the entire study for tracking and evaluative purposes. The program itself, however, was developed with minimal guidance from the university research teams. Museum staff ensured sessions centered on the collective interests of the participant group and each session incorporated a tea or coffee hour, consistent meeting space, and three key activities that were designed according to a prearranged theme— a gallery lecture, artmaking, and object handling activity. For example, Session 2 of the second cycle at Site 2 took place in the glass room and their core activities were a hieroglyphics writing activity and a presentation and object handling exercise using the museum’s Egyptology collection (Museums on Prescription Draft Session Plan Schedule).

While the informational and tactile components of this program were essential, the emphasis on relationship-building and establishing social connections was a defining piece of this model. This point was illustrated by the interviewee at Site 2:

> The idea was, you know, whether people liked that sort of thing or not, everyone had to at least try to do it. Even if everyone hated it, that was fine, because the point is not to do the activity. The point was to do something together. So, even if they were bonding based on a mutual hatred for what we were doing, it didn't really matter. That's actually fine. That was the point, really. Similarly, with, you know, how much of whatever we talked about that they remembered almost wasn't the point either. The point was the attendance. The point was doing a thing they all enjoyed together, and the bonding.

As a result of the positive feedback provided by program participants, cultivating friendship and camaraderie became the impetus for a legacy program at Site 1. This aspect of the program is not only substantiated by interview responses but also by the research outlined in the final

study report developed by partner researchers (Todd et al., 2017). Participants were able to build up their sense of confidence for social interaction as well as establish a sense of “pleasant familiarity” with the group. One group from one museum continued to meet after the ten-week program concluded, which suggests the museums’ programs encouraged opportunities for social connection. That said, however, fostering a sense of rapport among the participants was contingent on maintaining low attendance numbers. At Sites 1 and 2, attendance maximums were predetermined to ensure productive interaction among the group and appropriate time to interact with objects from the permanent collection. Site 1 adhered to an attendance maximum of 12 and Site 2, a limit of 15.

On the other hand, Sites 3, 4 and 5 engaged in a completely different museums on prescription format through a unique system of ticket distribution. Sites 3, 4 and 5 partnered with local organizations to offer their services to clients and social prescriptions were treated as general admission tickets to the museum. The prescriptions were distributed to partner organizations and allocated as the partner representatives saw fit. Site 4 provided pre-printed general admission tickets to their partners as social prescriptions. Sites 3 and 5 ensured partners received physical prescriptions that were distinguishable from regular tickets and authorized the visit of more than one person so the client could visit with a companion or family. For Site 3, the unique ticket type also assured ease of use and seamless documentation on the prescriber’s side while for Site 5, it helped their partners differentiate the prescription from the general admission tickets they recieve for facilitated group visits to the museum.

This model included exceedingly less moving components than that of at Sites 1 and 2, as illustrated by one interviewee response who said their model was “low key” and “low stakes (Site 4).” Prescriptions as general admission tickets meant that referred clients' experiences were indistinct from that of everyday visitors. When asked to describe how a referred client’s visit is different from that of a typical visitor, Site 4 said “...it was very much just about opening the doors, not providing programming in addition to” while Site 5 said their museum offered “...nothing more” to referred clients. While initially this may make the format of museums on prescription seem somewhat inessential, according to the museum staff, this approach guaranteed clients a high level of autonomy, access, and anonymity that sustained the well-being value of visiting a museum. This was an idea most clearly conveyed and articulated by Site 3’s interviewee:

> The prescription was designed to support the autonomous choice of the identified patient so the patient would then have the opportunity to choose from a number of activities that pre-existed. I think that's an important distinction, that nothing was custom created for the prescription…That person takes that prescription to the desk, the person retrieves the prescription. They are no longer a patient, they are now a visitor and that visitor is reminded of the number of different things on offer that day. Autonomous visits to the galleries. Major exhibitions. So that sort of baseline belief that encounters with art, encounters with beautiful spaces, have a well-being attribute to which we have some good data on as well… Confidentiality is essential to this, as a baseline of the person feeling like their identity is in their hands as they go to the museum, or as they choose that as part of their healthcare plan.

Partnership and collaboration

Despite the variation in design and approach, one thing was indisputable across sites: partnership is the backbone of museums on prescription. One interviewee introduced their museums on prescription model as a "specialized collaboration; a partnership (Site 3)." When asked what three words best describe their museums on prescription program, two interviewees responded with the word, "partnership," (Sites 4 and 5) and one interviewee, "collaborative" (Site 1). Two interviewees responded with variations of the word flexible (Site 1 and 5) to indicate that they left ample room for feedback from the various stakeholders and partners involved in their program. This point was further elaborated on by the Site 5 interviewee when asked what their role is in implementing the program: "I work with our partners too, you know, to make sure that the program is meeting their needs." Moreover, when describing the affordances associated with this work, one interviewee stated, "we're always sort of looking for a challenging project to do, and that was that, but you know the partnerships and the good work that was done from it pushed us in the direction that we weren't anticipating ever really going… (Site 2)."

Since credible prescribers are generally located outside of a museum, it is logical that partnership and collaboration would be seen as vital and indispensable ingredients to this line of programming. Sites 1 and 2

were connected to prescribers through partnerships with universities and local charities; Site 3 partnered with a local doctors' association; and Sites 4 and 5 were linked to community health centers and a local advocacy group. In most of the museums on prescription schemes included in this case study, partnerships not only facilitated the prescription and recruitment piece but also other program areas including program design (Site 1), acquiring program funding (Site 1), evaluation (Sites 1, 2, 4, and 5), and participant transportation (Site 2). Four of the sites (Sites 1, 2, 4 and 5), were approached by a prescribing organization or partner to initiate their museums on prescription program. In these situations, where the museum is approached by the partner, the museum is first identified by the partner as a community asset. This is particularly true for Sites 4 and 5 where Rx: Community health centers used asset maps to identify community resources and prospective partners for prescription support like museums, as documented in the Alliance for Better Health's final report of the social prescribing project (Mulligan et al., 2020).

Referrals

Although a physical prescription was not always present, a referral system was necessary for all five sites and their museums on prescription design. For Sites 1 and 2, referrals were presented to clients verbally and were managed primarily by association, which did not require a physical prescription. The interviewee from Site 2 explained that their museum had discussed the idea of incorporating prescriptions anyway, an idea inspired by the Beaney House of Art and Knowledge for their exhibit, *The Paper Apothecary*. However, the "prescription" in this scenario, which is entirely intended to serve legitimate health purposes, would have come from museum staff and not a physician which reasonably would have caused some concern. By contrast, however, physical prescriptions were administered for Site 3, 4, and 5. For Site 3, which was partnered with a local doctors association, prescriptions were delivered by physicians who were "...given, at first, a literal [prescription] pad [by the museum] and then eventually a virtual one because it was much easier for their system..." Sites 4 and 5, who were associated with various community health centers and community-based organizations, the partner representatives making the referrals were not solely the physicians; they were also issued by nurses, social workers, therapists, and even program facilitators.

Past well-being programming experience

Sites 2, 3, 4 and 5 saw their museums on prescription program as a continuation of the well-being initiatives already taking place at the museum. For Site 3, a flourishing, 22-year-old well-being program at their museum helped to establish "a kind of methodology," a through-line to new health and well-being opportunities like museums on prescription. Site 4 saw museums on prescription as another way of offering another access point to the museum much like the series of accessibility programming they have been developing for ten years. Site 5 used museums on prescription to activate the partnership they already had with organizations focused on underserved communities. Interestingly, the interviewee from Site 2 found that their museum's experience with past well-being programming became a necessary asset to their museums on prescription approach. Their previous well-being program broke down the internal barriers that would have been a major obstacle for their museums on prescription program: "I think the bigger hurdle was signing up for the project before this one…That took ages to get going and to convince everyone that it was a good idea and it was needed… and I think when we did that one, people got a real sense of the power of the collections that we had and what we were capable of doing."

Confidentiality

When asked how much interviewees knew about the referred clients, it was clear that confidentiality and privacy concerns have a varying degree of impact on museums on prescription. For sites that developed programming exclusively for their referred participants, confidentiality ensured a positive, unbiased experience for the participants. Site 1 observed that the researcher responsible for participant recruitment was careful to provide participant information in order to guarantee "… a level playing field…" for the participants. Whereas Sites 3, 4, and 5 used confidentiality to establish the museum as a neutral space and to protect client information that was intended to only be accessible by the prescribers. In most instances, the museum knew nothing at all about the referred clients, aside from the occasional name (Site 5), inferences from anecdotal information provided by the partners (Site 3), or information they had on hand about the partners' clientele base (Site 5). In a way, confidentiality paired with the high level and autonomy granted to referred individuals meant the museums were often not permitted comprehensive levels of tracking and evaluation. Sites 3, 4, and 5 were only able to track referral data to the extent that

they knew which prescriptions were “filled.” Only Sites 3 and 5 carried out this step and it was performed primarily for the purpose of aiding their partners’ evaluation of the program.

Staff and training

Data acquired from interviewees, specifically, job titles and museums on prescription responsibilities, suggested that leading staff on these projects are usually in roles connected to the museum programming. More specifically to museums involved in customized programming, however, leading staff also had ties to education and audience development. The reason for this was best stated by the interviewee from Site 2, “...if you were a museum that didn't have an education person or an audience person on staff, this would be hard, because you need to have an engaging person leading a session like this to make it effective.” This point is further supported by the evidence presented in their partners’ study report (Todd et al., 2017). The study report documents responses by participants that demonstrate program facilitators’ pivotal role in creating a positive experience for the participants. Study researchers ascertained that “...the role of the facilitator as a museum expert *and* as a socially engaging and welcoming person, was seen to be essential.” On the other hand, in regard to non-leading staff roles, four sites’ interviewees indicated that their frontline staff or visitor experience team also played a vital role to museums on prescription programming. They were positioned to greet the referred clients (Site 2, 3, 4, and 5) and in some cases, answer questions pertaining to the museums on prescription programming (Site 5), but most importantly, they were there to help establish the “chain of welcome (Site 3)” that is critical to this type of programming.

Strictly speaking to museums on prescription programming, little or no immediate training was conducted at the sites. Site 1, who had not previously hosted well-being programming for socially isolated adults, held a training to talk about interacting with an older demographic, but primarily utilized their “existing skills in public interaction, communication and object handling.” Site 2 required no training, but the interviewee did do some independent information gathering at their partner site. For Site 3, 4, and 5 training was solely a means to establish clarity of intent across the organization; to ensure visitor experience teams (Site 4 and 5) and other public facing staff and stakeholders (Sites 3 and 5) were on the same page.

From the museum practitioner's perspective, what are the affordances and constraints associated with museums on prescription work?

Affordances

Interview responses revealed three perceived affordances for the museum: i) museums as well-being spaces; ii) new direction; and iii) new stakeholder engagement.

All five case study sites perceived that a primary affordance of museums on prescription was that it enabled them to build on their value as a space for health and wellness. An interviewee from Site 1 expressed that museums on prescription "demonstrated and developed the museum's benefits to the community for health and well-being" and exemplified the "wider benefits of the museum to other local authority managers." Site 3 discerned that the prescription component, in particular, provokes attention "that can have a lot of benefit in terms of politics, in terms of shaping the way people think about the role of the arts and culture and health." Since the development of the museums on prescription program, their museum has begun to see their organization as a "hub for imagining how healthcare and the cultural sector can collaborate." Site 5 spoke to this benefit as well:

> It's helping us establish an image of museums as a space for well-being...we have always been known as an educational space, as a space where you go in to learn something. Which we still are, but the social prescribing has, I think, opened the minds of a lot of people to recognize that we're also the space that facilitates well-being.

In addition, case study sites felt that museums on prescription allowed their museum to embrace new directions, including new programs and new approaches to their practice. Site 1 interviewees mentioned that some benefits to museums on prescription were "venturing into something different" and "getting our collections into the minds" of people from an older demographic who may not have had access to their museum. Site 2 interviewee stated that their program enabled the museum to think more boldly and deeply about future well-being programming:

> ...it was something I always kind of wanted to learn more about, you know. We're always sort of looking for a challenging project to do, and that was that. But you know the partnerships and the good work that was done from it pushed us in the direction that we weren't anticipating ever really going into and we find ourselves to this day going, “Actually, how do we do that? How do we do the next thing?

Finally, case study museums said that museums on prescription prompted some kind of new stakeholder engagement at their museum. For example, Site 2 explained that their program helped the museum gain the public recognition necessary to obtain more funding for the museum, which will inevitably sustain their well-being focus. Site 1 interviewees voiced that museums on prescription attracted new audiences to their museum. Site 4 felt that museums on prescription broadened the support of the museum’s internal stakeholders:

> [The] main benefit was really getting actually everyone in the building understanding why we would engage in something like this... the best thing for us was that we were able to speak clearly, cohesively as an entire community within the building, staff-specific, about the fact that we have programming and we do things to support well-being and health. It's not always the lens that people apply to the work that we do in the gallery and certainly being a part of the pilot gave people a bit of a better sense of how we do that work.

Constraints

Case study sites identified three key challenges to museums on prescription, including i) capacity; ii) limited access; and iii) funding.

For variable reasons, capacity or constraints associated with stakeholder time resonated with interviewees at all 5 case study sites. For Site 1, finding staff time to create new content for the program once all pre-existing content had been recycled was a challenge. Likewise, for Site 2, the challenge was having to balance staff time and labor between museums on prescription and conflicting priorities. At Site 2, another impact of limited capacity was an “almost nonexistent” amount of dialogue and communication between museum staff and partners. Sites 3 and 5 aspired to expand their museums on prescription initiatives, but the capacity of staff and partners was a

barrier to progress. Museums on prescription at Site 5 was a one-person department, so their ability to broaden their programming is contingent on the capacity of a single staff person and the availability of their partners. Site 3 was in a unique position where all their prescribers were strictly physicians. Physicians, especially this past year, were understandably "very, very busy," but this was an obstacle to broadening their prescribing network and encouraging a public discussion about museums on prescription because they were unable to evaluate what the basis was for a prescription and the extent at which their prescriptions were fulfilling the needs of patients as well as doctors.

Secondly, some case study sites felt that their program was not serving enough people. This perceived lack of access was the result of a limited partnership base. This was a constraint voiced exclusively by Sites 3 and 5 because of their aims to expand their partner network. According to interviewee at Site 3:

> It's great to have this prescription, but if it's only reaching a certain number of people that are being funneled through a certain number of doctors with a certain number of criteria, your exclusion criteria is going to be an imposition, as opposed to something that helps you identify who's best suited. Well, we're getting very exclusive very quickly if we can only receive our patients through these particular referral sources.

Similarly, the interviewee from Site 5 described that one prevailing barrier is the need for a system that gives prescribers easy access to the prescription.

Funding challenges were caused by budgetary constraints, which was the case for Sites 1 and 4*.* The interviewee from Site 4 observed that the museums on prescription program did not receive the same "pick up" as it would have had they incorporated a program element designed to "lower any perceived or physical barriers to the collection" or familiarize the referred client with the museum space, but adding an additional programming component was not in the budget. Site 1, a council-run museum, received some funding from their program, but had a difficult time finding the budget for necessary resources. Concerns from Site 1 was that the museum would be unable to negotiate for the program as well as their legacy project in the future because the council would know they could not profit from it.

In what ways has Covid-19 impacted museums' ability to participate in social prescribing programs?

Covid-19 closed down museums and this continues to be an impediment to museums on prescription related ambitions and undertakings at all sites. Although the museums on prescription programming at Sites 1 and 2 have been inactive for years for reasons unrelated to Covid-19, the pandemic fully stopped all pursuits to reinstate museums on prescription. At Site 1, pandemic closures resulted in staff and budget cuts which has reduced staff capacity and made the museum reluctant to continue their museums on prescription endeavors, which includes their legacy project. For their museum, going forward their greater priority is generating enough income to sustain the museum. Site 2 said that even if they were able to restore museums on prescription programming after the museum reopens, there remains a tremendous amount of concern for referred participants who are, in some cases, the most "susceptible." There is the option to minimize contact using alternative, virtual outlets, but their worry is these outlets will not be as impactful without the one-on-one relationship-building and object-handling components of their previous in-person programming.

For Sites 3, 4, and 5, all museums on prescription programming, pilots and otherwise, were forced to cease completely. As said by an interviewee, "It kind of full-stopped our ambitions of moving forward with the next phase. It obviously had negative consequences for those hoping to fulfill their prescriptions. We don't get to hear those stories, we don't know those stories." For Site 3, the unprecedented situations created by the pandemic meant that scaling up and pitching museums on prescription to a broader partner base had to be put on the back burner temporarily. Site 4 had to halt any possible expansion in terms of more specialized programming.

Despite the unprecedented consequences of the pandemic, interview responses from Sites 3, 4, and 5 revealed that there are silver linings. Site 4 used their experience with museums on prescription programming to gain institutional buy-in for more virtual well-being programming and online access resources pages after the museum closed. Site 3 found that the closure not only allowed for more thoughtful consideration into potential program improvements, but it encouraged them to reshape their mindset toward future approaches to well-being programming. They have begun the process of "creating a dedicated online space for the prescription." Site 5, who formalized their museums on prescription program back in 2019, has since introduced some virtual events to their program schedule and has

opened their museums on prescription program back up in anticipation of museums' reopening by distributing prescription passes back out to their partners.

Discussion

The purpose of this study was to richly describe museums on prescription through the perspectives of museum practitioners. Facilitated interviews and program documentation collected from six museum staff from five museum sites disclosed several major findings which are discussed by research question.

What are the defining characteristics of MoP models?

The findings suggest there are four key characteristics to museums on prescription. Firstly, for all five museums on prescription schemes, general practitioners and healthcare or community representatives referred individuals directly to museum services, indicative of Kimberlee's social prescribing *light* model (2015). In a social prescribing *signposting* model, referred individuals would have received prescriptions that were more informational, with access to more general health and welfare resources, and it would have been almost entirely contingent on the individual to make that initial connection to the museum.

Secondly, although no two museums on prescription programs were entirely identical, the findings suggest there are at least two program formats that characterize museums on prescription— customized programming that is exclusive to referred individuals and partner ticket distribution. Strangely, these model types appear to be geographically distinct, with the former primarily documented as taking place in museums located in the UK. The former also seems to be the most researched program format throughout museums on prescription literature, utilized by various museums including the Crocker Art Museum, Whitworth Park and Whitworth Art Gallery, and seven UK museums in a museums on prescription initiative for older adults (Koebner et al., 2018; Thomson et al., 2018; Thomson et. al, 2020). Although the latter is less formally documented, the ticket distribution method utilized by Sites 3, 4, and 5 shows promise for an assortment of reasons, namely, its ability to reach and open access to a substantial population size and partners with minimal staff involvement, and assured patient confidentiality. Interviewee responses also highlighted significant opportunities for growth and expansion which could

demonstrate that the ticket distribution format has an important potential as a litmus test for museums to gauge what their capacity is for museums on prescription programming.

Thirdly, and of particular importance, was the dependency on partnership and collaboration. Presumably, partnership is not only necessary for purposes related to broadening outreach, but also because most museums do not have the infrastructure or certifiability to distribute medical prescriptions. That does not suggest that clinical professionals do not work in museums and there is not a discussion to be had regarding whether prescriptions could come from within the museum, as one interviewee who contributed to this study is currently an arts therapist and runs an art therapy program through the museum. The necessity for partnerships, particularly where there is trust and communication, is reflected in the work of previous research as well (Baddeley et al., 2017; Koebner et al., 2018; Pescheny et al., 2018). In their study of the Crocker Art Museum's Art Rx, Koebner et al. (2018) found that a valued and appreciated partnership was viewed as a "sustaining feature of the program" (p. 424). Where there is not a sufficient relationship between the museum and their social prescribing partner, that can become a major constraint. As with Site 2, who expressed that the lack of communication between partners limited the museum's ability to benefit from the expertise and experiences of their partners in order to make the program better.

Another major finding was that museums on prescription for these sites did, in fact, incorporate a prescription, in the form of either a verbal referral or paper prescription. What was absolutely critical to the prescription component was a collective understanding across stakeholders that the prescription serves a legitimate healthcare purpose. As illustrated by interview responses, particularly from Site 2, museum staff make prudent choices to ensure this process is not confused for a novelty. One reference was made to *The Paper Apothecary* as an example of what would have been an unbecoming approach to museums on prescription. *The Paper Apothecary* was an exhibition hosted by The Happy Museum Project at the Beaney House of Art and Knowledge in which "happiness prescriptions" were created and distributed by museum staff to museum visitors (Jennings, n.d.). Although a delightful sentiment and intriguing audience engagement strategy, the exhibition stands in stark contrast and does not intend to meet the same objectives as museums on prescription. These findings were somewhat unexpected as some museums on prescription models do not always require a referral or physical prescription (Koebner et al., 2018). In certain museums on prescription models like Art Rx at the

Crocker Art Museum, self-registration without referral is encouraged and is publicly accessible through their website.

From the museum practitioner's perspective, what are the affordances and constraints associated with museums on prescription work?

In regard to affordances and constraints, there were three major findings. Firstly, interviewees from all sites found that museums on prescription allowed their museum to cultivate and develop their thinking around the museum as a space for health and well-being. This resonates with the findings from Art Rx in which museum staff commented that their museums on prescription programming allowed them to imagine how they might "expand the horizons on how a museum has value to a community and why they are essential" (Koebner et al., 2018, p. 423).

Secondly, although the affordances voiced by museum staff from all five sites were profoundly positive, the consensus among interviewees was that the limited capacity of either museum staff or partners was a major constraint and hindrance to program progress. This constraining factor restricted the scope of the program at all five sites, with varying impacts to either content development, program evaluation, or program expansion. Unsurprisingly, capacity is a challenge not only apparent in this study, but in others as well (Chatterjee & Noble, 2016; Kilgariff-Foster & O'Cathain, 2015; Pescheny et al., 2018; Skivington et al., 2018). An observation made was that for most of the participating sites, four to be exact, museums on prescription was a program developed and executed by one or two people within the institution. This could be due, in part, to the fact that all sites were engaged in museums on prescription pilots at the time data collection took place, as most organizations would not impart an overabundance of resources for a pilot. However, the substantial amount of evidence showing that staff capacity is limited suggests there is an argument for increased staff on museums on prescription projects. Despite the challenge, the interviewees were unanimous in their position that the affordances and rewards far outweighed the challenges. This shared attitude, that the reward is not only extended to the referred individual but the museum as well, supports the idea that museums are becoming more so committed to the health and well-being of their communities (Chatterjee & Noble, 2016).

The third and most unforeseen finding was related to funding. Contrary to recent research which cites funding as a major constraint to social

prescribing services (Bertotti et al., 2018; Dayson et al., 2020; Pescheny et al., 2018; Polley, Whiteside, Elnaschie, & Fixsen, 2020; Skivington et al., 2018), financial support was not the most significant obstacle present at these sites. This is likely because none of the museums interviewed had to acquire a significant amount of funding in order to run their museums on prescription pilot. For the museums that adopted a ticket distribution format, there was not an extraordinary need for more funds and were primarily able to use existing resources. Although finances were not an immediate concern for a few of the sites, there are implications that limited budgets for program expansion and increased pressure to make a profit after the pandemic closures may affect a couple of the sites as they reopen.

In what ways has Covid-19 impacted museums' ability to participate in social prescribing programs?

Finally, the most exciting finding was that in spite of pandemic closures, social distancing, and the unrivaled impact of Covid-19, a few of the sites were able to find somewhat of a benefit to their time away from in-person programming. Interviewees from three of the sites indicated they were still able to use that time to further the well-being and/or museums on prescription initiatives at their museum. For these sites in particular, museum staff were able to use that time to explore more accessible, digital and virtual avenues for their well-being programs. It goes without saying, however, that even with the silver linings there is a shared concern for what museums on prescription will look like once in-person programming returns. Similar to the predictions of researchers made in 2020, museum staff, like that of all involved in social prescribing schemes, are having to consider "novel ways to recruit, support, and deliver social health and wellbeing activities" (Fixsen et al., 2020, p. 11). Museum staff are having to explore creative solutions to their various concerns including but not limited to budget and staff cuts; conflicting development and fundraising priorities; lost social connections and connections to museum objects due to safety protocols; lack of access to and communication with healthcare partners; and greater safety precautions for vulnerable populations.

Limitations

Three limitations had considerable influence on this study. Foremost, is the study's limited scope on account of the study's lack of geographical variety. The intention of this study was to capture a manifold of

museum staff perspectives from different social prescribing networks. However, due to the lack of research and advertisement for museums on prescription programs, there was a significant challenge in identifying sites where there was not an overlap in social prescribing networks. Museum staff from sites 1 and 2 as well as 4 and 5 share very similar experiences as they were involved in the same social prescribing pilots. The scarcity of museums on prescription research means this is a limitation that likely would not have improved with a larger sample.

Secondly, recruitment and data collection for this study took place approximately one year after Covid-19 arrived in the UK and North America, which means that museums on prescription programs at the participating sites have been nonoperational for a year or longer. All experiences shared by the museum staff in this study are not recent, which means some critical information, views, or opinions could have been lost with time. Lastly, there is a dearth of supporting documentation included in this study. Ideally, more documentation would have been collected, but the sites' participation and overlap in social prescribing pilots meant resource-sharing was common and evaluation and reporting was not typically performed by museum staff. As for documents that are considered in this case study, all final reports provided by the sites, although rich in detail and quality research, had limited application to this case study because museum staff perspectives were not considered part of the research objectives.

Implications

The social prescribing movement has gained considerable support and momentum in recent years, but without more extensive and complete evaluation of community organizations involved in social prescribing ventures, like museums, there is a risk that social prescribing will fall short in its desired objectives to more effectively address patient care and mitigate stress on the healthcare sector. This study builds on a virtually nonexistent and weak literature-base to lay the groundwork for more meaningful research into the role of museum staff in delivering prescription-based interventions. Whereas this study reveals various prudent and salient details regarding the design and feasibility of museums on prescription, there are noteworthy gaps in the research presented here that act as important implications for future research.

Although this study identified two distinct models and several defining features of museums on prescriptions, this study is encumbered by major limitations including a small and homogenous research sample

that comprised mostly program pilots. This limitation was further compounded by the effects of Covid-19, which stalled the implementation, evaluation, and expansion of museums on prescription in the UK, Canada, and beyond. Consequently, this study took place during a major transitionary period for museums characterized by an overwhelming amount of unknowns. Future research on museums on prescription should be conducted once museums reopen and have had an opportunity to recover from the ill-effects of the pandemic. It is expected that with the appropriate timing, research has the potential to yield more stable and reliable anecdotal and qualitative evidence, especially with regard to museums' future endeavors in this work. Further, a more expansive and geographically diverse sample that includes programs located in different countries and pilots as well as more permanent museums on prescription programming will also distinguish whether the model types, affordances, and constraints presented in this research hold true across social prescribing initiatives. It is recommended that future research employ a similar study design that incorporates qualitative surveys to reach a wider pool of participants as well as facilitated interviews, to account for the disparities which will likely exist in the survey responses. Although there are certainly shortcomings to the study presented here and areas for improvement, this study connects the views of museum staff to the growing body of research on museums on prescription.

I believe this study also puts forward major implications for the museum as a clear and indisputable asset to the healthcare community. The findings from this study suggest there are two prevalent, possibly geographically distinct, models used in museums on prescription. One model which is more simplistic in design, but is backed by effectively no substantial data, and another which is far more complex, but has rich, albeit minimal, data supporting it. Despite this distinction, at the core of both of these models is a high level of understanding for program scalability, collaboration, and effective partnership. These are three areas of which museums all around the globe already excel at, which would suggest that museums on prescription could be a feasible endeavor for museums everywhere including the US.

It is common thought that museums on prescription has to be the product of the ambitions set forth by countries with universal healthcare. While it certainly helps to have this type of governmental support, this study suggests that more value should be placed on institutional commitment and partnership. There are countless

museums in health programs in the US that include healthcare partners and in some cases, referrals, yet, museums on prescription has not saturated the American museum field as it has in the UK and Canada. The fact of the matter is that the physical prescription is the only element that separates museums on prescription from museums in health. Implementation of a museums on prescription program is highly attainable using the same collaborative practices that most American museums have already grown accustomed to. Though more research should be conducted outside of the UK and Canada, there is significant promise for museums on prescription as a viable program format to be used by American museum practitioners and healthcare professionals.

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Appendix A: Call for Participants

CALL FOR PARTICIPANTS

University of Washington | Graduate Thesis Research Study

Museums on Prescription

PARTICIPATION ENTAILS:

A 45-minute interview hosted on Zoom. Interviews are recorded solely for transcription purposes and all data is anonymized. Participation in this study is entirely voluntary and participants can choose to withdraw at any point in time.

WHEN:

February 20 - March 31

WHO:

Sarah Huckaby - Master's Candidate, Museology - University of Washington - snh66@uw.edu

WHAT:

A graduate research study investigating museums on prescription from the perspective of the museum practitioners involved in them. Museums on prescription is part of the rising social prescribing initiative aimed at linking patients with non-medical services and resources for the betterment of their overall health and well-being. Museum programming has a long-established reputation for being a viable form of health intervention and recently, it has found its place as an essential component of social prescribing. This study contributes to the growing body of research surrounding museums in health by exploring what comprises museums on prescription models and how they operate from the views of museum staff.

This study seeks to explore the following research questions:

1) What are the defining characteristics of museums on prescription models?

2) From the museum practitioner's perspective, what are the affordances and constraints associated with museums on prescription work?

3) In what ways has Covid-19 impacted museums' ability to participate in social prescribing programs?

WHY:

This study is made possible through the participation of museum professionals like you. Your contribution ensures this study realizes its goal to connect museum staff experiences with the growing body of knowledge surrounding museums on prescription.

Please contact me if you have any questions. Thank you for your consideration!

Appendix B: Interview Instrument

INTERVIEW GUIDE

Interview Date: Institution: Interviewee:

Hello, thank you for joining me today and choosing to take part in my graduate research study. This interview is approximately 30-45 minutes and will be recorded. If at any point you have any questions or concerns, please feel free to let me know. All responses are entirely voluntary, though any information you can provide is greatly appreciated.

Characteristics

1. Could you describe what the museums on prescription model looks like at your museum?

2. What three words would you use to best describe the characteristics of the museums on prescription model at your museum?

3. What motivated your museum to get involved in museums on prescription?

4. I'm interested in the referral process. Am I right that people are referred to the museum by a link worker? How does that referral process work? Prompts: Are people referred to your museum specifically, or to a museum in general? What exactly does the "prescription" say? Who specifically is referred to your museum? Approximately how many referrals does your museum accommodate a month? In a year?

5. Now, I'd like to talk about what happens when people who are referred arrive at the museum. Can you walk me through that process? Prompts: Do they have to show someone their "prescription?" How much do you know about the people who arrive at your museum with a "prescription?" How is the experience that these people have in the museum similar to and different from the experience that an average visitor would have?

6. Who are the external partners and stakeholders involved in making this service possible?

7. What is your role, as a staff member, in organizing and implementing this model?

8. What other staff roles, training, and resources are required in order to execute this work?

Affordances and Constraints

9. From your perspective, what are the main benefits to the museum of being involved in museums on prescription? (Clarify, not the benefits to the people participating, but to the museum. What impact does this have on the museum itself?)

10. From your perspective, what are the main challenges to the museum of being involved in museums on prescription?

COVID-19

11. How do you think that Covid-19 has impacted your museum's ability to deliver this service?

Thank you again for your contribution to this study. To close, I have one final question. Would your organization be open to sharing any relevant documentation such as program strategies or proposals to further supplement my research?

(NO) I completely understand. Thank you and should you have any further questions about this study down the line, please don't hesitate to reach out to me or my thesis chair, Jessica Luke at jjluke@uw.edu.

(YES) Thank you! At your earliest convenience, please send those documents to my email. Have a wonderful day, should you have any further questions about this study down the line, please don't hesitate to reach out to me or my thesis chair, Jessica Luke at jjluke@uw.edu.