Evaluating the impact of membership of

Active Retirement Ireland on the lives of older people

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Executive summary

Public discourse in relation to older people has often tended to construct them as "a burden" on the government and public policy has focussed narrowly on the costs of health-care, long-stay care and pensions. This is also evidenced by the fact that most of the resources devoted to healthy ageing in the community are spent on medical services provided by a range of professionals while a relatively small proportion is devoted to providing social, physical, cultural and educational programmes designed to promote and preserve health. This ignores the fact that it is increasingly recognised at international policy level that healthy ageing requires a broad holistic approach to health production; this requires not only investment in medical care, but also investment in health-promoting behaviours in the community which can help to prevent the onset of ill-health and to delay mortality. Older people are now living longer and tend to be healthier than were previous generations of older people. It is increasingly recognised that people need to have access to meaningful forms of engagement in society at a time when they may be retiring from employment and/or be less engaged with family.

Active Retirement Ireland (ARI) aims to foster independence, solidarity and support among older people in Ireland. It is a national umbrella body for 550 affiliated Active Retirement Associations (ARAs) with an estimated membership of over 23,000 men and women, throughout Ireland. ARI (formerly known as FARA) has been in existence for 27 years. The impact of being a member of an ARA has not yet been comprehensively assessed. This year (2012), the European Year of Active Ageing and Solidarity between the Generations, is an appropriate time for such an evaluation.

The main questions posed by this research are to establish:

1. What constitutes healthy ageing and a good quality of life for older people?
2. What are the processes through which quality of life for older people is enhanced?
3. Does involvement in a social organisation such as ARI promote a healthier lifestyle and/or lead to enhanced quality of life in older ARA members?
4. What are the next steps for ARI in pursuing the aim of enhancing quality of life for older people in Ireland?

In addressing these questions, the research also considers whether ARI succeeds in being an organisation that people are proud to be part of - locally, regionally and nationally; whether it is a recognised voice for older people on issues that concern them; and whether it is working towards becoming a self-sustaining organisation.

A review of international and national guidelines for healthy ageing found that key international health policy bodies recommend that governments and non-governmental

organisations should provide opportunities for older people to participate in social, physical, cultural and educational activities and to volunteer.

A mixed-methods study was conducted to assess the impact of being a member of an ARA from the perspective of ARA members themselves. A self-completion postal questionnaire survey was distributed to all 541 chairpersons of Active Retirement Associations (the number affiliated to ARI at the time the survey was distributed) and to 341 members of Active Retirement Associations; five focus groups were conducted with 44 ARA members – (14 men and 30 women); interviews were conducted with 20 ARA members (7 men and 13 women) and with eight non-members of ARA's (6 men and 2 women). The questionnaire captured information on the nature and level of involvement of ARA members in activities and the impact that being an ARA member had on their lives. It assessed older people's levels of quality of life and of loneliness, using established measures to enable comparability with the national population. It also explored their opinions of their local ARAs and of the national body ARI, as well as eliciting their suggestions for improvements and their views on the most important issues for older people.

The interviews and focus groups enabled the research team to explore members' motivations for joining ARA's and their assessment of the impact of membership on their lives in more depth than is possible in a questionnaire. In addition they also identify barriers to membership as well as also providing recommendations for ARAs and ARI in the future.

Key findings of the research are as follows:

Active Retirement Ireland is a national organisation whose growing number of affiliated ARA's provides a wide variety of physical, social, educational and cultural activities for over 23000 older people throughout Ireland.

Motivations for joining an ARA include the following: ARAs provides a means of integrating into the community for people who have moved into a new area on retirement; this includes returning emigrants or migrants. Joining an ARA provided a ready-made social network for people who had recently retired and had lost the social networks associated with employment. Those who were recently bereaved or who had been carers for relatives indicate that joining an ARA provided an important source of social support for them. Others joined in order to contribute to society, a common motive for volunteering. Finally some joined because they wanted to participate in particular activities or to be part of an Active Retirement Association for social reasons. The research identified a number of barriers to joining an ARA. Potential members may have stereotyped ideas of what takes place in an ARA; for example, that ARAs are for very old people or only for women. Similarly there is a perception that ARAs only provide stereotypical activities associated with older people, such as bingo.

Most ARA members (77%) are women and they tend to be actively engaged in the community, frequently make social visits, attend religious events regularly and vote often.

ARA members spend an average of 13.7 hours per month in ARA activities. Chairpersons spend approximately 15.5 hours per month as opposed to members who spend approximately 10 hours per month on ARA activities, suggesting that chairpersons spend at least 5.5 hours per month volunteering their time to organise activities.

If we assign an estimated economic value to volunteering (using an opportunity cost method), we calculate that all 541 chairpersons contribute an average of €197,091.93 hours worth of voluntary work per annum to organising activities for ARA members. Using a replacement cost method i.e. the amount one would have to pay someone on the average industrial wage to do the equivalent work, we estimate that chairpersons contribute €788,008.05 worth of voluntary work per annum.

Impacts of ARA membership

ARA members report higher levels of quality of life than do older people in the general population as found in TILDA. (It should be noted that TILDA is based on a sample of people aged 50 and over while this study is based on a smaller sample of ARA members aged 55 and over). They report high levels of satisfaction with life and high levels of optimism. ARA members strongly agreed that joining an ARA had improved their mental health including making them feel valued, having enhanced self-esteem, feeling needed and, to a lesser degree, having a reason to get up in the morning. They had a lower loneliness score when compared to members of the general population of older people in Ireland. ARA members agreed that their physical health had improved since joining their local ARA.

Members strongly agreed that the fact that they are members of an ARA benefits their local community and indicated that joining an ARA had helped them to enlarge their circle of friends. They strongly agreed that it enhanced their sense of independence and confidence to do things for themselves and that life was more fun, exciting and enjoyable since joining an ARA. Respondents said that being a member encourages them to engage in activities that they would not have otherwise engaged in, adding a new dimension to their lives.

ARA members report being more aware of policy issues for older people in Ireland and being more inclined to act upon them since joining an ARA, suggesting that ARI provides a potential forum for greater engagement with issues affecting their lives.

Members reported that they were proud to be a member of their local ARA, although this did not necessarily extend to the national organisation, ARI. They indicated that the ARAs were democratic – that their opinions and suggestions were valued and would be acted upon. They also felt that ARI was effective in acting as an advocate for its members at national level.

The perception of ARAs and of ARI was generally positive and participants identified the number of members as its main strength; nevertheless, members identified a number of improvements that would enhance the organisation. Members felt that there was a need for the national organisation (ARI) to ensure better flows of communication between itself and local ARAs and that there could be better communication between ARAs at local level. For example, more well-established ARAs could pass on the benefits of their experience to new ARAs and ARAs could join together to organise activities and trips. Other concerns for the future included difficulties in acquiring funding for activities since the recession.

ARA members made a number of recommendations to help increase membership of the organisation including changing the name of the organisation, using direct personal encouragement to join by members, increasing the profile of the national and local organisations through publicity, and promoting ARAs through retirement courses.

Conclusion

The research has found that ARA members have identified a range of positive impacts that they associate with their membership of ARAs. It should be noted that it is not possible to attribute benefits directly and solely to being a member of an ARA. It is probable that there is a degree of self-selection is involved in that healthy and optimistic individuals may be more likely to join an ARA in the first instance. However, the international literature review has also found positive associations between engaging in volunteering and other activities of the kind provided by ARAs and enhanced physical and mental well-being and quality of life; in addition some ARA members directly attribute their improved quality of life to their ARA membership. ARAs yield considerable health and social gains for older people throughout Ireland and provide important social networks at a time when existing networks for older people are becoming less available The important role played by ARAs and ARI as partners in health production in relation to healthy ageing for older people deserves to be explicitly recognised in policy documents such as the National Positive Ageing Strategy.

Key recommendations

- The benefits to psychological and physical well-being and quality of life and the fact that ARA membership appears to contribute to healthy ageing are evident. The relative lack of similar services provided by the State suggests that the government should not only continue to provide financial support for ARI, as part of its health promotion activities, but also should consider increasing such support.
- ARA has succeeded in becoming an organisation of which people are proud to be a member at a local level; however this does not appear to extend to regional or national level. ARI needs to increase its presence and profile with its own members and to increase flows of information from national to local organisations.

- Given the benefits in terms of enhanced physical and psychological well-being, ARAs and the ARI should continue in their attempts to attract new members. It should approach workplaces and trade unions and might offer pre-retirement courses as a means of attracting new members and raising additional funding.
- The organisation needs to develop its regional structure and strengthen its outreach activities.
- ARI needs to work to diversify its membership in terms of age and gender; in order to do this, it needs to act to break down existing stereotypes associated with older people. It may do this in conjunction with organisations such as Older and Bolder who advocate for older people.
- If ARI wishes to attract more men as members, it needs to provide activities that are attractive to men.
- Given that health promotion policy for ageing was last comprehensively set out in 1998, there is a need for policy for active and healthy ageing to be clearly articulated in the forthcoming National Positive Ageing Strategy and the role of ARA's in supporting healthy ageing needs to be recognised in the strategy.

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Chapter One: Introduction

There has been an increase in the proportion of people aged 65 and over in Ireland, which now stands at 11% (Eurostat, 2011). With extended life expectancy and a reduction in premature mortality, it has been recognised that many of today's older people are healthier than were their counterparts in the past. This means there is great potential for older people to contribute to society. However, this is dependent on opportunities for meaningful engagement being available to them. Retirement from the labour market is recognised as a transition point that may be experienced as a time of loss of identity and of rolelessness. It is widely recognised at national and international levels that engaging in meaningful activities in a social context enhances the quality of life and even the physical and mental well-being of older people. The recognition that some older people may miss the social interaction they previously enjoyed in the workplace or in rearing and caring for family formed part of the rationale for founding the first Active Retirement Association in Ireland in Dun Laoghaire in 1978. Active Retirement Ireland,[1] the national umbrella body for Active Retirement Associations, has been in existence for 27 years and has grown steadily during that time; it is now one of the largest organisations for older people in Ireland whose 550 affiliated ARAs have over 23,000 members. It promotes opportunities for older people to self-organise and engage in social, physical, cultural and educational activities. It has an ethos of encouraging self-support and volunteering. In this European Year for Active Ageing and Solidarity between the Generations, ARI has decided to commission an evaluation of the impact it has on its members.

The purpose of the current independent evaluation is to assess:

To what extent is ARI achieving its central aim of encouraging healthier lifestyles and enhancing well-being?

Specific objectives are to assess:

1. What constitutes healthy ageing for older people?
2. What are the processes through which quality of life for older people is enhanced?
3. Does involvement in a social organisation such as ARI promote a healthier lifestyle and/or lead to enhanced quality of life in older people?
4. What are the next steps for ARI in furthering this aim?

[1] Formerly known as the Federation of Active Retirement Associations (FARA).

1.1 Active Retirement Ireland: structure

Active Retirement Ireland obtained funding from Atlantic Philanthropies in 2007 and appointed a new CEO in 2008. Subsequently, the national body changed its strategic direction from being primarily an administrative body whose main function was to provide co-ordination and support for the ARAs throughout the country to adopting a more proactive role in representing the concerns of older people in Ireland, acting to increase and diversify membership and to become self-sustaining. Active Retirement Ireland was incorporated as a company limited by guarantee in 2008. The objectives as stated in the Memorandum of Association are:

- To encourage retired men and women to maintain their independence and to participate through the active retirement movement in social contacts and self-help activities of a cultural, educational and sporting nature aimed at enhancing quality of life.
- To promote a more positive attitude to ageing and the retirement process.
- To enable retired people to enjoy a full and active life and to advocate for them.
- To be a recognised voice for retired people on social, health, learning and economic issues in collaboration with other organisations.

The organisation is run by voluntary committees at local, regional and national level. There are approximately 4,200 volunteers working in ARAs throughout the country (Active Retirement Ireland Strategic Plan, 2012-2014). Although it was originally primarily a Dublin-based organisation, the number of ARAs has grown (see Appendix A, Table 1) and they are now spread throughout the country into rural areas. The organisation is structured through eight regional committees whose role it is to bring the local associations together for information, training seminars and activities. Each regional committee includes at least nine volunteers. Each of the 550 local associations is run by a committee of approximately eight volunteers (Harvey, 2012). The vast majority of members are female (82%) and most are aged between 60 and 80 years (McKenna, 2009). As evidenced by these statistics, the organisation faces challenges around recruiting males and younger retired people. Therefore Active Retirement Ireland has committed in their Strategic Plan 2012-2014 to trying to broaden the demographic mix of age and gender, attracting more men and younger members. The organisation receives funding from a variety of sources including statutory and philanthropic sources together with income from membership fees and fundraising events.

ARI identifies itself as being “an attractive and inclusive membership-led organisation for older people, which supports members to realise their full potential”. In seeking to realise their aims, ARI developed a three-year strategic plan that identified the following outcomes as needing to be achieved between 2012 and 2014:

- Be an organisation that people would be proud to be part of locally, regionally and nationally.

- Be a recognised voice for retired people on social, health, learning and economic issues in collaboration with other organisations.
- Work towards becoming a self-sustaining organisation.

The evaluation is timely in that it should help inform ARI if it is achieving these objectives from the perspective of its members, even though it was not specifically designed for this purpose.

The overall outcome of the three-year strategic plan is to have an organisation that is embedded in the needs and expectations of the members and a model of good practice for the participation of older people in developing responses and activities suited to their needs. One of the recent initiatives of ARI is a regional development and outreach team of volunteers, whose role it is to support existing and new ARAs and to encourage recruitment. A business development executive has recently been employed to develop strategic investment opportunities. The aims of the local Active Retirement Associations (ARAs) are to enable older people to lead a full, happy and healthy life by offering organised opportunities to take part in a wide range of activities. The ARAs are self-organised and independent local groups whose members decide what activities are on offer. ARI embraces the community development model of empowering people to do things for themselves – activities are chosen based on what members like to do and on their ability to participate. The approach to active ageing is holistic and this is reflected in the broad range of activities it offers, which typically include:

- Physical activities such as bowls, swimming and exercise.
- Social activities such as tea dances, evenings out, holidays and short leisure breaks.
- Cultural visits to museums, heritage centres and galleries.
- Learning activities such as creative writing, mobile phone training, arts and crafts.
- Providing information on issues such as health, welfare rights and pensions.

All activities are designed to reduce isolation and are aimed at keeping older people independent, active and healthy.

1.2 Contextualising the work of Active Retirement Ireland: international and national guidelines

The purpose of this section is to contextualise the work of ARI in relation to current policy debates and trends in the international and national ageing sector. The concepts of active ageing and quality of life provide a basis for assessing the impact of being a member of Active Retirement Ireland. Many of the activities promoted by ARI are designed to promote active and healthy ageing among older people in Ireland. It is widely recognised at international policy level that demographic ageing has resulted in a generation of “young older people” who are fitter, healthier and more active than preceding cohorts, and who are free from the obligations of the paid labour market (Erlinghagen, 2010; Warburton and Stirling, 2007). The

assumption that this cohort of the population should be active is supported by the theoretical concept of “active ageing”. Active ageing is a holistic concept; it has been defined by the World Health Organization as “the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age” (WHO, 2002). “Healthy ageing”, which is a component of active ageing, is defined as “the process of optimising opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life”(Agren and Berensson, 2006). Some of the guiding principles of policy frameworks for healthy ageing are:

1. The belief that it is never too late to promote health.
2. The belief that healthy ageing policies should rely strongly on prevention.
3. The assumption that older people are of intrinsic value (rather than a burden to society).

International and national policy bodies endorse the concept of active ageing and suggest that participating in social recreational activities enhances the quality of life and well-being of older people (Agren and Berensson, 2006; WHO, 2002;). The concepts of “active ageing” and “healthy ageing” are internationally recognised concepts that encompass many of the activities that are offered and the ethos of independence and self-support that is promoted by Active Retirement Ireland. There is recognition at an international level that active ageing has positive impacts on older people in terms of their physical, mental and psychological health.

The World Health Organization has set guidelines and targets for healthy ageing. One of the most widely used measures of well-being is quality of life. Bond and Corner (2004) identify seven aspects of quality of life specifically for older people:

1. Subjective satisfaction (people’s own perception of their satisfaction with life)
2. Physical environment (including housing and transport)
3. Social environment
4. Socio-economic factors
5. Cultural factors
6. Health status
7. Personality and personal autonomy.

Healthy ageing policies generally promote healthy lifestyles because it is accepted that they lead to:

- Fewer disabilities associated with chronic diseases for older people.
- Reduced healthcare costs.
- Older people having a positive quality of life in older age.
- Greater participation in society (WHO, 2002).

They encompass physical, psychological and social aspects of the older person. Since older people tend to slow down their level of physical activity, it is a goal of the WHO to encourage them to maintain or increase their previous level of activity (WHO, 2003). Specifically, the WHO recommends that people should have "at least 30 minutes of regular moderate-intensity physical activity on most days" (WHO, 2004) and that countries should develop national physical activity guidelines. It also suggests that governmental and non-governmental organisations should work in partnership to provide programmes to encourage people to engage in physical activity (WHO, 2004). This, it believes, will play a major role in reducing healthcare costs and promoting health.

Another major component of healthy ageing is psychological well-being. It is recognised internationally that programmes to encourage healthy lifestyles, promote volunteering and involvement in education, and promote social interaction are important for psychological well-being (Oxley, 2009).

Finally, the United Nations recognises that social and cultural participation contributes to healthy ageing. It has articulated its view that:

> *"Older persons should have access to the educational, cultural, spiritual and recreational resources of society and should be able to pursue opportunities for the full development of their potential". The UN specifically recommends that member states should encourage: the empowerment of older persons to fully participate in the economic, political and social lives of their societies, including through voluntary work; the provision of opportunities for individual development, self-fulfilment and well-being throughout life as well as in late life through access to lifelong learning and participation in the community; ensuring the enjoyment of economic, social and cultural rights and civil and political life of persons" (United Nations, 2002).*

It specifically recommends the following actions to member states (United Nations, 2002):

- Provide opportunities, programmes and support to encourage older persons to participate or continue to participate in cultural, economic, political, social life and lifelong learning.
- Promote civic and cultural participation as strategies to combat social isolation and support empowerment.
- Facilitate older people to engage in mutual self-help and volunteering and promote opportunities to realise their full potential.

1.3 National guidelines on health promotion for older people

The most recent policy document on health promotion specifically for older people in Ireland is the 1998 health promotion strategy entitled "Adding years to life and life to years. A Health Promotion Strategy for Older People" (Brenner and Shelley, 1998). It advocates a holistic approach – suggesting that physical, psychological and social well-being are needed. It sets out goals for physical health, mental health and social interaction, and associated actions.

According to the strategy, the general goal in relation to mental health is to reduce the prevalence and severity of mental illness in older people (Brenner and Shelley, 1998). One of the recommended actions to achieve this is "wider availability of programmes for older people designed to develop self-esteem, personal relationships and skills to cope with stressful situations".

The strategy also sets out a general goal for social interaction for older people: "the goal is to help maintain the well-being and autonomy of older people by increasing their involvement in social activities". The associated recommended actions are "to encourage older people to be involved in community activities as participants and organisers" and "to enable older people to develop their creativity as well as to enjoy the arts" (Brenner and Shelley, 1998).

The goal for physical health was taken on board by the Department of Health and Children[2] and they developed specific guidelines for physical activity, *The National Guidelines on Physical Activity for Ireland* (Department of Health and Children, Health Service Executive, 2009).

Overall, the health promotion strategy provides a sound basis for health promotion for older people. However, with the exception of physical health, recommendations have not been implemented to any great extent by the statutory services (see section on health services for older people below). Many of the programmes and activities provided by ARAs and the general approach of ARI itself appear to address some of these goals.

The National Positive Ageing Strategy is due to be published in the near future and it may be expected to set out appropriate goals and actions for health promotion for older people.

[2] Now Department of Health.

Chapter Two: The impact of volunteering and participation in activities for older people

Introduction

In this chapter we outline previous research findings in relation to the impact of the kinds of physical, cultural and social activities participated in and/or organised by older people on their quality of life. We first discuss the definition and measurement of quality of life, since it is a broad, holistic concept that provides a useful way of assessing the impact of ARA membership, whose wide range of activities may be expected to affect the physical, psychological and social aspects of people's lives. Since many ARA members give their time voluntarily in their capacity as chairpersons or committee members, and since volunteering is the focus of much previous research for older people, we then examine the evidence previously gathered in relation to the impact of volunteering generally. Finally, we look specifically at the impact of specific types of activities (physical, cultural, social and educational) on the well-being of older people.

2.1 Measuring quality of life for older people

Maintaining a high level of quality of life into advanced age is a growing public health concern as the older population continues to expand (Acree et al., 2006). This is particularly important in the Irish context with Eurostat recently projecting that people aged 65 years and over will account for 22 per cent of the total population in Ireland by 2060; this is double the current figure of about 11 per cent (Eurostat, 2011).

Quality of life is acknowledged to be complex and there is much debate regarding how to define it (Moons et al., 2006). The World Health Organization (WHOQOL,1995) has defined quality of life as an "*individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns."* This definition reflects the generally agreed view that quality of life is subjective, whereby individuals are the only people who can reliably estimate their quality of life (Ferrans, 1996). It also incorporates the view that quality of life must address individuals' perceptions of both positive (e.g. contentment, mobility) and negative dimensions (e.g. negative feelings, pain) (WHOQOL, 1995). The WHO developed a scale for the assessment of quality of life in older adults, in a transcultural perspective (Power et al., 2005). This instrument, known as WHOQOL-OLD, recognises the multidimensional nature of quality of life, measuring it across six broad domains as follows:

- Physical domain (including energy and fatigue; pain and discomfort; sleep and rest).
- Psychological domain (body image; negative/positive feelings; self-esteem; thinking, learning, memory and concentration).

- Level of independence (mobility; activities of daily living; dependence on medical substances; medical aid).
- Social relationships (personal relationships; social support).
- Environment and accessibility (financial resources; freedom; physical safety and security; health and social care accessibility; physical environment, i.e. pollution, traffic, noise, climate, transport).
- Spirituality/religion/personal beliefs.

The current study uses this definition of quality of life to inform the design of interviews and focus groups (see Chapter 3). For the quantitative aspect of the research (the survey), the CASP-19 scale is used to measure and provide a score to assess quality of life. This scale is explained in more detail in Chapter 3 and it is used to enable comparison with national and international studies such as the Irish Longitudinal Study of Ageing (TILDA) and the English Longitudinal Study of Ageing (ELSA) (see Chapters 3 and 4).

2.2 Impact of volunteering and participation in activities

This section reviews the evidence on volunteering and participation in social, physical, cultural and educational activities**.** It is clear that there are different levels of evidence for the impact of different types of activities, with a relatively large body of evidence on volunteering, relatively little on social engagement, a good deal on physical activities and less on cultural and educational activities.

2.2.1 Impact of volunteering

There is a large body of literature that focuses on the effect of volunteering, a common form of social participation among older people. Since many ARA members volunteer their time in their role as committee members, secretaries or chairpersons, we begin by considering the impact of volunteering on the well-being and quality of life of older people. We then go on to consider the impact of other forms of participation – social, physical, cultural and educational activities in a social context.

The government of Ireland has defined volunteering as "*the commitment of time and energy, for the benefit of society, local communities, individuals outside the immediate family, the environment or other causes. Voluntary activities are undertaken of a person's own free will, without payment (except for reimbursement of out-of-pocket expenses)*" (Department of Social, Community and Family Affairs, 2000).

Motivations for volunteering

A large body of research has documented the reasons why older people choose to volunteer. Some of the most commonly stated reasons are altruistic or humanitarian concerns such as the desire to help vulnerable members of their community, to "give something back" and to share their experience (Clary and Snyder, 1999; Morrow-Howell et al., 2009; O'Dwyer and Timonen, 2009; Okun and Michel, 2006). Older people are also motivated by self-oriented concerns. For example, they volunteer in order to add meaning to their lives, to acquire a sense of belonging or satisfaction at feeling needed, and for the purpose of social interaction and making friendships during the course of the voluntary work (Lie and Baines, 2007; O'Dwyer and Timonen, 2009; Warburton and Crosier, 2001). Linked to this, Li and Ferraro (2006) have reported that older people may volunteer in order to combat depression, which may result from role losses such as widowhood.

A second body of literature looks at the relationship between socio-demographic variables and the decision to volunteer. A number of factors have been found to be consistently correlated with volunteering such as higher socio-economic status, higher formal education, being married or living in a steady partnership, good self-rated health, owning a car, having a religious affiliation, rurality, larger social networks, and engagement in other social activities (Barrett et al., 2011; Caro and Bass, 1995; Erlinghagen and Hank, 2006; Parkinson et al., 2010; Supan et al., 2005; Warburton and Crosier, 2001; Warburton and Stirling, 2007). By contrast, being aged 75 years and over, being involved in paid work and having poor self-rated health are negatively correlated with the decision to volunteer (Barrett et al., 2011; Erlinghagen and Hank, 2006; Supan et al., 2005). Finally, the international evidence suggests that women are more likely to volunteer than men (Australian Bureau of Statistics, 2010). However, there appears to be little variation in the likelihood of volunteering between older women and men in Ireland (Barrett et al., 2011; Breen, 2011).

Morrow-Howell (2010) notes that volunteering is a dynamic process − that "participation starts and stops, waxes and wanes in response to changes in individuals' lives as well as in response to the nature of the volunteer service". Butrica et al. (2009) proposed that the reasons underlying why older people stop and start volunteering include the associated benefits and costs. Life transitions such as health, work and marital status all serve to alter the associated benefits and costs. In reviewing the available evidence on transitions into and out of volunteering, Morrow-Howell (2010) concluded that a more nuanced understanding of what influences older adults to start, continue or quit volunteering will be important to organisations in recruiting and retaining volunteers.

Impacts of volunteering

The Irish Longitudinal Study on Ageing (TILDA) reported that one in five older adults aged 65-74 years do voluntary work on a daily or weekly basis in activities that support communities and individuals across Ireland (Barrett et al., 2011). Considerable evidence has emerged over the past few decades linking volunteering with a variety of quality of life and well-being indicators (Barrett et al., 2011; Lum and Lightfoot, 2005; Musick et al., 1999; Shmotkin et al., 2003). Longitudinal research has found volunteering to be associated with delayed mortality (Lum and Lightfoot, 2005; Von Bonsdorff and Rantanen, 2011). Furthermore, lower morbidity and longer life have also been linked to the particular experience of giving as opposed to receiving support. This relationship has been attributed to the notion that being useful to others instils a sense of feeling needed, which in turn encourages better health and greater longevity (Gottlieb and Gillespie, 2008). Long-term volunteering acts as a buffer against depression and predicts better self-rated health, higher levels of physical activity and enhanced life satisfaction (Hao, 2008; Li and Ferraro, 2005; Von Bonsdorff and Rantanen, 2011). Another study links volunteering with higher levels of functional ability and attributes this to social integration and meaningful engagement (Moen et al., 1992).

It is difficult to say with certainty whether volunteering causes people to be healthier or whether healthier people are more likely to volunteer. This is due to the fact that the so-called "healthy participant effect" cannot be fully controlled for; people with good health, adequate social and economic resources and high self-esteem are more likely to volunteer. Therefore it remains unclear whether activities such as volunteering contribute to the health of older people as opposed to healthy persons being more likely to be engaged in volunteer activities (Von Bonsdorff and Rantanen, 2011). This notion of self-selection may, in some instances, lead to an over-estimation of the beneficial effects of volunteering (Li and Ferraro, 2006; Shmotkin et al., 2003). However, it is likely that there is a reciprocal effect.

More generally, TILDA measured quality of life among older people using the CASP-19 scale and found that the lowest mean quality of life scores were to be found among the sections of the population who never volunteer. Furthermore, higher quality of life scores were associated with higher levels of volunteering (Barrett et al., 2011). In a comprehensive review of the literature on the relationship between quality of life and volunteering, Cattan et al. (2011) determined that a positive association exists between quality of life and volunteering among older people. This review identified that volunteering serves to maintain and may even improve quality of life among certain groups of older adults.

The possible mechanisms for the effect of volunteering on quality of life and well-being discussed in the literature include the fact that volunteering provides a role identity for those outside paid work, helps build self-esteem and a sense of control, and increases social connection (Warburton and Crosier, 2001). It involves physical and mental effort, which is likely contribute to the decreased risk of adverse health outcomes (Von Bonsdorff and

Rantanen, 2011). According to Wahrendorf et al. (2006), the quality of exchange experienced by volunteers is what matters for well-being. Where volunteering activities result in high "cost" while providing poor "gain", frustration or lack of reward is likely to occur with adverse effects on well-being. In contrast, doing voluntary work in the context of a balanced social exchange strengthens the sense of well-being in older people.

Volunteering and social capital

The concept of social capital helps understand some of the motivations for and the impacts of volunteering. The meaning and measurement of social capital has been the subject of much debate in the literature (Wiggins et al., 2004). Putnam (2001) regards social capital as a public good that resides in the shared values and mutual trust of members of a community and is available to them all. He placed a strong emphasis on voluntary co-operation of individuals within clubs, churches and other formal associations in increasing social capital within a community. Others argue that social capital is not a public good but an asset of an individual or group who participates in social networks, which can be drawn upon to obtain information and assistance of various kinds (Bourdieu, 1986). Gray (2009) adopts a definition of social capital that incorporates elements of both Putnam and Bourdieu's definitions. The author defines social capital as an individual resource, which is influenced by one's past and present activities, but is also contingent on the attitudes of others. One key underlying element of involvement in social activity is that it generates a considerable amount of social capital for those involved and consequently for society (Gottlieb and Gillespie, 2008; Rozario, 2006). Indeed Putnam (2001) asserts that membership of clubs, societies and churches is important in building individual social networks.

Social capital is thought to have an independent and additive effect on volunteering as a form of social participation. It allows individuals access to additional resources, which increase chances of volunteering in the community. For example, as many volunteers are said to be recruited by friends, relatives and associates, people with greater social capital in the form of regular contact with family and friends are thought to be more likely to become volunteers (Babchuk and Booth, 1969). McNamara and Gonzalez (2011) have found the "personal ask" to be an effective means of recruiting volunteers, with older adults being more likely to have become involved in the volunteer activity when they were personally asked by a friend or acquaintance, rather than through an advertisement or other media channel. Indeed Morrow-Howell (2010) identified that older people with more social capital tend to volunteer.

2.2.2 Impact of social participation

As has already been mentioned, less is known of the impacts of involvement in social activities other than formal volunteering on the quality of life of older people. Social activity means participating in activities that require interacting with others in a way that involves

communication and establishing a connection (Martinez et al., 2009). The Irish Longitudinal Study of Ageing (TILDA) found a significant association between quality of life and social engagement, whereby quality of life is higher where there is greater social engagement (Barrett et al., 2011).

Research demonstrates that feeling productive and engaged in regular structured social activities as one ages promotes life satisfaction, helps delay mortality, disability and cognitive decline, and is important to psychological health (Berkman et al., 2000). The American Longitudinal Study of Ageing identified that lower death rates were closely related to higher levels of social contact, with older volunteers who interacted more with family and friends and who attended religious services being found, on average, to live longer (Harris and Thoresen, 2005). Furthermore, active social contact (that is, contact which promotes the development of meaningful social roles and active engagement in local communities) has a positive impact on older people's quality of life and health (Greaves and Farbus, 2006; McAuley et al., 2000). Active social contact reduces depressive symptoms, increases self-esteem and self-worth, and lowers blood pressure (Andersson, 1998; Ciechanowski et al., 2004).

As well as looking at the impact of volunteering and social interaction, we need to consider what is known about the impact of participating in physical activities on older people, since this is an important component of ARA membership.

2.2.3 Impact of participating in physical activities

A large body of evidence concludes that engaging in physical activity produces beneficial effects on the physical and psychological health of older people. There is broad agreement both in international health policy organisations and in research communities that participating regularly in physical activity helps to prevent conditions such as heart disease, diabetes and osteoporosis, reduce falls, and delay mortality (Cooper et al. 2010; Daugbjerg et al., 2009; Weerdesteyn et al., 2006; WHO, 2003). Regular participation in even moderate physical exercise enhances the psychological well-being of older people. A major review of 36 studies of community-dwelling adults found that exercise increased emotional well-being, self-esteem, self-efficacy (people's belief that they can exert control over their own lives) and sense of mastery (being able to use, understand or have control over their own lives).

Maintaining physical activity in older age can have many psycho-social benefits. One study by Klusmann et al. (2012) of a physical activity intervention was shown to positively improve older women's views of their own ageing. Furthermore, exercise appears to reduce depression, and may decrease the likelihood of developing dementia and help combat memory impairment (Blake et al., 2009; Lautenshlager et al., 2008; Middleton et al., 2008). Feelings of loneliness are associated with reduced physical activity (Newall et al., 2012).

The types of physical activity that can potentially produce beneficial effects to older adults vary. The American Heart Association recommends that activities should enhance aerobic capacity, muscle strengthening, flexibility and balance abilities, with an emphasis on muscle strengthening activity as it prevents muscle loss, benefits bone structure and aids prevention of functional limitation (Nelson et al., 2007). Overall the Association recommends that older adults perform 30 minutes of moderate intensity exercise five days a week, as well as muscle strengthening of at least two 45-minute sessions a week (Nelson et al., 2007). Lifestyle activity is physical activity that occurs doing everyday tasks (e.g. sweeping, cleaning). Lifestyle activities such as journeys out of the house for shopping or other activities are important for older adults in maintaining their physical activity levels (Davis et al., 2011). This would include attending activities of the kind typically provided by ARAs.

2.2.4 Impact of participating in cultural activities

Research on the impact on older people of participating in cultural activities is somewhat more recently developed than research on physical activity. In fact, some reviewers suggest that many of the existing studies have limitations in terms of scope, size and generalisability (Health Development Agency, 2000). Nevertheless, there is increasing evidence that engaging in and attending cultural and creative activities and programmes such as painting, drama, music and arts festivals increases physical and psychological well-being. Perhaps the most compelling evidence comes from rigorous controlled studies carried out in the US by Cohen and colleagues. They conducted a community-based study, which found that cultural programmes for older people gave the following benefits: improved physical health improved, fewer doctor's visits, increased self-esteem, reduced loneliness and increased activity (Cohen et al., 2006). This has been attributed partly to an increased sense of mastery or control over a skill or activity (Cohen, 2009). In addition, the increased social contact generated by these programmes is thought to be beneficial in itself (Glass et al., 1999). Greaves and Farbus (2006) have found that community programmes which encourage social contact result in increased social support, increased alertness, increased social activity, enhanced self-worth and increased optimism about life. Studies have shown that engaging in the arts has positive effects on people with dementia (Knocker, 2002).

2.2.5 Impact of participating in educational activities

Older people choose to participate in learning programmes for a number of reasons. Motivations for continued learning among older adults have been found to include wanting to keep the brain active, enjoying the challenge of learning new things, wishing to learn about specific topics of interest, wanting to meet new people, and wishing to alleviate loneliness (Dench and Regan, 2000; Mehrotra, 2003). Aldridge and Lavender (2000) found continued learning to have many benefits among adults, including improved self-confidence, increased social networks, and both physical and mental health benefits. Furthermore, pursuing lifelong learning is important among older people in maintaining a positive mental attitude (Keddy and Singleton, 1991). Continued education and training has been found to serve preventative, remedial and preparatory functions for older people. Specifically, it helps older participants to master the developmental tasks associated with their stage in life, and allows them to learn more things of interest, meet people they find interesting, contribute to society, and improve their social life (Mehrotra, 2003).

2.3 Barriers to participation among older people

Older adults are more likely than younger adults to experience restrictions and limitations to social participation. In fact, as age increases, social participation has been shown to decline as part of the ‘‘normal’’ ageing process (Levasseur et al., 2011). It is therefore important to gain an understanding of the barriers to participation in order to determine how to overcome them.

Harvey (2012) examined the motivations and barriers of a diverse group of older people in attending Active Retirement Associations. This research found that for younger retirees, such as those in their 50s, the age gap between themselves and other people in the organisations aged from their mid-60s upwards is a large one to bridge, and acts as a deterrent to joining an Active Retirement Association. Furthermore, there was a gender imbalance in ARAs whereby many associations are female dominated and do not provide activities that are of interest to men. The research also identified reasons for exits among members. These included a change in personal circumstances, which may involve the person taking on a carer role, and also a gap between the member’s expectations and the reality of being a member of such a group.

One potential barrier to participation in services provided by voluntary associations appears to be a lower level of formal education. Research has demonstrated a positive association between increasing education and greater social engagement and participation (Barrett et al., 2011; Scharf et al., 2005). Since higher education is associated with greater income and wealth, it often translates into more opportunities to engage in different social and leisure activities (Barrett at al., 2011). In line with this Raymond et al. (2012) found that socio-economic and health disparities may greatly influence the possibilities and opportunities for social participation among older people.

Issues of access and availability appear to be crucial factors for the engagement of older people in formally organised social activities. This is particularly true in the case of transport and appropriateness of venues, which have been identified as barriers preventing people from attending activities. Additionally, older people's enjoyment of activities, and in turn the likelihood of maintaining their attendance at such activities, is mediated by the extent to which activities are tailored to individuals' abilities and interests (Greaves and Farbus, 2006). These findings are echoed in research carried out by Martinez et al. (2009). Perceived barriers included a lack of interest or desire to be active, poor health, mobility difficulties, lack of energy, vision impairment, the need to use assistive technologies such as a cane, transportation, money, safety concerns, unwillingness to travel at night, not wishing to rely on others for transport, and overcrowding on public transport.

A large body of literature identifies barriers to volunteering, including concerns about financial costs, particularly among older people with low incomes where out-of-pocket expenses are incurred (Davis-Smith and Gray, 2005; Warburton and Stirling, 2007). Where poor health affects mobility and activity it can, therefore, reduce participation in voluntary organisations (Breen, 2011; Li and Ferraro, 2005). A further barrier includes the feeling of being "tied down" by regular time commitment or the lack of flexibility. A major attraction of retirement is the escape from the nature of such a routine (Smith 2004; Warburton and Crosier, 2001). Older people may often lack spare time, despite assumptions to the contrary (Warburton and Crosier, 2001). Due to dominant discourses focusing on the negative aspects of ageing such as poor health and economic dependency, older people may feel that there is inadequate support for them to pursue further social roles such as volunteering (Gallagher, 1994; Warburton and Crosier, 2001; Warburton and McLaughlin, 2005). Other identified barriers to volunteering include poor management of volunteer programmes (Hendricks and Cutler, 2004; Smith, 2004); the nature of activities involved (e.g. monotonous or lacking diversity); exclusionary attitudes towards new volunteers (Warburton and Crosier, 2001); older people not feeling supported and/or lacking adequate recognition for their skills and experience; and advancing age (Smith, 2004).

2.4 Existing health and psycho-social services for older people in Ireland

It is useful to consider the existing range of services available for older people; this enables us to develop an understanding of the current focus of public policy in relation to active ageing. It also helps to contextualise the work of ARI in relation to existing structures and institutions. It is clear that most resources for health care in Ireland tend to be narrowly focussed on hospital and medical services despite recent calls for a broader view of health production which would acknowledge the role of material and psychosocial forces in producing health (O'Shea and Connolly, 2012). We look briefly at state provision of health services for older people in Ireland and it is evident that the focus for older people's services is mainly on hospital care, long-stay care, medication and curative approaches in the community and

relatively few resources are devoted to health promotion. We outline some of the main statutory health services provided to older persons in Ireland, focusing mainly on community services as opposed to hospital or long-stay care settings. Then we describe services provided by non-statutory organisations, which may be funded and/or organised by the Department of Health, other government departments or local authorities.

With regard to statutory services, the Health Service Executive (HSE) provides a number of supports to older people in Ireland. There is an older persons' services manager appointed across each region. However, these managers do not have a set role and their duties vary from region to region. While some older persons' services managers have a very hands-on role running residential units, others are more active in the community working with various organisations that deal with older people. Older people can generally access HSE services via their local primary health care team (PHCT).

In terms of psycho-social supports, the main statutory service available is day care centres. While day care centres can be directly managed by the HSE, they can sometimes be run through voluntary organisations. In addition to providing their own services the HSE fund external agencies to provide supports. Day care centres aim to meet the psychosocial needs of older people through promoting social contact among older people and preventing loneliness and many also provide a range of medical services. They also seek to provide social stimulation in a safe environment for older people with mild forms of dementia.

The HSE also provides home care packages to assist persons who are ill, have a disability or are returning to their home from long-stay care with a comprehensive support service. Although the service is not exclusively targeted towards older adults, it is largely utilised by older people (HSE, 2012). The service is provided free to those with a medical card and may be provided directly by the HSE or by organisations on behalf of the HSE. Home help services and meals on wheels are provided by the HSE, and by voluntary organisations. However, a limiting factor is that there is no entitlement to home care services and provision is fragmented across Ireland (Timonen et al, 2012).

A range of medical professionals provide physical and mental health services to older people in Ireland, including public health nurses (PHNs), general practitioners (GPs), occupational therapists, physiotherapists, speech and language therapists, social workers, psychologists, psychiatrists and community mental health nurses. PHNs provide preventative, curative and palliative nursing services, which they can tailor to the needs of the individual in the home. GPs prescribe medicine, and may recommend various services to patients such as occupational therapists, physiotherapists and others. Occupational therapists provide assistance for those who have a disability, whether physical, social or psychological, to allow for as much independent living as possible. Physiotherapy services offer assessments and focus primarily on restoring the body to full physical functioning by developing exercise programmes for individuals (HSE, 2012; Our Lady's Hospice, 2012). Speech and language

therapists are professionals who assess, diagnose and manage persons who have developed speech and language difficulties or impairments. In terms of psychological and mental health services, social workers mainly provide care to those with mental illness or psychological problems. This may include providing counselling and emotional support to clients. The role of community mental health nurses is to provide psychiatric and physical care as well as support to patients and their families in the community. This may include individual counselling with patients, group therapy, family support, and providing educational inputs to community groups. Psychologists and psychiatrists also provide mental health services; this may involve medication along with counselling and therapy sessions. As we can see, the main focus of these formal state services is on medical treatment of the physical and psychological health needs of older people. Although there are some psycho-social services provided by community mental health nurses, it appears that there is relatively little direct state provision of the kinds of broad social, physical and cultural activities for older people that promote healthy and active ageing. In order to fill this gap in provision, a number of non-governmental organisations in Ireland focus on the well-being of older adults or of those who care for them, many of whom are, themselves, older.

In addition to Active Retirement Ireland, these include Age Action, Age & Opportunity, the Alzheimer Society of Ireland, the Carers' Association, the Irish Association of Older People, Men's Shed project, Older and Bolder (an alliance of age-related organisations), Senior Citizens' Parliament and Third Age. Some of these groups offer practical support (e.g. the Carers' Association, the Alzheimer Society); others play an advocacy role (e.g. Senior Citizens' Parliament, Older and Bolder); others provide a range of services and programmes and may also engage in advocacy (e.g. Active Retirement Ireland, Age & Opportunity) (see Appendix B for a list of organisations and an outline of some of the services they provide)[3].

Some of these organisations were founded in order to provide services for older people due to perceived gaps in the provision of statutory services, and/or to promote a more positive perception of older people in society. Organisations such as Age & Opportunity aim explicitly to promote the increased participation of older people in society and provide a wide range of programmes to encourage this (O'Shea and Ní Léime, 2012). Some organisations encourage social and recreational activities, independence and peer support (e.g. Third Age and Active Retirement Ireland) (O'Shea, 2006). Some of these organisations, although largely run by volunteers, receive core funding from the HSE, the Department of Health, and/or other government departments or agencies. For example, Active Retirement Ireland receives core funding from the HSE and from the Department of the Environment, Community and Local Government. Age & Opportunity receives core funding and some project funding from the HSE, Arts Council funding for the annual Bealtaine festival (which celebrates creativity in older age), and Irish Sports Council funding for the "Go For Life" physical activity programme. In addition, several local authorities also provide funding for social, educational and cultural

[33] It should be noted that this is not a comprehensive list, but rather is an indicative outline of services provided by ngo's sometimes in conjunction with the State.

programmes and events for older people. For example, several local authorities fund programmes for the Bealtaine festival (Ní Léime and O'Shea, 2008) and libraries also fund educational and computer programmes. Such funding is discretionary and is not provided by all local authorities (Ní Léime and O'Shea, 2008). Finally, many community organisations, development partnerships and the Vocational Education Committees (VECs) provide or fund repeated or once-off courses and programmes for older people, as do some Family Support Agencies. Again, this occurs on an ad hoc basis and is not provided in a comprehensive way throughout the country; similarly, funding is not guaranteed to continue from year to year.

In terms of policy for healthy ageing, there has been no comprehensive policy document for older people since 1998 although the National Positive Ageing Strategy is expected to be published in late 2012 and presumably will set out principles, goals and targets that will encompass the need for social, physical, cultural and educational activities for older people. In the absence of a comprehensive policy, it is clear that funding for this type of programme is currently provided from a variety of sources and is not guaranteed, despite the apparent health benefits.

Summary

This brief overview has examined evidence in the literature on the impact and motivations for engaging in volunteering and in social, physical, cultural and educational activities for older people, their motivations and the barriers they may encounter in so doing. It suggests that while there is ample evidence on the impacts for older people of engaging in volunteering and in relation to physical activities, research into the impacts of social engagement, cultural activities and educational activities is less well developed. However, in all fields, it appears that positive impacts of engagement on physical and mental well-being are indicated. While there is some recent evidence on social engagement and quality of life in Ireland from TILDA, there is very little qualitative Irish research investigating the processes by which such positive impacts are achieved (Timonen et al., 2011).

The brief outline of health and psycho-social services for older people indicates that the main focus of the state is on providing professional, medical and home care services for older people in the community, particularly for those who are mentally or physically ill. There appear to be relatively few psycho-social, physical or educational services for community-dwelling older adults provided directly by the state that have a health promotion (as opposed to a medical treatment) focus. Because of this, several voluntary organisations provide psycho-social services that complement the formal state services; some of these receive partial funding from the state and/or from local authorities. The wide range of activities and opportunities for voluntary engagement provided by Active Retirement Associations suggests that Active Retirement Ireland is a major provider of psycho-social activities. There is a recognition that such services are valuable; however, funding and provision remains uneven

across the country and is not guaranteed. Funding is therefore vulnerable to cutbacks, particularly in the context of economic recession. There is a need for policy for active and healthy ageing in Ireland to be articulated to underpin the provision and funding of such activities. The next chapter outlines the methods used in conducting the current research.

Chapter Three: Methodology

Introduction

This chapter describes the methodological approach followed in the research, and provides an outline of the data collection instruments used and the recruitment methods used.

3.1 Overview of methods

A multi-level mixed method approach was used to address the aims and objectives of the research. A selective review of national and international policy guidelines and a review of existing HSE supports for older people were conducted. A self-completion questionnaire was issued to all chairpersons of ARAs in Ireland and to a stratified sample of ARA members to assess a wide range of issues (detailed in the next section) including their experience of ARA membership, their views on local ARAs and the national organisation, and their own self-reported well-being. In order to provide richer data to gain a more nuanced understanding, five focus groups and 20 interviews were conducted with ARA members to gain a more in-depth accounts of their experiences of being a member; eight interviews were conducted with non-members to assess barriers to membership; and two interviews were conducted – one with the Chief Executive Officer and one with the Chairperson of ARI – to elicit views on the current role, strategic direction, challenges and future plans for ARI. Ethical approval to conduct the research was obtained from the NUI Galway research ethics committee prior to fieldwork being carried out. A steering committee was appointed (composed of an ARA member, a member of Age & Opportunity, a member of Galway city VEC, an expert in ageing research and the CEO of ARI) and they advised on the content and format of the research instruments as well as on the implementation of the research plan.

3.2 Survey of chairpersons and members

The questionnaire survey was intended to capture a large range of data from members of Active Retirement Associations, including attitudes to Active Retirement Ireland, impact of membership, and a range of quality of life, loneliness and socio-demographic measures across a large sample of ARA members. The survey was piloted by being distributed to one rural and one urban Active Retirement Association. The main survey distribution took a two-pronged approach. First, all chairpersons of Active Retirement Associations (referred to as ARAs henceforth in this report) in Ireland were issued a postal survey for completion, using the ARI database. As a result, 541 chairperson surveys were issued in June 2012[4]. However, it was

[4] This was the number of listed affiliated Active Retirement Associations (minus the two to whom the pilot survey was issued) at the time the survey was distributed; this number has since increased to 550 – see Chapter 1.

also considered important to elicit the views of members who may not have a specific organisational role in an ARA. This latter group posed recruitment difficulties as there is no available register of all ARI members. Therefore, associations of differing sizes were recruited instead, and all members involved in each randomly selected association were asked to complete and return the postal survey. The following sampling strategy was adopted to ensure recruited organisations were representative of organisational size and location: the 541 associations were stratified by membership size into three groups (groups with less than 20 members, groups with 20-79 members, and groups with 80 or more members). Subsequently, eight associations were randomly selected from each group. Questionnaires were distributed to a mixture of rural and urban groups. The surveys were then distributed to secretaries of the relevant associations who distributed them at their next ARA meeting, asked members to complete them and then collected and returned the surveys to the research team. In total, 341 surveys were distributed to members in 24 organisations.[5]

3.2.1 Survey design

The survey consisted of six sections. Each section covered a specific topic including the respondent's background, the nature of their membership and their level of involvement, as well as measures of quality of life and loneliness. Sections 1-4 and 6 included questions on the respondent's membership role with their local ARA, the types of activities they engage in, whether they do voluntary work in the community, their reasons for joining an ARA, their opinions on their local ARA and on ARI as a national organisation, and their demographic characteristics. Section 5 contained two important measures of well-being. The first was the loneliness scale. The second was the quality of life measure. These scales were the same as those utilised in The Irish Longitudinal Study on Ageing (TILDA) survey and were chosen to allow direct comparison with the results of that survey.[6]

The loneliness scale for this survey was a replica of the modified University of California Los Angeles Loneliness Scale used for the TILDA 2011 report "Fifty Plus in Ireland" (Russell 1996 cited in Timonen et al. 2011). This scale included five questions. The respondents could choose one of three responses to each question (Often, Some of the Time, and Hardly ever or Never). Each question was scored and the five scores were then summed together to give a total score for the scale. The scores range from 0 to 10, where a score of 0 indicates an absence of loneliness and 10 is a feeling of being extremely lonely.

[5] It is acknowledged that there are weaknesses associated with this recruitment method as ideally the members themselves should be recruited directly. However, given the importance of understanding members' opinions of ARI, this distribution method was the best available option given the lack of an available member database.

[6] It should be noted that TILDA is a larger population-based sample of those aged 50 and over, while the current study is on a much smaller specific sample of ARA members aged 55 and over. This should be borne in mind when interpreting comparative findings.

The quality of life scale utilised was the CASP-19 (Control, Autonomy, Self-realisation and Pleasure) scale (Hyde et al., 2003). This scale is designed specifically for the measurement of quality of life in older age. This has been used previously in studies related to older adults (e.g. TILDA, ELSA). Quality of life is measured across four domains: control, autonomy, self-realisation and pleasure. A score is calculated based on the sum of the domain scores. A score below 19 indicates an absence of quality of life, with a maximum score achievable of 57.

3.2.2 Response rate

Of the 882 surveys distributed, a total of 480 completed surveys were returned resulting in a response rate of 54%. The response rate for the chairpersons' survey was 50% (270/541) while the response rate for the members' survey was 62% (210/341).

3.3 Qualitative research

In order to explore both general issues and individual experiences associated with ARA membership, both focus groups and interviews were conducted with members of various Active Retirement Associations around the country. Furthermore, eight interviews were carried out with eligible people who were not members of a local ARA.

3.4 Focus groups

Five focus groups ranging in size from eight to eleven participants were conducted with a total of 44 ARA members – 14 men and 30 women.

Researchers sought to elicit the experiences of members of small (1-20), medium (21-79) and large (80 upwards) ARAs. One focus group was conducted with the members of a small ARA, one with member of a medium-sized ARA and one with members of a large ARA. Two of the focus groups took place in rural locations and participants in these were mainly from rural areas, while one took place in an urban area. The remaining two focus groups comprised members from various ARAs who held roles of responsibility within their ARA, such as outreach officer or development officer. These focus groups were held in a central location in Dublin and included members from both urban and rural ARAs.

The research team asked Active Retirement Ireland to provide contact details for chairpersons/secretaries of ARAs from varying geographical locations and attempted to incorporate gender and age diversity. Staff in Active Retirement Ireland made contact with the various ARAs; the local organisation set up the focus groups based on the requirements of the research team who requested a gender mix, if possible.

The focus groups investigated the following topics:

- Perceived motivations for and barriers to joining
- Experiences of being a member
- Quality of life
- Social capital
- Recommendations on how Active Retirement Ireland should develop into the future.

3.5 Member interviews

The individual interviews with members were designed to allow a more in-depth exploration of individual experiences of being a member of an ARA. This enabled researchers to uncover the processes by which membership impacted on the quality of life of participants from their own perspective. It also enabled an exploration of the motivations for joining and the impact of membership using a life-course perspective.

Interviews were carried out with 20 members (7 men; 13 women) of ARAs that varied according to size and geographical location. Participants were recruited from two large (n=8), two medium (n=6) and two small (n=6) ARAs; The chairperson or secretary of each group was asked to act as a gatekeeper. Interviewees were randomly selected from a list provided by the chairperson or secretary. The research team tried insofar as possible to ensure a broad geographical spread of participating ARAs. In addition to the issues investigated above in the focus groups, the semi-structured interview schedule explored life-course factors influencing motivations to join and offered the opportunity to gain a more detailed account of the ways in which membership was perceived by participants to affect their quality of life.

Interviews were carried out in a manner and in a location chosen by the participants. In most cases, face-to face interviews were carried out in a location convenient to the participant. However, in one case the interview was carried out over the telephone. All interviews and focus groups were audio-recorded and transcribed verbatim. Information sheets were provided to participants and all interviewees and focus group members signed consent forms.

3.6 Non-member interviews

Interviews were carried out with eight non-members of ARI (6 male; 2 female) who were recruited using a snowball sampling technique. The purpose of these interviews was to identify the barriers that prevent people from becoming members of Active Retirement Ireland and also to provide further insight into how Active Retirement Ireland can encourage more people to join.

Topics covered in the non-member interviews included:

- Awareness of ARI and their activities
- Barriers to joining
- Involvement in other activities
- Ideas for increasing ARA membership.

Two of the non-member interviews were carried out face-to-face while the remaining six were carried out over the telephone.

Finally, two interviews were conducted with ARI personnel – one with the Chief Executive Officer of ARI and the other with the Chairperson of ARI − to elicit their views on the strengths and challenges faced by the national organisation and their main aims for the future.

Chapter Four: Research Findings

Introduction

This chapter draws on the findings of the postal survey with members and chairpersons, the five focus groups and twenty interviews with members, eight interviews with non-members, and two interviews with leading personnel in Active Retirement Ireland. The survey findings presented are based on the two surveys combined, but in cases where there are notable differences in terms of gender, age or positions in the organisation, these are highlighted. Where appropriate, comparisons are made between chairpersons and members and where there are notable differences by gender and age, these are highlighted.

This chapter is structured in the following way: The first section presents a socio-demographic profile of the survey respondents. The next section outlines their level of involvement in their Active Retirement Association, their reasons for joining and the types of activities they engage in. The following section sets out the findings in relation to the quality of life and loneliness of respondents, and their level of community engagement and social contact. The final section presents findings in relation to the views of members on their local ARA and on Active Retirement Ireland itself. It focuses in particular on the perceived advantages and disadvantages of membership and presents members' recommendations for the future for Active Retirement Ireland, and then outlines the issues identified as priorities that ARI should advocate for on behalf of older people in Ireland. The quantitative results are illustrated and supported by quotes from respondents in the postal survey and, in some cases (motivations, satisfaction with and perception of impact of ARI, quality of life, loneliness, social contact), by quotes from interviews and focus groups. In addition, the findings in relation to loneliness and quality of life are presented and discussed, drawing comparisons with nationally representative scores from TILDA (Barrett et al., 2011).

4.1 Profile of respondents

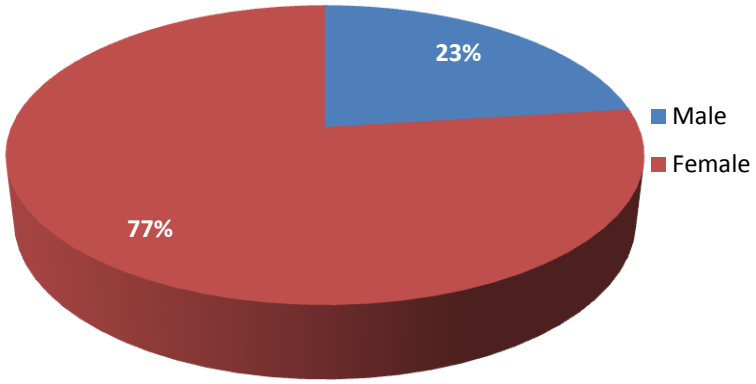
The ARI survey collected a wide range of data from respondents on various socio-demographic characteristics including gender, age, marital status, education, life-time employment status and self-reported health.

4.1.1 Gender

Seventy-seven per cent of the ARI survey respondents are female while 23% are male, reflecting the fact that a major proportion of ARA members are female (Figure 4.1). This is similar to the findings of an earlier study by McKenna (2009) where respondents estimated that 80% of ARI members were female. Therefore, it appears that there has been relatively

little change in the proportion of men and women involved in ARI in the intervening period. It is worth noting that a slightly higher proportion of respondents to the chairpersons' survey are male (26%) as compared to 19% of respondents to the members' survey.

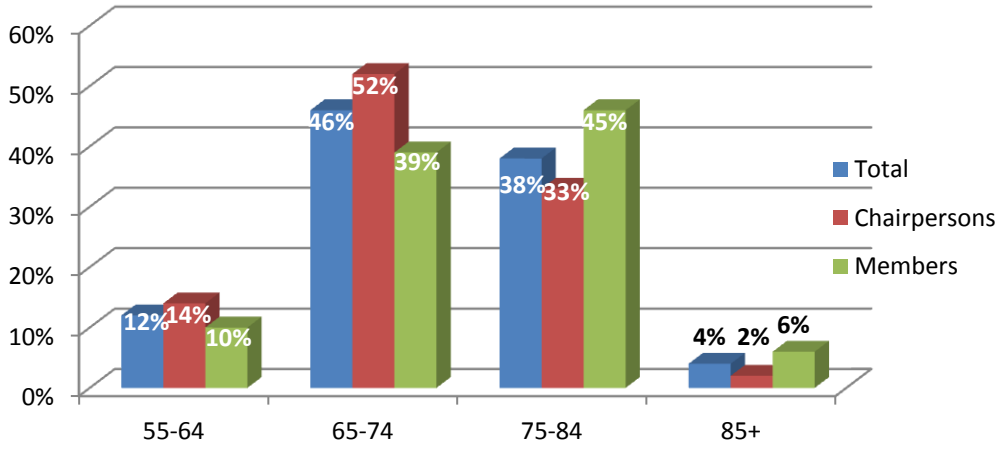
Figure 4.1: Gender of all respondents



4.1.2 Age

Most respondents to the ARI survey (84%) are aged between 65 and 84 with just under half aged between 65 and 74 years at the time of the survey.[7] Figure 4.2 below gives a detailed breakdown of the age distribution of respondents across the two surveys. Chairpersons tend to be concentrated in the younger age categories with over half (52%) of chairpersons aged between 65 and 74, as opposed to 39% of members. In addition, there are proportionally fewer chairperson respondents in the older age categories with only 33% of chairpersons (compared to 45% of members) in the 75-84 age group and only 2% of chairpersons compared to 6% of members in the 85-plus age group.

Figure 4.2: Age categories of respondents



[7] Again, this generally reflects the pattern reported in the ARI survey of members (McKenna, 2009).

4.1.3 Marital status and living arrangements

Over half of the respondents to the ARI survey (54%) are married (or living with a partner). A further 34% are widowed, 9% are single and 4% separated or divorced (see Appendix A, Table 2). A greater proportion of men in this survey (74%) are married (or living with a partner) compared to women (47%). Conversely, a larger percentage of women are widowed (39%) compared to men (17%). Some of these differences may be attributable to longer life expectancy among women compared to men (Department of Health, 2011). Fifty per cent of married members have a partner who is also a member of an ARA. Eighty-one per cent of married men stated that their spouse is also a member of an ARA compared to 38 per cent of married women. Many respondents (47%) live with their spouse while 36% live alone, suggesting that ARAs provide an important social outlet for this group. Nine per cent live with family members other than their spouse while 7% live with their spouse along with other family members (see Table 3 in Appendix A).

4.1.4 Education

Forty-two per cent of respondents stated that secondary school was their highest level of educational attainment, followed by primary education at 24%; 22% had third-level education; 9% had a diploma and 3% didn't specify. There are some gender differences worth noting: a higher percentage of men (35%) had primary education as their highest level of education compared to women (20%). In addition, 45% of women reported second-level education as their highest educational achievement compared to 34% of men. There were certain age differences that reflect national trends (see Table 4 in Appendix A). Younger age cohorts tended to have a higher level of educational attainment with approximately 25% of those aged 55-64 and 65-74 achieving third-level education. This declines slightly to 17% of those aged 75-84 but rises again for those aged 85 plus with 21% of this age cohort reporting third-level education as their highest level of educational attainment. This anomaly may be due to the relatively small numbers in this age cohort.

4.1.5 Employment status

Given the name of the organisation (Active Retirement Ireland), it is not surprising that most respondents describe themselves as retired (84%) with a further 7% describing themselves as looking after their home and family; only 5% of respondents stated that they were employed part time with less than 2% describing themselves as permanently sick/disabled or unemployed. Respondents were asked to provide a description of the main occupation they had pursued for most of their life (see Table 5 in Appendix A).[8] Some of the most commonly

[8] Occupations were subsequently categorised according to NACE (European Classification of Economic Activities) categories (Eurostat, 2008)

cited occupational categories by respondents included administrative and support services (14%), human health and social work (12%), education (10%), public administration and defence (7%) and agriculture, forestry and fishing (6%). Overall though, the most common occupational category for all respondents was "other" (27%), which includes "home duties". Interestingly, the most common economic activities for men were agriculture, forestry and fishing (14%) followed by administrative and support services (13%) while the most common economic activity for women was "other" (including home duties) at 36%, followed by human health and social work (16%) and administrative and support services (15%).

4.1.6 Self-rated health status

Respondents were asked how they rated their own physical health. Self-rated health and self-rated health compared to that of peers has been found to be a predictor of future morbidity and mortality (Ford et al., 2008; Lee, 2000). Borawski et al. (1996) suggest that health-optimists have a better three-year mortality outcome than health-pessimists.

Overall, 40% of respondents rated their own health as either "very good" or "excellent". This compares with results from TILDA (Barrett et al., 2011) where 42% of adults aged 50 years and older rated their own health as either "very good" or "excellent".[9] The percentage of respondents rating their health as "good" or better in this study (82%) was higher than the result from TILDA (Barrett et al., 2011) of 75%. In addition, only 19% of all respondents rated their health as either "fair" or "poor".

Generally there was little gender difference in self-rated health, although a higher proportion of men (15%) were likely to rate their own health as "excellent" compared to women (10%). Furthermore, a higher percentage of chairpersons (43%) than of members (36%) were likely to rate their health as "very good" or "excellent".

In general, higher percentages of those in younger than in older age groups rated their health as "good" or "excellent", suggesting that self-rated health may decline with age (see Table 4.1). For example, 60% of those aged between 55 and 64 reported their health as "very good" or "excellent" compared to 39% of those aged between 75 and 84, and 38% of those aged 85-plus. However, a slightly lower proportion of those in the age group 65-74 rated their own health as "very good" or "excellent" (35%).

[9] The difference in age cohorts between this study and TILDA should be noted. TILDA is based on a large sample of the national population aged 50 and over. The ARI study includes people aged 55 and over.

Table 4.1: Self-rated health status of respondents by age group*

Self-rated health status	*Age Group 55-64*	*Age Group 65-74*	*Age Group 75-84*	*Age Group 85+*
Excellent	25%	6%	12%	19%
Very Good	34%	29%	27%	19%
Good	31%	46%	39%	43%
Fair	10%	18%	19%	19%
Poor	0%	1%	3%	0%

When rating their own health compared to that of their peers, respondents were more likely to rate their own health as more favourable (see Figure 1 in Appendix A). For example, just under one-fifth (18%) rated their health as "excellent" when compared to their peers, a much higher percentage when compared to the (non-comparative) self-rated health question where 11% rated their health as "excellent". Overall, 52% of the sample rated their health as either "very good" or "excellent" when comparing their health to their peers, compared to the 40% in the self-rated health question outlined previously. Therefore, it appears that respondents rate their own health more favourably when comparing their level of health to that of others in their age group.

4.1.7 Life satisfaction and optimism

All respondents to the ARI survey were also asked to rate their own satisfaction with their life, as well as whether they would consider themselves to be a positive person. These questions were included in the survey to try to gauge whether people who are involved in ARI generally have a positive outlook on life. In response to the statement "I am satisfied with my life" almost 95% of respondents either agreed or strongly agreed with this statement.[10] When asked if they would describe themselves as a positive person, again 95% either agreed or strongly agreed. There was relatively little difference between men and women in response to both questions. While it is not possible to explore the association between membership and life satisfaction or optimism in more depth, overall it seems that ARA members are generally relatively happy and optimistic in their outlook.

[10] Respondents could answer these questions by responding to a five point scale ranging from very satisfied to very unsatisfied.

4.2 Motivations for joining an ARA

This research provided an opportunity to gain an understanding of the reasons why ARA members chose to join their local ARA. In this survey, respondents were presented with a list of possible reasons for joining an ARA and were asked to rate how important each reason was to them for joining their local ARA. Respondents could state that each reason was either very important, important, don't know, very unimportant or very unimportant. Table 4.2 below details the full list of reasons presented to the survey respondents. Each respondent also had the opportunity to select "other" if they felt there were additional reasons for joining ARI. To understand how important the different reasons are overall, each reason was given a score to say how important that reason was to respondents. For example, an average score close to 5 means that overall, the reason was generally considered very important by respondents whereas an overall average score close to 0 means that reason was generally considered quite unimportant. This way, it is possible to identify the important motivating factors behind why members joined their local ARA.

Table 4.2 lists the reasons chosen by respondents in order of importance. For example, "to meet new people" is considered the most important reason by survey respondents as to why they joined their local ARA. This is followed closely by "to be a part of the community". The average scores decrease as they descend down the table indicating that those responses close to the bottom of the table are the reasons that are considered the least important. For example, "to meet a new partner" is not considered to be a particularly strong motivation for people to join their local ARA. It is interesting to note, though, that the top four most important reasons why people join their local ARA are social or altruistic in nature. These were followed by wanting to be part of the Active Retirement organisation, suggesting that the organisation itself is attractive to members.

Table 4.2: Reasons for joining an Active Retirement Association

	Number	*Total Mean Score*
To meet new people	390	4.56
To be a part of the community	341	4.46
To engage in more social activities	354	4.43
To help other people	270	4.41
To be a part of the Active Retirement organisation	361	4.40
To engage in more exercise and physical activities	316	4.26
To feel useful or needed	299	4.23
To engage in more cultural activities	273	4.12
To learn new skills	255	4.03
To motivate me to leave the house	308	4.02

I was asked by a friend/acquaintance	220	3.79
A friend or friends were already members	223	3.71
Because I was lonely	158	2.94
My partner was already a member	123	2.41
To meet a new partner	158	1.65
Other **	25	4.62

* It is important to note that respondents provided an answer to most, but not all, reasons. The number of respondents to each statement is presented in the 'Number' column.
** "Other" was also considered very important but is not discussed in detail here due to the small numbers that chose to provide an answer to this option.

There were some differences in motivations between members and chairpersons: a higher proportion of chairperson than of member respondents joined "to help other people". Having this motivation at the outset may help explain how chairpersons adopt such a major role in their local ARA. In contrast, members were more likely than chairpersons to choose "because I was lonely" or "to motivate me to leave the house" as their reason for joining.

Quotes from the interviews and focus groups illustrate in more detail how some of the motivations identified above emerge for the ARA members as a result of particular life-course events, including bereavement and migration, or for a combination of reasons. Additionally, various other motivations for joining an Active Retirement Association emerged from the qualitative research. The most common reason given was "to meet new people", emphasising the social function that ARAs serve. However, the reasons for members wanting to meet new people varied. Some participants reported joining their local ARA on moving to a new area or upon becoming widowed and wanting to meet new people:

> *"I suppose something really to do. My wife died in 2003 so we used to go socialising and to socials dancing and I suppose then I got back to it again. Just something really to do and meet people."* **[Source: Male ARA member; Focus group]**

A very common motivation was that some people had recently moved to a new area or returned to their own community after being away for a number of years due to emigration or migration, and joined an ARA in an attempt to become part of the community:

> *"Well, I came back from England having been there for 43 years and came back close to where I came from, but of course people had moved on and I had lost contact to a great extent so a woman said to me, 'Oh we've got an Active Retirement group here. Would you like to come?' And I went and it was a great way of getting back into the community and getting to know people."* **[Source: Female ARA member; Focus group]**

Other participants referred to the loss of their primary social network upon retirement. In such cases the primary motivation for joining was again to establish or re-establish relationships with people in the community:

"When I worked I was always involved with large groups of people…I had lots of contacts. I didn't realise when I retired that I had lost that … I was still involved in the golf club but I realised that when I went along with [wife][11] to the active retirement, here was a bunch of people that I have known for years…I had never really got to know them because I was always working away or travelling. So, suddenly found all these people that I thought I knew and realised I didn't know them at all. So, I got to know them again and that was an interesting experience." **[Source: Male ARA member; Focus group]**

Some people wanted specifically to be part of the Active Retirement Association, which implies that the ARAs in some areas have quite a prominent, well-established profile. Specific activities, such as art or bowls, were the primary attraction for some participants. Others were motivated to join upon hearing about the experiences of other ARA members. Some people reported wanting to get involved in activities with like-minded people. "To learn new skills" was an important motivation for younger ARA members but less so for older groups.

Another typical motivation for joining among interview participants was the fact that they were asked to do so by another member who was a friend of theirs. Women were more likely than men to say that they joined because friends were already members:

"Because she's [a member of the ARA] a friend of mine really. She's great for joining things. She was in the ICA for years and years and she joined here and she said to me, 'Wouldn't you join the active retirement?"' **[Source: Female ARA member; Interview]**

Others joined at least partly to alleviate loneliness after bereavement and to feel useful or needed, as the following quote illustrates:

"I heard about Active Ireland Association before but I didn't join it. Like that, I thought it was very old. I didn't realise it was so much but I was walking around the RDS one afternoon and I went over to the stall, their big stall and I made some enquiries and I also was widowed and was feeling a bit lost and lonely and I felt that this could suit me. I only lived down the road. So, I did three years ago and thoroughly enjoying it since." **[Source: Female ARA member; Focus group]**

Many people talked about Active Retirement Ireland providing a reason to get out of bed every morning. Indeed, for some it served to fill a gap after retirement, providing a routine and sense of purpose. In other cases it acted as a replacement for other community activities previously engaged in, such as GAA:

"We were all involved in things down the years like. There was a void there. You fill that, you know." **[Source: Male ARA member; Focus group]**

[11] [11] Words in [ ] inserted by authors.

Some men who had previously been involved in the GAA appeared to feel that there was no longer a role for them in the GAA after a certain point – that they should make way for younger men. This was not true for all men as some belonged both to the GAA and to an ARA. In all, there was a wide variety of motivations for joining an ARA. Having explored the reasons for joining, we now outline the nature and level of respondents' participation.

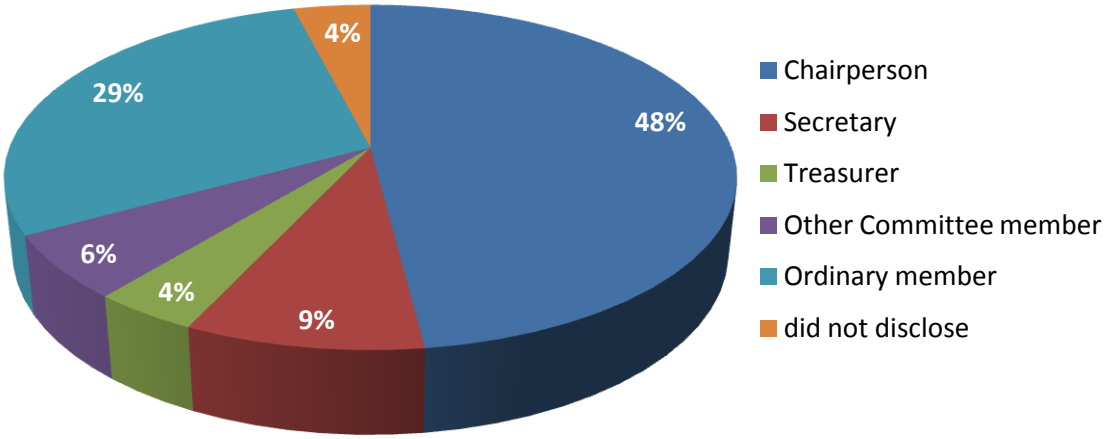
4.3 Level of participation and role within local ARA

Given the wide range of activities that local ARAs offer their members and the large contribution that members make to each organisation, the survey also aimed to gain an understanding of both the nature and level of respondents' involvement in their local ARA.

In line with the age profile of respondents, the majority of respondents are long-established members of the organisation. Most respondents (56%) had been members for five years or more; 29% had been members for between three and five years; 11% were members for between one and two years and 4% were members for one year or less. The average age at which respondents joined their ARA was 66 years – just a year over mandatory retirement age; women tend to join at a younger age (65 years) than men (68 years).

As is evident from Figure 4.3, 48% describe themselves as chairpersons, while 29% describe themselves as members in their local ARA. A further 10% describe themselves as either treasurers or other committee members and the remaining 9% describe their role as secretaries in their local ARA.[12]

Figure 4.3: Respondents' role within the organisation



[12] As may be expected, most of those who completed the chairperson's survey (83%) were chairpersons, while 10% were secretaries and the remaining 7% didn't specify their role. Most of those who completed the member's survey (70%) were members while 12% were committee members, 15% were either secretaries or treasurers, and 3% were chairpersons.

The survey sought to estimate how much time people spend involved in their local ARA. Respondents were asked how many hours on average per month they spend involved with their local ARA. On average,[13] respondents contribute 13.7 hours per month to their local ARA organisation. Men reported a higher average number of hours involved in their local ARA (16.5) per month than women (12.8). Chairpersons, as may be expected, reported a higher average number of hours involved in their ARA per month (15.5) than "ordinary" members, who spend an average of 10 hours per month involved in their local ARA.

In general, the number of hours per month spent in ARA activities decreases with age. For example, those in the youngest age category (55-64 years) participate on average 15.6 hours per month. This figure decreases to 13.5 hours for those aged 65-74 years and to 13 hours for those aged 75-84 years. The 85-plus age group is an exception to this trend, participating on average 18 hours per month. However, it is worth noting here that there was only a relatively small number of respondents in the over-85 age category.

4.4 Participation in activities

Respondents were asked to specify what types of activities they take part in and how often they participate in each activity. Using categories suggested by ARI, the activities presented to each respondent were categorised as follows: social activities, physical activities, cultural activities and educational activities. Each respondent reported their frequency of participation by selecting one of the following categories: one to three times a week, once a month, once every three months, once a year, do not participate. Respondents were also given the option of specifying "other" activities that were not listed. It is important to note that despite providing the option "do not participate", many respondents tended to specify only the activities they were involved in.[14] The level of participation in each of the activities is outlined and discussed in the following sections.

The programme of activities varied across ARAs. Certain activities, such as meetings and outings to places of interest, were engaged in by all ARAs involved in the research. Apart from this each ARA's programme of activities tended to vary. Some ARAs placed a major emphasis on one particular activity, such as art or bowls, while other ARAs had a wide variety of activities that changed according to members' interests.

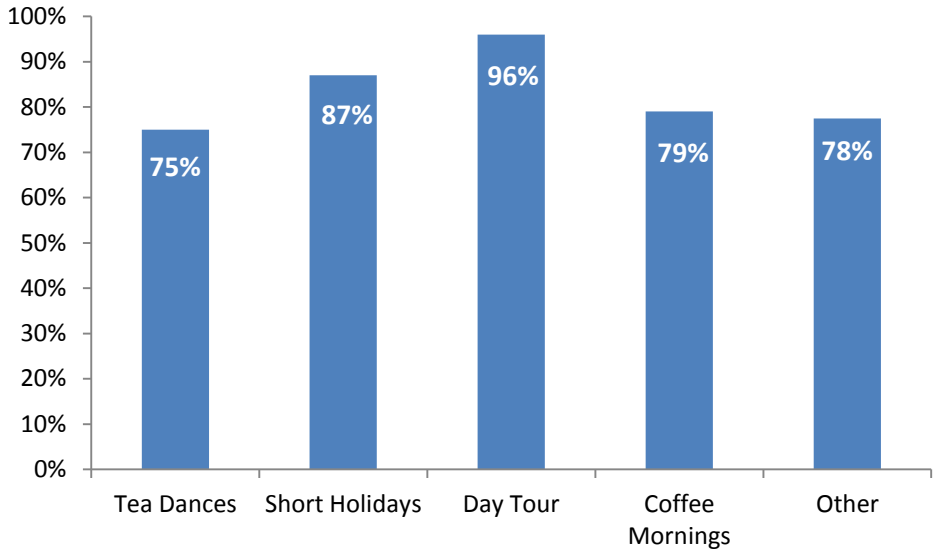
4.4.1 Social activities

Approximately 83% of respondents took part in some form of social activity with their ARA at some time. The most popular social activities reported by respondents of all age groups and of both sexes were day tours, with 96% of respondents participating in a day tour at least

[13]The question on number of hours per month spent involved in their ARA did not distinguish between volunteering/organisational hours or hours spent participating in activities.
[14]In other words, they did not tend to tick "do not participate".

once a year followed by short holidays with other ARA members (87%), coffee mornings (79%) and tea dances (75%). Respondents also reported taking part in "other" social activities (78%) including lunch, ARA meetings, and card games[15] (see Figure 4.4).

Figure 4.4: Social activities (on at least one occasion a year)[16]



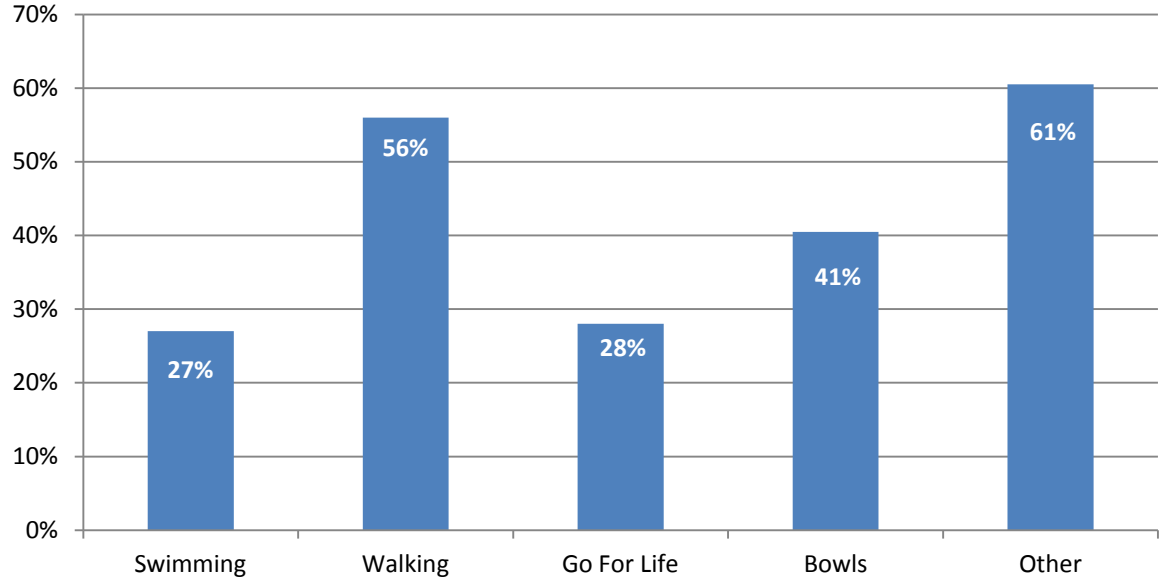
Younger respondents were more likely to take frequent day tours; 48% of those aged 55-64 years took part in a day tour once every three months compared to 11% of those aged 85 years and over, who were generally more likely to participate in day tours once a year. Further differences were found in terms of educational attainment, whereby a higher proportion of those with secondary (43%) and third-level education (48%) took day tours once every three months than those with primary education only (27%). This may reflect differences in income affecting ability to pay for the cost of these tours.

4.4.2 Physical activities

Approximately 86% of all respondents took part in some form of physical activity with their local ARA at some time. Walking with other ARA members (56%) was the most popular physical activity listed, followed by bowls (41%), "Go For Life" (a physical exercise programme led by a trained peer) (28%), and finally swimming (27%). Under the category "other" (61%) a number of physical activities were listed including dancing, chair exercises, skittles, boccia, yoga, aqua-aerobics and gardening (see Figure 4.5).

[15] 70% of the 78% did not specify what these "other" activities were.
[16] The results are presented for participation on at least one occasion a year, given the likelihood that some of these activities may only occur once a year for participants.

Figure 4.5: Physical activities: once a week



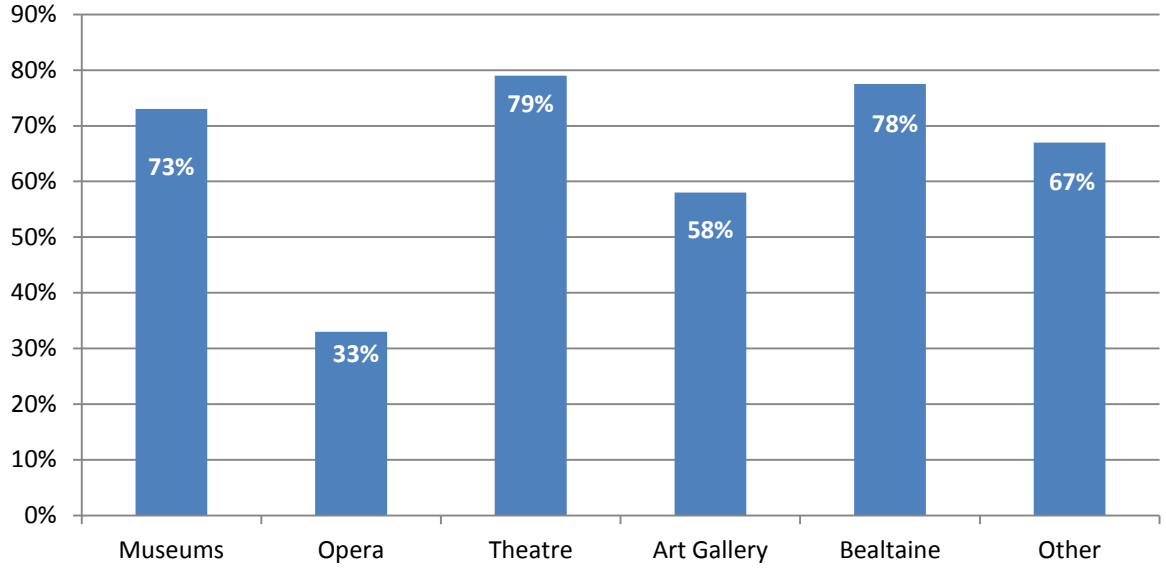
There were some gender and age differences in relation to engaging in physical activities. Bowls and walking were the most common physical activities reported for men whereas walking was the most common activity reported for women. Women were more likely to participate in "Go For Life" activities than men. Across all age groups, walking was the most popular physical activity. Participation in "Go For Life" was most common amongst the youngest age group and participation decreased with age: 33% of the youngest age group (55-64 years) participated in "Go For Life" at least once a week compared to 25% of the oldest age group (85 years and over).

4.4.3 Cultural activities[17]

Approximately 81% of all respondents took part in some form of cultural activity with their ARA at some time. The most popular cultural activity respondents engaged in was attending the theatre, with 79% of respondents attending the theatre at least once a year. This was closely followed by participating in the Bealtaine Festival (a national arts festival celebrating creativity in older age) (78%), visiting museums (73%), visiting art galleries (58%) and to a lesser extent attending the opera (33%). Respondents also reported engaging in "other" cultural activities (67%) including dancing, attending the cinema, and heritage activities (listed in order of frequency).[18] (see Figure 4.6)

[17] The results are presented for participation on at least one occasion a year, given the likelihood that some of these activities may only occur once a year for participants.
[18] 64% of the 68% of respondents did not specify the nature of these "other" activities.

Figure 4.6: Cultural activities: at least once a year



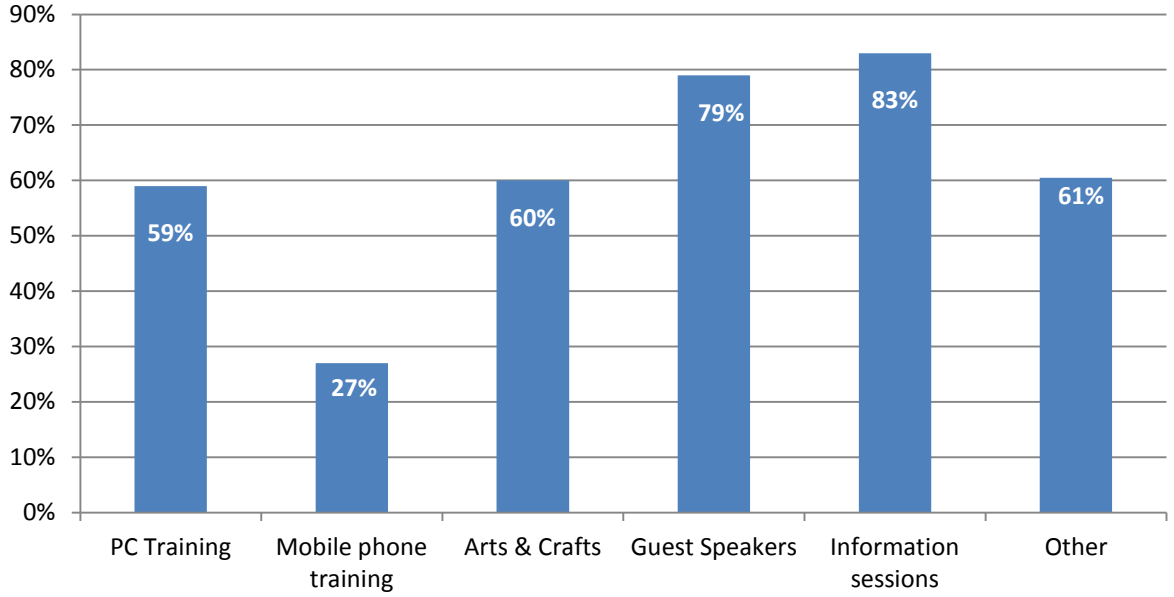
The popularity of certain activities was found to differ across the age groups. While Bealtaine was a popular cultural activity for all age groups, respondents in younger age groups (85%) were more likely to participate than those in the oldest age group (44%). A higher proportion of women (81%) than of men (70%) participated in Bealtaine. Finally, a smaller proportion of those with primary education only than of those with a higher level of education participated in the Bealtaine festival. This reflects previous findings in Ireland (Lunn and Kelly, 2008).

4.4.4 Educational activities[19]

Approximately 74% of all respondents took part in some form of educational activity within their ARA. Eighty-three per cent of respondents attend information sessions on a range of topics at least once a year. This was followed by attending a guest speaker at an ARA meeting (79%); Arts and Crafts (60%); computer training (59%); and mobile phone training (27%). "Other" activities, attended by 61% of respondents, included creative writing and painting.[20]

[19] The results are presented for participation on at least one occasion a year, given the likelihood that some of these activities may only occur once a year for participants.
[20] A high proportion (58%) of the 61% who chose "other" did not specify the nature of the "other" activities.

Figure 4.7: Education and training: at least once a year



A higher proportion of those with a third-level education (87%) attended guest speakers regularly compared to those with a secondary (82.5%) or primary (60%) level of education. A similarly broad range of activities was reported in a previous study of the activities of ARAs (McKenna, 2009).

4.5 Community and social engagement among ARA members

Community and social engagement has been shown to be beneficial to older people in terms of both physical and mental health (Morrow-Howell, 2010). Therefore, it was considered important to capture the level of social engagement among ARA members by identifying their levels of social contact with friends and family, their voting behaviour, their frequency of religious service attendance, and particularly their levels of involvement in other voluntary work in their local communities. These are indicators used in previous national and international research to assess social engagement; each of these measures is presented in more detail next.

4.5.1 Social contact

Previous research suggests that there is a positive relationship between social engagement and both mental and physical health (Conroy et al., 2010; Lee et al., 2008; Sirven and Debrand, 2008). In this survey, respondents were asked how often they met and spent time with friends, neighbours or relatives. The frequency of contact was measured by selecting either two or more times a week, once a week, a couple of times a month, once a month, or less than once a month. Overall, results suggest that members of ARI visit friends and family regularly, with two-thirds (64%) of respondents visiting friends or family at least once a week

and another quarter of respondents (25%) visiting friends or family at least once a month. Those from older age cohorts are the most likely to visit or meet others frequently: 75% of the 85+ age group have social contact at least once a week compared to 70% of the 75-84 age group; 61% of the younger age group and 54% of the youngest age group. Previous research indicates that men are generally less likely to have as many social contacts as women (McLaughlin et al., 2010; Okamoto and Tanaka, 2004). This has been generally borne out by the research here. Women are more likely to have social contact with others once a week or more (65%) compared to men (62%). In addition, a higher percentage of men (16%) have social contact with others less than once a month compared to women (9%).

Previous studies suggest that, typically, those with a higher level of education have more social contact than those with a lower level of education (Agahi and Parker 2005). In the TILDA study (Barrett et al., 2011), a higher level of education was found to be a predictor of greater levels of social contact (Timonen et al., 2011). However, in this survey this was not the case: 66% of those with a primary and 66% of those with a secondary level of education reported meeting friends or relatives at least once a week. In comparison, only 60% of those with a third-level education reported meeting friends or family at least once a week. This apparent anomaly is probably related to the fact that the ARI sample is based on an older age cohort than that in the TILDA study.

4.5.2 Voting and religious attendance

According to Timonen et al. (2011), voting may be considered a civic form of social engagement. A very high percentage (94%) of all respondents to the ARI survey indicated they had voted in the last general election. This is higher than the proportion reported by TILDA in 2011, which found that over 80% of older adults (50 years of age and older) voted in the last general election. Attending religious services is another common form of social interaction for older people and has been associated with better quality of life and health outcomes (Idler et al., 2009). Four-fifths of respondents to the ARI survey (86%) attended religious events at least once a week. Similar percentages of men (50%) and women (47%) attended religious events at least once a week. However, 41% of women as opposed to 28% of men attend such events more than once a week. A higher proportion (47%) of those in the oldest age group (85-plus) as opposed to only 27% in youngest (55-64) age group attended more than once a week. This is a similar pattern to that reported in TILDA, where older people were more likely than their younger counterparts to attend religious events frequently (Timonen et al., 2011).

4.5.3 Community volunteering

Volunteering has been found to be associated with better physical and mental health, increased satisfaction with life and decreased depression (Haski-Leventhal, 2009; Morrow-Howell, 2010; Tang et al, 2010). Many of those involved in ARI also volunteer in the

community, with approximately 52% of all respondents engaged in voluntary work with another organisation (apart from their local ARA). This may be broadly compared to the TILDA study (2011) where 42% of older adults reported being involved in some form of volunteering activity.[21] In addition, respondents, on average, contribute 11.5 hours (range 0-130) to these activities each month (in addition to their Active Retirement activities). Given the high percentage of respondents engaged in additional community voluntary activity, it is interesting to explore the type of voluntary work respondents are involved in. Overall, there is a mixture between community activities, parish, sports-based and support/service delivery organisations. The types of voluntary work most commonly engaged in are, in order of frequency: volunteering (unspecified), Tidy Towns committees, parish activities, the GAA, St. Vincent de Paul, Meals on wheels, the Credit Union, Community Activity Groups support groups, cultural, heritage, social and sports clubs (see Table 4.3).

Table 4.3: Community voluntary activity

Voluntary Activity	*All Respondents*
Volunteering (not specified)	16%
Tidy Towns	12%
Parish (religious) Activity (e.g. choir)	9%
GAA Club	8%
St. Vincent De Paul	8%
Meals on Wheels	8%
Credit Union	7%
Community Groups (e.g. Neighbourhood Watch, Senior Citizens)	7%
Senior Help Line	6%
Support Groups (e.g. Alzheimer Society)	6%
Cultural Activity Groups (e.g. Heritage Association)	6%
Social Groups (e.g. Bridge Club, ICA)	4%
Sports Organisations (e.g. Golf)	3%

Chairpersons were more likely to take part in community activities than other members. Three-fifths of chairpersons (60%) versus 41% of members take part in community activities. On average, chairperson respondents contribute 12.5 hours (range 0-130) a month to other community activities. Members contributed on average 9.2 hours (range 1-35) a month to volunteering in the community.

It should be noted that TILDA is based on a larger population-based sample of people aged 50 and over in Ireland as compared to this smaller sample of ARA members aged 55 and over

Men were more likely to volunteer (60%) than women (53%). The most popular activities for men were sports-based activities (typically GAA) followed by cultural activities and community groups such as Neighbourhood Watch. For women, the most popular activities were community groups and services such as Meals on Wheels and parish activities. On average men contribute 14.0 hours (range 1-72) per month volunteering compared to 11.0 hours for women (range 0-130).

Generally, respondents who do volunteer in the community are more likely to be younger: 62% of those aged 55 to 64 currently engage in voluntary work compared to 58% of those aged 65 to 74, while 48% of those aged 75 to 84 actively volunteer in the community. Looking within each education group, third-level graduates were the most likely to volunteer proportionally; 68% of third-level graduates volunteer compared to 55% of those with secondary level education and 41% with primary level education. A similar pattern was found for older people in the general population (Timonen et al., 2011).

4.6 Quality of life

Measuring quality of life is important in a study like this as it allows us to make comparisons with those who are not members of ARI, both nationally and internationally. Quality of life has been found to have a relationship with social functioning, depression, health, and financial circumstances (Blane et al., 2004; Netuveli et al., 2006).

The mean quality of life score for all respondents was 46.5 (see Table 4.4 below).[22] By comparison, the mean score for TILDA was 42.7 and for the ELSA survey in the UK was 42.5 (McGee et al., 2011; Netuveli et al., 2006).

Table 4.4: Quality of life comparisons with TILDA and ELSA23

	ARI mean score	*TILDA mean score**	*ELSA mean score***
Total quality of life (0-57)	46.5	42.7	42.5
Control (0-12)	8.7	7.1	7.6
Autonomy (0-15)	11.0	10.8	10.2
Pleasure (0-15)	13.2	13.8	13.1
Self-realisation (0-15)	11.4	10.8	9.9

* McGee et al., 2011; ** Netuveli et al., 2006

[22] See Chapter 3 for detailed explanation of how this CASP-19 measures quality of life.
[23] It should be noted when interpreting comparisons that TILDA is based on a much larger population-based sample of older people aged 50 and over in Ireland, and ELSA is based on a larger population-based sample of those aged 50 and over in the UK, whereas this ARI study is based on a smaller specific sample of ARA members aged 55 and over.

If we examine the individual domains, there was a particularly high score in the self-realisation domain suggesting that ARA members believe that they are fulfilling their own potential. There was also a notably higher score in the control domain compared to the other studies, suggesting that respondents have a strong belief in their ability to participate in society and engage with their social environment.

There was no notable gender difference in relation to either the overall score or the individual domains. However, while there was little difference in the overall score between chairperson and member respondents, there was a notable difference regarding the self-realisation domain. As Wiggins et al. (2004) note, self-realisation refers to the "more reflexive nature of life" in which the freedom to engage in society can be realised. The mean self-realisation score for chairpersons was 11.9 whereas for members it was 10.6. This suggests that chairpersons possess higher feelings of self-esteem as well as self-efficacy. It is not possible to state with confidence whether these traits were present in chairpersons before joining an ARA or whether the experience of being a chairperson contributes to feelings of self-realisation and self-efficacy.

The quality of life scores suggest that members of Active Retirement Ireland report a better quality of life than both the Irish and UK national surveys of older adults (McGee et al., 2011; Netuveli et al., 2006). However, it is important to note the small sample utilised for this study in comparison to those national surveys. Indeed, there was a general consensus among the interview and focus group participants that membership within an Active Retirement Association has a positive impact on quality of life as defined by participants themselves:

> *"[Active Retirement] adds to my quality of life, if you like, because I like being involved with people and I like meeting people and talking with people…it certainly was a way into the community which I hadn't had before really since my children left school. That was kind of a community. That was a long time ago. My other community, if you like, was work and when I left work I lost a lot of that particular social network. This has added hugely to my quality of life."* **[Source: Female ARA member; Focus group]**

Those in younger age groups had higher quality of life scores than those in older age groups. The mean quality of life score for the youngest age group (55-64) was 48.4 and in ascending sequence of age, it was 46.6 (age group 65-74), 46.1 (age group 75-84) and for the oldest age group (85+) the mean score was 44.6.

In general those with a lower level of education had a higher quality of life score. Those with a primary level education had a mean score of 47.2; those with a second-level education reported the lowest score of 46.0 while those with a third-level education had a mean quality of life score of 46.8 and those with a diploma/trade qualification reported a mean score of 46.1. Previous research suggests that persons with a higher education tend to report a better quality of life (Von dem Knesebeck et al., 2007). However, this was not the case in this

research; this may well be because there was a financial barrier in Ireland to accessing secondary (and third-level) education for the cohorts who make up the majority of respondents in this study.

4.7 Loneliness

Research suggests that social interaction is important for psychological well-being. Loneliness is defined as the subjective perceived experience of social isolation (De Jong-Gierveld and Kamphuis, 1985). It is recognised that an individual can experience social isolation but not feel lonely. Therefore loneliness is recognised to be a subjective experience for older adults and can be difficult to measure (Victor et al., 2005).

The loneliness scale utilised for this survey was a replica of the modified University of California Los Angeles Loneliness Scale used for the "Fifty Plus in Ireland" report (Russell 1996, cited in Timonen et al., 2011). On this scale, the scores range from 0 to 10 where a score of 0 indicates an absence of loneliness and a score of 10 indicates feeling extremely lonely.

The analysis of survey results found that the mean loneliness score for all respondents in this ARI study was 1.47 (range 0-8). Overall this score compares favourably to the TILDA "Fifty Plus in Ireland 2011" study where there was a mean score of 2.0, suggesting that respondents to the ARI study were less likely to report feelings of loneliness than older people in the general population in Ireland (Timonen et al., 2011).[24] Indeed, some of the interview and focus group participants who were not otherwise active in the community talked about experiencing a sense of isolation and loneliness upon becoming older. For these participants their membership of ARI generally served to alleviate that sense of loneliness, as the following quote indicates:

> *"For me, the quality of life it's given me from loneliness to not having time to bless myself now in this organisation. It's just made me very, very active and aware."*
> **[Source: Female ARA member; Focus group]**

There was a marked gender difference; male respondents had a mean loneliness score of 1.09 (range 0-8) whereas female respondents had a higher mean score of 1.61 (range 0-9). Again, this reflects the results of the TILDA study which found that men are less likely to report feelings of loneliness than women. Loneliness has been associated with low self-rated health and chronic illness as well as certain poor health behaviours (Lauder et al., 2006; Mullins et al, 1996). This is generally reflected in this survey. Those who reported their health as "fair" had a higher loneliness score (1.80) compared to those who reported their health as "excellent"

[24] It should be noted that the TILDA study is based on a larger national sample based on those aged 50 or over, whereas this ARI study is based on a smaller sample of ARA members aged 55 and over. This should be borne in mind when interpreting comparative findings.

(0.85). As expected, those who reported their health as "poor" had the highest mean loneliness score of 2.5.

The oldest age cohort (85+) had the highest loneliness score (2.1). This supports previous research where older age was found by some though not all researchers (see Victor et al., 2005) to be a predictor of a higher likelihood of feelings of loneliness (Savikko et al., 2005). The youngest age category (55-64) reported a score of 1.5, the 65-74 age group reported a score of 1.6 and the 75-64 age group reported a loneliness score of 1.3.

4.8 Members' views of their local ARAs

Each respondent was presented with a list of positive and negative statements that were designed to capture different domains of health and well-being to assess whether and how respondents felt their membership of an ARA has impacted on these different aspects of their lives. The statements covered how they felt their ARA membership affected their physical and mental health, their social connections, their independence, their involvement in the community and their awareness of issues for older people, as well as general statements about their local ARA itself. Some statements for some domains were positive while others were negative. Some of these statements are also designed to ascertain whether, in the opinion of members, local ARAs are achieving their aims. The results are presented in Table 4.5 and then discussed in more detail below, occasionally drawing on qualitative findings to illustrate in more detail why respondents hold the opinions they do.

Each respondent was asked to state whether they strongly agreed (5), agreed (4) , neither agreed nor disagreed (3), disagreed (2) or strongly disagreed (1) with the list of statements provided in Table 4.5 below. The scores were aggregated to assess how strongly the respondents, on average, felt about each statement. A mean score close to 5 indicates respondents, on average, feel very strongly about a particular impact statement whereas a score close to 1 means respondents, on average, strongly disagree with a particular impact statement.

Table 4.5: ARA membership

		Mean score
Physical Health	I have lots more energy since joining ARA	3.73
	My physical health has greatly improved since joining ARA	3.57
Mental health	My ARA membership makes me feel valued	4.16
	Since joining my ARA, I feel better about myself	4.05
	I believe my ARA membership gives me a sense of being needed	4.03
	My ARA membership gives me a reason to get up in the morning	3.04
	I used to feel more lonely before joining my ARA	2.99
Community	I believe my ARA membership really benefits the local community	4.05
	Since joining ARA, I don't engage with other community activities outside of ARA as much	2.53
Social	I have met most of my current friends through my ARA membership	3.39
	I don't believe my ARA membership has enlarged my circle of friends	2.50
Independence	My life has become more fun/exciting since joining ARA	4.26
	I enjoy life a lot more since joining ARA	3.85
	My ARA membership has given me the confidence to do more things by myself	3.61
	Since joining ARA, I have become a lot more active and independent	3.55
Policy	My ARA membership has made me more aware of issues for older people	4.23
My ARA	I am proud to be a member of my ARA	4.42
	I feel I can freely choose the activities I want to participate in	4.27
	Since joining ARA, I have access to new activities that I would not had access to otherwise	4.01
	I've learnt lots of new skills and knowledge since joining ARA	3.64
	I want my ARA to better incorporate my needs into their activities	3.37
	I find it difficult to get my ARA to listen to my suggestions	2.36
	I believe joining my ARA has not met my expectations	2.23

Table 4.5 shows the statements presented to respondents grouped by domain as well as their relevant agreement scores. Scores above 3.5 approaching 5 indicate increasingly strong agreement while scores between 2.5 and 3.5 indicate not very strong agreement; scores of

2.5 approaching 0 indicate increasingly strong disagreement. Respondents agree (relatively strongly) (3.57) that their ARA membership has positively impacted their physical health and more strongly agree (3.73) that they have more energy since joining their ARA. It is possible that respondents may have considered themselves quite healthy prior to joining their local ARA, and therefore their ARA membership may not have strongly impacted their physical health.

There is much stronger agreement that ARA membership has impacted positively on respondents' mental health; respondents strongly agreed with statements that indicate that being part of an ARA is good for their self-esteem; that being in an ARA makes them feel valued (4.16) and that it makes them feel better about themselves (4.05) and gives them a sense of being needed (4.03). There is less strong agreement that ARA membership reduces feelings of loneliness (2.99) and acts as a motivating factor for getting up in the morning (3.04).

Respondents strongly agree that their own ARA membership benefits their local community (4.05), and disagree that they have become less involved in the community (2.53). The fact that many respondents are heavily involved in community volunteering supports this (see Table 4.3). Data from the focus groups also support this and indicate that many ARA members tend to be heavily involved in other community activities. It is not possible to say for certain whether they would have been involved in other community activities even if they were not members of an ARA, but for some members, joining an ARA served to reintroduce them to the community as the following quote indicates:

> *"And I went [to ARA] and it was a great way of getting back into the community."***[Source: Female ARA member; Focus group]**

In the case illustrated by the following quote, it appears that attending a talk on elder abuse at her local ARA motivated her to get involved in visiting older people in her local community:

> *"I mean the abuse some people; you know... we had a talk on this [in the ARA]. It made you very much aware of older people on their own - family coming and demanding this and demanding that. So, we have some older people living alone where I am and you know it's nice to keep in touch with them."* **[Source: Female ARA member; Interview]**

Respondents felt that ARA provided them with an enhanced social network; they disagreed (2.50) with the statement that they had not enlarged their circle of friends since joining the ARA. They agreed (but not very strongly (3.39)) that most of their current friends were made in the ARA, suggesting that many members had other friends as we might expect at this stage of their lives.

The following quote illustrates the difference being a member of an ARA made in the life of this former carer:

> *"I had a very quiet life here for years because when the family was young, I couldn't go anywhere. Then when they grew up, my husband was in bad health and he died in 1975 so I was on my own until the club [ARA] came along and I joined the club and as I say it gave me a new lease of life because I love socialising. I love dancing."* **[Source: Female ARA member; Focus group]**

Respondents also agreed that they had increased their sense of independence (3.55) since joining their local ARA and had gained confidence to do more things by themselves (3.61). In a similar vein, many respondents agreed strongly (4.26) that "My life has become more fun/exciting" and less strongly that they "enjoy life a lot more since joining the ARA" (3.85). The following quote illustrates that this sense of confidence appears to emerge at least in part from the solidarity and support ARA members give to each other:

> *"We back each other like and when you get the backing of the group it gives you confidence."* **[Source: Female ARA member; Focus group]**

There was very strong agreement (4.23) that membership of an ARA increased their awareness of issues for older people in Irish society. The quote below illustrates this, and indicates that not only are they more aware, but they are also more inclined to take action:

> *"...if pensions are threatened or something like that. If there's some kind of campaign to make an impact on your Ministers, and sometimes they [ARI] send around cards or emails you send to your Minister. Before, I mightn't have bothered. Since I got involved in this [ARA], I do."* **[Source: Male ARA member; Focus group]**

One of the aims of ARI is for its members to be proud to be part of it. There is a very high level of agreement (4.42) with this statement "I am proud to be a member of my ARA", which suggests that ARI is achieving this aim (see Table 4.5). Specifically, respondents are proud to be a member of their local ARA; it is not entirely clear whether this translates into being proud to be a member of ARI, the national organisation. The qualitative findings suggest that at least some focus group and interview members do not have a great awareness of the national organisation or of what it does.

Respondents agree that they can freely choose the activities they want to participate in, suggesting a sense of ownership and control (4.27). This is supported by the interview findings. The following quote suggests that they enjoy this freedom:

> "*But that's why I like that I am a member of the Active Retirement. I can opt in or opt out at any time, whatever I want and if I don't want to take part or go on day trips...I don't have to go."* **[Source: Female ARA member; Interview]**

It appears also that ARA members feel their suggestions to try out new activities are listened to and acted upon by their local ARA committee. Several interviewees said that they are regularly asked for suggestions for new activities and that if they do suggest something, every effort is made to provide it:

> *"I've seen it happening. I know it myself. I've seen it happening where someone would say 'Oh, you should do this!' Two weeks after it will happen. They give it a trial."* **[Source: Male ARA member; Interview]**

There is a sense that members' opinions are valued and sought after. In fact, some of the chairpersons indicated that they would like to have more suggestions from the members.

It is clear that being a member of an ARA gives respondents access to activities that they would not otherwise engage in (4.01) and that they have learned a lot of new skills and knowledge as a result (3.64). This suggests that being a member of an ARA encourages them to do things they would not otherwise do:

> *"Well, I've tried things that I wouldn't have tried. I did the art classes. We did computer classes as well. See, I wouldn't have pushed myself to do those things."* **[Source: Female ARA member; Interview]**

There are a series of negative statements with which respondents did not agree. These mainly corroborate the findings in relation to some of the earlier positive statements – first they disagreed with the statement that their ARA did not listen to their suggestions (2.36). They also disagreed (2.23) with the suggestion that joining ARA had not met their expectations.

These findings suggest that respondents value being a member of their local ARA for a wide variety of reasons, including that it gives them a sense of pride, it bolsters self-esteem, self-confidence and independence, it enhances awareness of older people's issues, and provides opportunities for social interaction and specific activities that appeal to them.

4.9 Members' views of the national organisation, ARI

This section presents respondents' views on Active Retirement Ireland, the national organisation, its capacity to advocate for older people, and the extent to which it gives "added value" to the local ARAs.

A large majority of respondents (93%) agreed that ARI was a strong advocate for older people in Ireland. Several emphasised that the large number of members provides a strong support base for any issues they wished to advocate upon:

> "*As part of a larger organisation we have more influence.*" **[Source: Female ARA member; Survey]**

> *"Numbers count, we have numbers."* **[Source: Male ARA chairperson; Survey]**

Respondents appeared to believe that ARI does have a recognised voice at national level. They perceived that ARI had been vocal on certain issues, including protection of entitlements, and that they themselves had been encouraged by ARI to take part in campaigns on issues concerning older people. They valued the fact that the organisation could make use of the large number of members to attempt to influence policy, especially to protect entitlements.

4.9.1 Added value to ARAs

When asked whether they believed that ARI, the national body, added value to their local organisation, 89% agreed with this statement while 11% disagreed. They were asked to explain what was the nature of this added value and said that ARI provided support and guidance (87), communication (33) strength of voice (41) and opportunities for networking (7).

4.9.2 Support and guidance

Some ARA members highlighted the importance of the provision of support and guidance from the national body, while others indicated that ARI gave them an arena in which to develop a broader awareness of issues in society that affect them:

> *"They provide a framework in which to work, give guidance and support."* **[Source: Male ARA chairperson; Survey]**

> *"It provides a forum for interested citizens to look at the wider perspective."* **[Source: Female ARA chairperson; Survey]**

There was also a sense that it provided a channel for the views of ARA members to be expressed at a national level.

4.9.3 Communication

Several people mentioned the function that ARI serves in facilitating communication both between ARAs and with ARI itself. One chairperson emphasised the usefulness of inter-ARA communication:

> "*Keeping in touch with information about other groups.*" **[Source: Male ARA chairperson; Survey]**

They felt that it provided opportunities for networking between ARAs and a number of people mentioned the ARI cruise that had taken place the previous year as something that they enjoyed participating in as a group.

Having outlined the perceived strengths of ARAs locally and ARI as a national organisation, next we present perceived barriers to joining and members' views on issues that present challenges for the organisation, locally and nationally, and members' recommendations for improvement.

4.10 Barriers to joining and challenges for ARI

This section presents findings on barriers to joining ARAs and outlines members' views of perceived challenges the organisation faces at local and national level and their recommendations for ways in which both local Active Retirement Associations and the ARI itself as an organisation might enhance its effectiveness into the future. The data on which the barriers section is based come from interviews with members and non-members. Data for the other sections are from focus groups, interviews and surveys.

4.10.1 Perceived barriers to joining

Members and non-members identified a number of key barriers to belonging to an ARA, as follows:

Fear of exclusion

It emerged from interviews that psychological factors such as fear that they would not be welcomed or accepted by existing members and shyness can act as a barrier to joining an active retirement group. Members of active retirement groups discussed the difficulty of going to the first meeting, particularly where individuals do not know existing members already:

> *"Yeah, I was going to say other than the first walking through that door, if you're on your own and you think 'I'd like to go to that', I think that first initial walking across the threshold is hard but once they've managed to do that they never look back. I do think that's difficult."* **[Source: Female ARA member; Focus group]**

Indeed, this fear of feeling excluded was also referred to in interviews with non-members:

> *"For myself unless I have someone that I can go down with …I have no buddy…that you could travel with and then you're down there and you feel like they all have their own buddies. It's a kind of a clan then. You're out of it."* **[Source: Female non-ARA member; Interview]**

Lack of advertisement

There was a sense within some of the groups and from some non-members that local active retirement associations were not well advertised. Some members reported that they would not have heard of the organisation but for word of mouth:

> *"It's not advertised. I wouldn't have known about it, you know what I mean? You know what I mean, you wouldn't have heard of it. I wouldn't have ever heard of it only for my sister-in-law was doing something else here."* **[Source: Male ARA member; Interview]**

In the case of non-members, most reported knowing that an Active Retirement group existed in their area but had little or no knowledge beyond this. Some were vaguely aware of some of the activities of their local ARA through media advertisement, whereas others had no knowledge of the type of activities run by their local ARA. Two non-members had never heard of the Active Retirement Association, suggesting that there is a need for more advertising at local level.

Perception of age group and activities involved

It was evident that in some cases people were initially deterred from joining their local ARA because they perceived the age profile of members to be much older than they were. Some participants talked about being in denial about having reached this stage in life:

> *"A lot of people say that they joined with reluctance - that they were a bit reluctant to admit to themselves that they were of an age for an active retirement, including myself, and then once you got there you realised, well look, let's face it I'm nearly seventy. What the hell do I think I am? You know, I'm not going to join the youth club and then you find, you know, that there's a lot of other people who thought similarly."* **[Source: Female ARA member; Focus group]**

Furthermore it emerged that there can be a stigma associated with ARA membership whereby people assume that the activities will be confined to stereotyped hobbies associated with older people, such as bingo and crochet, rather than the wide range of activities that are actually available at many ARAs. Some people had stereotyped perceptions around the capabilities of people who are members of ARAs. The following statement from a non-member illustrates this perceived stereotype:

> *"Well, I just don't feel... when you say an active retirement group, I think of a lot of elderly people, sort of doddery people staying around the place trying to organise themselves to do something, you know…I haven't started drooling yet, you know."***[Source: Male non-ARA member; Interview]**

This suggests that the common perception of ARAs in society and of their membership is not reflective of what actually takes place in such organisations.

Not enough space in ARA

In some areas there may be a waiting list to become a member of the local ARA. This can arise for a number of reasons. In some circumstances insurance will only cover up to a certain number of people to be present at meeting premises at one time. In others there is a decision made within the ARA to cap the number of members at a certain level in order to keep the administration of the association manageable for committee members:

> *"Well, actually we have now a hundred and... some figure of a hundred and twenty five and we have a waiting list. Now, the waiting list only builds up with about five a year. It's a very small number, so there would be somebody on our waiting list that would wait for maybe two or three years."* **[Source: Male ARA member; Interview]**

Other commitments

A number of non-members reported having other interests or commitments which deterred them from becoming members of their local ARA, such as caring for family members. In some cases the participants reported that they would not have the time to dedicate to being a member of an ARA, while others felt they had sufficiently busy and fulfilling lives without being a member of an ARA:

> *"I'm very involved in lots of things so it didn't interest me that much…I play golf. I sail. I'm a member of two historical societies. I'm a member of a musical society. So, I think that's about enough to keep me going."* **[Source: Male non-ARA member; Interview]**

Transport

Lack of private or public transport was not widely perceived to act as a barrier among members, as many members share lifts where necessary. Similarly, a lack of available transport was not cited as a barrier by any of the non-members involved in the research. However, there was evidence to suggest that where members are reliant on non-members for transport to and from ARA activities it can limit their flexibility around attending. Some people suggested that insurance considerations would prevent them from offering lifts to other members.

Gender imbalance

Some members referred to the gender imbalance in existing groups as acting as a potential barrier to men's involvement. The vast majority of members in most ARAs are female. Participants offered a number of explanations for this, including the fact that older men

are shy of groups of women or are less inclined to become involved in community activities. While these factors may partially contribute to the low attendance of males, there was evidence to suggest that gender imbalance itself acts as a barrier to men joining:

> *"A guy, a retired guy came into me one day and he started asking me 'How many men? How many?' And I never saw him again because I'd say there weren't enough men, you know?"* **[Source: Male ARA member; Focus group]**

Furthermore, it was suggested that gender-stereotyped activities in some cases can serve to deter males from joining.

4.11 Perceived challenges for local ARAs and ARI

Respondents were asked how the experience of membership of their local ARA could be improved. It may be noted that just over a quarter of all respondents (125) suggested that any improvements are needed to enhance members' experiences of local ARA participation while only 94 suggested that ARI needed improvements. In fact, the focus groups and the interviews indicated that most members were very appreciative of their local chairpersons and committees and felt that they provided a great service. However, they did identify a number of issues that they felt should be addressed. Some of these are issues for the national organisation or overlap between the local and the national levels. To avoid repetition, these issues are presented thematically and we indicate whether they apply to the local or national organisation or both. Table 4.6 and Table 4.7 below demonstrate both the similarities and differences between the suggestions by members for local ARAs and the ARI.

Table 4.6: Suggestions on how local ARAs could be improved

Themes	*Number*	*Percentage*
Communication	**66**	**52%**
Membership	**52**	**41%**
Funding	**7**	**5%**
None Needed	**2**	**2%**
	127	**100%**

Table 4.7: Suggestions on how ARI could be improved nationally

Themes	*Number*	*Percentage*
Communication and networking	**58**	**41%**
Publicity	**20**	**14%**
Advocacy	**12**	**8%**
Membership	**4**	**3%**
None needed	**49**	**34%**
	143	**100%**

4.11.1 Communication and networking

Although generally the perception of ARAs was positive, and some people had mentioned communication as a strength of the local and national bodies, a large minority of respondents felt that there was a need for better communication between ARAs at a local level as the following quote illustrates:

> *"Communication, contact with other ARAs [needed] on a regular basis."* **[Source: Male ARA chairperson; Survey]**

It appeared in some cases that information from the national organisation was not being passed on by the chairpersons of local ARAs. Since all work is carried out on a voluntary basis, sometimes chairpersons and committee members appeared to find it an onerous task to filter information from the national body as well as running the organisation.

A small number of respondents felt that the national body (ARI) was not doing enough to liaise with local ARAs. Some people were aware that ARI now had Development Officers for many years at regional level, but had not yet been contacted by them as the following quote suggests.

> *"I'm sure they have development workers. I know they have development workers. We have never seen a development worker here. Yeah, I mean they've never contacted us to say the development worker would like to call and see us or anything like that. I mean, if they don't do those kind of things we're not going to know what's going on. But then that's the lack of communication within the organisation."* **[Source: Female ARA member; Focus group]**

There appears to be a desire for more contact from the national organisation from some members:

> "*No ARI rep at any general meetings.*" **[Source: Female ARA chairperson; Survey]**

> "*No contact with ARI for support and little direct involvement.*" **[Source: Male ARA chairperson; Survey]**

This was echoed by members in one of the focus groups. This issue of communication is discussed further in the next section, which outlines recommendations members made for how ARI should proceed in the future.

4.11.2 Membership issues

Respondents emphasised the need to recruit new members, especially men, and to retain and encourage existing members. Most respondents seemed to regard this as an issue for local ARAs. The need to increase membership was especially important for smaller groups, as having larger numbers would mean they could expand their activities as illustrated by the following quote:

> "*More members, difficult to do things with such a small group.*" **[Source: Female ARA member; Survey]**

There was a general view that ARAs should provide activities that would be appealing to men to address the gender imbalance that they perceived to exist:

> *"We have to change maybe our itinerary slightly to be more, I suppose, inviting…that men wouldn't want to do what women are doing, you know, that you maybe have to change a bit."* **[Source: Female ARA member; Focus group]**

Some suggested that ARAs in rural areas should arrange to provide transport in order to increase membership.

Some respondents felt that there was a need for more publicity both locally and nationally to publicise the work of the ARAs, to increase the profile of the organisation and enhance membership.

4.11.3 Funding

Perhaps not surprisingly, a lack of funding was highlighted as a challenge for Active Retirement Associations. In light of the current economic recession, various grants made available to ARAs for running activities have been reduced or abolished completely. This has placed an added strain on organisers of activities:

> *"I think the funding is the biggest issue for running things. I really do because the money is just not there anymore and we have to make do with small money."* **[Source: Female ARA member; Focus group]**

Interestingly, there was broad agreement that the membership fees of both ARA and of the ARI offered good value for money.

In summary, ARA members identified communication, membership issues, gender balance, transport and funding as the main challenges facing local ARAs. Next we turn to members' recommendations for improvements.

4.12 Suggestions for improvements to ARI

Finally, respondents were asked if they had any suggestions for how ARI as a national organisation should best develop in the future. This yielded a number of suggestions for where improvements could take place including communication, publicity, and membership recruitment (including recruiting more men). It is clear that many of these recommendations follow on from the challenges identified in the previous section.

While most members reported being generally satisfied with their experience as local ARA members, there were some suggestions for improving the operation of the organisation nationally. There was a feeling across the groups that there was a need for more communication between the national organisation and the local ARAs:

> *"More information as you see but there is a huge lack of information that's filtered down to local ARAs so that's important."* **[Source: Female ARA member; Focus group]**

While there are mechanisms in place for relaying information from the national organisation to local ARAs it was felt by a number of participants that these were not effective. For example, one of the most common means by which Active Retirement Ireland informs local ARAs of its activities is through a regular publication distributed to each ARA. However, this participant suggests that there are flaws with this system:

> *"They [head office] only send eight copies out for 128 members so the message of what they're about is not getting to the 128. It's getting to the group of us that would meet, so we need to look at that and if they have money for flaithiúlach for all the things why not use it on the magazine that's going to our people?"* **[Source: Female ARA member; Focus group]**

It also emerged that there was a need for more communication between ARAs. Participants highlighted that there is a need for a directory of ARAs to be compiled for two purposes – firstly it would promote networking between existing ARAs:

> *"I think they need to do more PR because they're the umbrella group and there's so many active retirements around. Even in [X] and [Y], that we don't know*

> *what's going on in any of those Active Retirement groups and if we did maybe we would have a contact number we could ring and join another active retirement group on something that they're doing that we couldn't afford to do on our own. And, you know, to kind of network with them. There doesn't seem to be any of that."* **[Source: Female ARA Member; Focus group]**

Secondly it would provide a point of reference for the general public considering becoming a member of an ARA:

> *"If they had something where if somebody rang up and were looking for information to join somewhere that they could send it out to them and see what the different active retirements were doing that they could pick."* **[Source: Female ARA member; Focus group]**

Following on from this, participants suggested that smaller ARAs looking to expand could learn from more established ARAs:

> *"Well we could get people to talk to us, you know and let us know…People from bigger groups, you know…They probably have speakers and information on them."* **[Source: Female ARA member; Interview]**

4.12.1 Recruitment of members

In considering how Active Retirement Ireland could encourage more members, participants put forward a number of suggestions. One suggestion was a "bring a buddy" scheme whereby each existing member is encouraged to bring a friend along to an ARA meeting and encourage them to join. They also suggested that ARAs should hold a series of "meet and greet" events specifically to attract members. They felt that if potential members could talk to existing members and get a flavour of what went on in ARAs, this may help to overcome some of the barriers. Some suggested that ARA members and/or ARI representatives should visit workplaces to inform potential retirees about their activities.

> *"Ask people to see what we do before joining; speak to people about ARI before they retire."* **[Source: Female ARA member; Survey]**

Such suggestions were echoed by interviewees and focus group participants:

> *"We had a problem getting new members in the golf club, right? You need new members because they're the lifeblood of the club…You can't keep it going so we introduced a programme of 'introduce a friend to golf'. I could see that working for active retirement. All the members you say 'bring a friend'."* **[Source: Female ARA chairperson; Focus group]**

It was suggested in interviews with members and non-members that a change in the name of the organisation may result in more people wishing to join their local ARA. According to

some interviewees there are negative connotations associated with the name "Active Retirement Association" which may be hindering ARAs' ability to attract members:

> *"[There] may be a barrier as far as that goes is the word 'retirement' within our name, you know, because people have a connotation against retirement, you know? You have to be a certain age. You have to be in a certain box."* **[Source: Female ARA member; Focus group]**

One particular ARA sought to increase its membership through inviting people to share their skills. They felt that this idea would be particularly relevant in trying to target males to join:

> *"Tomorrow morning I hope to go to the printer because we made a decision at our last meeting that we're going to produce fliers. You know, where we're going to list our activities and invite people if they have other skills to share with us because it's a question of sharing your skills. It isn't just draw all the time. You have to give as well and then maybe people with, for example, DIY skills. [NAME] has an idea for some time that we should compile a list of handymen or craftsmen."* **[Source: Female ARA member; Focus group]**

Both non-members and members suggested that it would be useful to include information about ARI in pre-retirement courses:

> *"A lot of people do a retirement course and maybe mention it at that."* **[Source: Male non-ARA member; Interview]**

Finally, many participants, including non-members, recommended that Active Retirement Ireland should be advertised more both at a national and local level:

> *"It could be advertised more in the papers."* **[Source: Female ARA member; Focus group]**

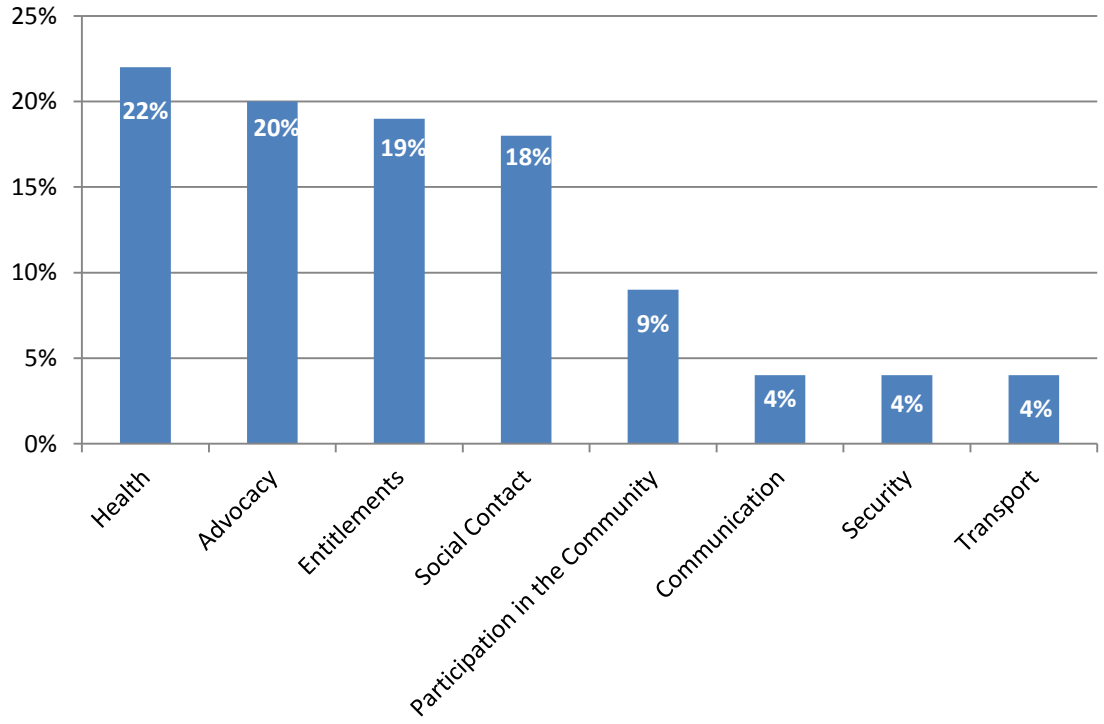
This, it was felt, would give more profile to the organisation and raise awareness of the kinds of activities it offers to older people.

4.13 Priority Issues for ARI to advocate for on behalf of older people

Finally, the respondents were asked about the policy priorities they believe ARI should pursue on behalf of older people in Ireland. This question is important because it offers a direct indication of what members of ARI see as important issues for themselves and also for older people in Ireland generally. In total 60% (290) of all respondents offered opinions on the priorities they believed the ARI should pursue. A number of priority issues were identified and categorised as follows: health (22%), general advocacy (20%), entitlements (19%), social

contact (18%), participation in community (9%), and communication (4%) security (4%), and transport (4%).[25]

Figure 4.8: Priority issues in the community



Participants also raised a number of priority issues for older people in the interviews and focus groups. A common concern that emerged related to government cuts to expenditure on health and social services having an effect on older people. Many participants expressed anxiety and anger at the possibility of losing their entitlement to receiving a medical card, and also around reducing the rate of state pensions. It was clear that participants felt a sense of entitlement to these provisions based on the fact that they had contributed to the economy throughout their lives. The following quote is typical and illustrates several of the themes identified above – health, entitlements and the need for advocacy:

> *"I think the likes of taking the medical card off the [older people] they're making it to be means tested…I think that's silly because people has paid into it all their lives with what few bob they have. They shouldn't be denied their medical card at the age of 70… I'd protest an awful lot when I'd see things the likes of say people getting things where people are entitled to them are not getting them…"*
> **[Source: Male ARA member; Interview]**

[25] Respondents often selected more than one priority issue.

4.13.1 Health

Health issues were mentioned most often. This included access to and cost of health services, and the need to promote physical health. For example:

> "*Health issues, cost of medication, hospitalisation, etc.*" **[Source: Female ARA chairperson; Survey]**

> "*Health issues (cost and availability of medicines).*" **[Source: Female ARA member; Survey]**

Respondents were also concerned with hospital waiting lists, the availability of nursing home places and the cost of nursing home beds:

> *"Better access to hospital, no waiting hours."* **[Source: Male ARA chairperson; Survey]**

> *"Availability of nursing home at reasonable cost*." **[Source: Female ARA chairperson; Survey]**

> *"Retirement homes for people who are no longer able to care for themselves."* **[Source: Female ARA chairperson; Survey]**

Finally, a number of respondents felt that ARI should encourage more physical activity programmes for older people – a health promotion issue:

> "*Encourage more active life for older people.*" **[Source: Male ARA chairperson; Survey]**

> "*More exercise programmes.*" **[Source: Female ARA member; Survey]**

This reflects respondents' perception that physical activity is an important means of enhancing their well-being.

4.13.2 Advocacy

Respondents felt that ARI should act as a national voice for older people in Ireland and increase awareness of older people's issues generally at a national level. In terms of a national voice, many respondents felt that priority should be given to having a voice at governmental level and one mentioned the need for a national strategy for older people:

> "*Lobby group for older people.*" **[Source: Male ARA chairperson; Survey]**

"*Give older people political participation.*" **[Source: Female ARA chairperson; Survey]**

"*National government needs to draw up a strategy for older people.*" **[Source: Female ARA chairperson; Survey]**

Finally, some respondents felt that ARI should act to combat and debate ageism and to promote a positive perception of older people.

4.13.3 Entitlements

There were concerns that existing entitlements across a range of issues should be maintained and that older people should be fully informed of their entitlements. The latter included travel pass, pension entitlements and general services. In particular, concern about maintaining the existing level of pension entitlements was expressed frequently. In addition to this, a number of respondents cited the importance of older people being fully informed of what their general entitlements are:

"Should have a local rep to advise on entitlements." **[Source: Female ARA chairperson; Survey]**

"More info about allowances should be given in clear concise manner." **[Source: Female ARA chairperson; Survey]**

Finally, some respondents felt that existing entitlements for older people should be preserved. There was a strong sense that entitlements were under threat due to the current economic recession.

4.13.4 Social contact

Another main priority identified by respondents was social contact. They felt that the ARI should act to combat social isolation and that they should concentrate their efforts particularly on older people living alone. They felt that ARI should focus on encouraging and facilitating older people to socialise and meet other people.

Summary

The major issues that ARA members identified as priorities for ARI to advocate for or act upon may be summarised as health, pensions, advocating for older people generally at national level, protection of entitlements, combating ageism, promoting positive conceptions of ageing, and promoting social interaction and contact for older people. A small proportion of respondents felt that the ARI should advocate at a national level around the issues of communication, security and transport for older people.

Chapter Five: Discussion, Conclusion and Recommendations

Active Retirement Ireland is a national organisation with a large and growing affiliated membership, which aims to encourage active ageing, independence and social interaction and the enjoyment of activities among older people. It also aims to promote a more positive attitude to ageing, to advocate for older people and to be a recognised voice for older people. The quantitative and qualitative findings suggest that ARI is, for the most part, achieving its main aims and that it being a member of an ARA has beneficial impacts on the quality of life of older people in terms of physical, psychological and social well-being. A number of recommendations for the future development of the ARI emerge from the research. There are some limitations as to the scope and size of the research; the qualitative part of the research is based on a relatively small number of interviews and focus-groups, even though every effort was made to ensure that it included men and women of varying ages, marital status and locations. In particular, a very small number of non-members was interviewed. The method of selection of members to complete questionnaires was unsatisfactory as there was no full data-base of members.

These findings are now briefly summarised and discussed.

5.1 Activities

One of the main features of all Active Retirement Associations is their programme of activities. The programme of activities helps shape members' experiences. Supporting McKenna (2009), activities across the ARAs are diverse, varying depending on the location and size of the ARA. Activities usually fall under one of the following categories: physical, social, cultural, educational, and other. The system in most ARAs for developing a programme of activities is on the whole reported by members to be democratic and open. Most participants felt that their suggestions would be taken into account should they express any preferences for activities. However, it emerged that in practice it was often committee members who were responsible for researching and planning suitable activities for their ARA. By and large, respondents were happy with the way their local ARA was run.

5.2 Motivations for joining an ARA

This research identified various motivations for membership, with the most important being social and/or altruistic. The most common and most strongly endorsed motivation was to meet new people, emphasising the important role ARAs play in providing or enhancing social networks for older people who may have recently lost an existing network. The reasons for wishing to meet new people varied. Some people were returning migrants; others had chosen to move to a new community in later life; others had lived in the area all their life but sought to re-establish connections with people in their community, having prioritised social networks

based around employment for much of their working life; finally, some people were recently bereaved. The research highlights that the means of forming social networks that are ordinarily open to younger adults may no longer be easily accessible post-retirement. For example, when people have children in school or are in employment they have considerable opportunities to meet new people. Replacing lost networks is a common motivation that has been found in previous research (Lie and Baines, 2007; Martinez et al., 2009; O'Dwyer and Timonen, 2009; Warburton et al., 2001). A high proportion joined in order to help others – wanting to contribute to society, again a common motivation for volunteering (Morrow-Howell et al, 2009). A similar proportion specifically wanted to join Active Retirement Ireland, suggesting that the organisation is relatively widely known in Ireland. For some people, being invited by a friend provided the immediate impetus to join. Specific activities, often bowls or affordable trips away, were also found to serve as a motivation for people to join, supporting the findings of Harvey (2012). In a small number of cases people were encouraged to join through advertisement or because their partner was involved. This was also reflected in Harvey's (2012) research. This research builds further on Harvey's (2012) findings by identifying two further motivations. Members spoke of seeking a routine following retirement as a reason for joining their local ARA. Furthermore, some people spoke of the desire to engage in activities with like-minded people. In summary, it appears that ARAs serve an important function in providing opportunities for social and community engagement for older people in the absence of pre-existing work or family networks.

5.3 Positive impacts of membership

The findings in relation to well-being generally reflect positively on membership of an ARA. Respondents reported lower loneliness scores than their peers, nationally in the TILDA study and internationally in the ELSA study. They also reported higher quality of life scores than participants in these two national studies. While it is not possible to attribute the relatively high quality of life score directly or solely to being a member of ARI, other research supports the argument that being a member of a voluntary or related organisation can have beneficial effects on an older person's quality of life (La Souza et al., 2011, Shmotkin et al., 2003; Wu et al., 2005).

Respondents also report high levels of satisfaction with life and high levels of optimism. The findings suggest that respondents tend to be actively engaged in the community; they volunteer often, frequently make social visits, attend religious events regularly and display a high level of formal civic engagement in the form of voting. Again, it is not possible to attribute these characteristics directly to being members of or having an organising role within ARAs. However, research on volunteering shows that volunteering in later life is associated with better self-rated health and life satisfaction (Timonen et al., 2011).

Members identified several benefits of being a member of their local ARA. The most common and strongly expressed benefit was pride in being a member of their local ARA; there is a general sense that their opinions as ARA members are valued, and that the organisation is democratic and values the suggestions of its members. Respondents typically agree that their life has become more exciting since joining an ARA. They mention that their membership has increased their awareness of issues for older people in Ireland, suggesting that ARI is achieving one of its strategic aims. Other benefits included feeling more energetic, confident, active and independent as a result of being a member of an ARA; this indicates that one of the broader aims of ARI relating to encouraging self-confidence and independence is being achieved.

One commonly cited advantage of membership is the way in which it helps to enhance individuals' social networks and the formation of meaningful friendships. This supports findings from previous research relating to social capital and ageing; this suggests that social participation is important in building individual social networks among older people (Gottlieb and Gillespie, 2008; Harvey, 2012; Putnam, 2001; Rozario, 2006). The organised trips away were commonly regarded as an advantage of membership for various reasons. In some cases it was because they made such activities more affordable, as noted in Harvey (2012). For others, it was the fact that there was no organising required from regular members – making the planning relatively stress-free. Furthermore, the acquisition of new skills, hobbies and/or knowledge was frequently referred to as a benefit of membership, in line with findings from Harvey (2012). People reported enhanced self-esteem and a feeling of being needed and valued due to their membership of an ARA, supporting previous research findings (Gottlieb and Gillespie, 2008; Greaves and Farbus, 2006). The fact that ARAs provide a routine and a motive for people to get out of bed in the morning was regularly mentioned as a key benefit of membership. Essentially, ARAs provide an important social network to replace previous networks that have recently been relinquished, such as those stemming from workplaces or children who have left home. People who were bereaved, particularly those who may have been caring for many years, may have lost their social networks and find ARAs to be supportive. This is consistent with previous findings in relation to the benefits of participating in volunteering and social groups as a means of re-engagement in the community. Those who have recently moved into an area either on retirement or returned emigrants found ARAs to provide a means of integrating with the community.

5.4 The Economic Impact of volunteering and participating in Active Retirement Ireland

The purpose of this section is to attribute a monetary value to the time spent by members involved in their ARAs. The time contributed by members to their ARA may be broadly divided into two categories: time spent in organisational work within an ARA and time spent participating in the activities provided by an ARA. Since organisational work contributes to the

welfare of other ARA members and is vital to maintaining the ARAs, it is useful to assign a monetary value to it as it strengthens the argument for support and investment in volunteer programmes. In addition, the benefit received by ARA members through engaging in ARA activities may be considered a health investment, and as such, is also worth valuing.

For the purpose of this study, we divide and value ARA members' time using these two methods: first, we value time spent in organisational work by assigning an equivalent 'work-time' estimate to capture the economic value associated with this type of contribution (Table 5.1). We apply this value to chairpersons only to provide a broad estimate of organisational time spent by those involved in a specific organisational role. Second, we value time spent participating in ARA activities by attributing a 'leisure time' value to capture the health investment value of engaging in these activities (Table 5.2). We apply this value across both members and chairpersons to estimate the value of investing in health through engaging in ARA activities.

To place a value on time, the approach adopted here uses the opportunity cost method[26] which applies a wage value (or a portion of wages) that a person could have earned if, instead of volunteering or engaging in activities, they had spent their time in the labour force. In this case, we use a proxy value of 25% of the average industrial wage to place a value on time spent by ARA members contributing to their ARA. Importantly, we consider the 25% of the average industrial wage to be an appropriate value for both organisational work time and time spent investing in health through engagement in ARA. Otherwise, assigning different values to each would weight one activity more (or less) in value than the other. In other words, in Table 5.1 and Table 5.2, the hourly value (the opportunity cost of time) attributable to both activities is the same.

In the self-completion postal survey, all respondents were asked how many hours they typically spend involved in ARA activities per month[27]. Those who responded to this question, (n=349), on average, contributed 13.69 hours per month of their time to their ARA. Respondents to the chairpersons' survey estimated that they spend an average of 15.5 hours per month participating in their ARA, while those who completed the members' survey estimated that they spend an average of 9.96 hours per month participating in their ARA. For the purposes of this study, we will assume that the extra 5.54 hours per month of time spent

[26] The opportunity cost approach is one of two methods within the input-related method[26] (Roy and Ziemek, 2000). Within this approach, there are two primary methods for valuing people's time. The first uses a replacement cost approach which calculates the value of volunteering by applying the cost of a hired worker to hypothetically 'replace' the volunteer in their tasks. The second approach uses the opportunity cost approach as applied here.

[27] This question did not specifically distinguish between hours spent involved in organisational work and hours spent involved in ARA activities.

by chairpersons compared to members is spent on organisational work for ARAs[28] as opposed to engaging in activities provided by ARA.

Table 5.1: Value of hours spent per annum organising ARA activities:

	Chairpersons	*All Chairpersons* ***
Number of Respondents	234	541
Average Hours contributed (per annum)	66.5 (5.54 x 12)	66.5 (5.54 X 12)
Opportunity cost: Leisure time*	€85,248.63	€197,091.93
Replacement cost**	€340,838.97	€788,008.05

*Based on 25% of Average Industrial Wage (AIW) (€5.48) as of the second quarter 2012 (Parsons et al 2003, CSO, 2012)

**Replacement cost: based on Average Industrial Wage of €21.91 Q2 2012 (CSO, 2012)

*** The values here are arrived at by applying the average number of hours to all chairpersons. This can only be regarded as a rough estimate as we have no way of knowing whether non-respondents spend a similar average number of hours per month organising activities for the ARAs

The average number of hours spent participating (as opposed to volunteering) in ARA activities in total by respondents is presented in Table 5.2 below. We might regard this as an investment by respondents in their own health (a contribution to the production of health of each of the respondents). Table 5.2 assigns a monetary value to the hours contributed to leisure activities in the organisation by both chairperson and member respondents. The figures should not be assumed to be an accurate representation of the monetary value of the leisure hours participated in as respondents were questioned about general hours contributed to the organisation each month and not solely to leisure or administrative activities. In relation to this, it is worth noting that there was a low response rate by members to this question (n=349). One possible reason for the low response rate by members may be the framing of the question. Some respondents may have presumed the question related to volunteering their time to organising within their ARA rather than simply participating in ARA activities. Thus many did not answer the question at all. The figures below offers an estimate of the monetary equivalent of time invested in their health that chairpersons and members spend within their local ARA each year.

[28] It should be noted that this is probably a minimal amount as chairpersons may on fact spend more hours organising

Table 5.2: Value of hours spent participating in ARA activities: Investment in own health

	Chairpersons respondents	All chairpersons in ARA	Member respondents	All members* (estimated)
Number	234	541	115	23,000
Average Hours contributed (per month)	9.96	9.96	9.96	9.96
Opportunity cost of leisure time*	€153,262.88	€354,338.55*	€75,321.50	€15,064,300.80*

*These figures are obtained by applying the average number of hours (9.96) to all 541 chairpersons of ARAs and to all 23,000 members. It should be noted that this is simply a broad approximation since we have no way of knowing if all members and all chairpersons actually do spend this average number of hours participating in ARA activities.

If the above figures were to be taken as an average and applied to all members, it is estimated that for the current membership (circa 23,000), they contribute the equivalent of €15,064,300.80 in time invested in their own health each year.

5.5 Quality of life and membership

Reflecting what has been identified in previous literature, participants highlighted a number of determinants of quality of life, including physical health, mental health, social interaction and friendships, independence, keeping active, having interests and having something to look forward to (Gabriel and Bowling, 2004; WHOQOL, 1995). When quality of life was measured, respondents reported higher quality of life scores than did those in surveys of the general older population (Barrett et al., 2011).[29]

Most of the participants regarded themselves as having a good quality of life and attributed this at least in part to their membership of their local Active Retirement Association. Membership was found to have a particular impact on the psychological and social domains of quality of life. This supports findings from previous international research on social participation among older people and its relationship with quality of life (Berkman et al., 2000; Ciechanowski et al., 2004; Greaves and Farbus, 2006; Oxley, 2009). To a slightly lesser extent individuals considered their membership to have a positive impact on the physical domain of quality of life, echoing previous findings (Lum and Lightfoot, 2005). While we need to be conscious that there may be a risk of self-selection into volunteering by healthy

[29]It should be noted that the ARI study has a smaller sample size and an older age cohort than TILDA

members, thereby influencing the findings relating to quality of life, the members involved explicitly stated in many cases that their membership has served to improve their overall quality of life.

5.6 Barriers to joining

This research identified a number of barriers to joining an ARA from interviews with members and non-members. A commonly identified barrier was a fear of being excluded by existing members, a previously identified barrier to older people becoming volunteers (Warburton et al., 2001). Negative perceptions regarding the activities and the age group of people involved also emerged as a barrier to individuals joining. This resonates with Harvey's (2012) research in which a sense of denial among older people about their age was identified as a reason for not joining. Many of the non-members reported having other commitments or interests and did not feel the need to join an Active Retirement Association to make their lives more complete, echoing previous research (Harvey, 2012; Warburton and Crosier, 2001). Further supporting Harvey (2012), the issue of gender was found to act as a barrier in this study whereby the disproportionate number of female members and stereotypically female activities on offer acted as a deterrent to men joining. It is fair to say that for some interviewees ARI was seen as a "women's organisation".

There were two further barriers identified that have received little attention in previous literature. The first relates to space, whereby some ARAs are simply not accepting new members because of restrictions in the size of their meeting place. In these instances, people are required to join a waiting list, which can sometimes require a wait of up to three years. Secondly, emerging from the interviews with both members and non-members, people are sometimes unaware of what Active Retirement Associations do or whether they have an ARA in their area.

5.7 Challenges

ARI in its strategic plan has identified organisational pride, becoming a recognised voice and becoming self-sustaining as priorities to be achieved in the next three years. While overall the experience of being a member of an Active Retirement Association was positive, individuals also recognised that there were some challenges associated with membership. Some of these resonate with challenges identified by the CEO of the organisation in an interview conducted as a part of this research, namely communication, the sustainability of the organisation, funding, and increasing the inclusivity and diversity of membership. The difficulty of attracting male members was a challenge identified by all ARAs involved in this research, supporting the findings of Harvey (2012) and McKenna (2009). Access to appropriate facilities was also raised as a challenge. In some cases facilities were in a poor state of repair whilst in other cases facilities had an extremely limited spatial capacity. In some cases, this meant that people with

physical disabilities did not have access to meetings. Reduced access to grants and other forms of funding was also raised as a recently emerging challenge for many groups. While existing members did not regard the membership fees as prohibitive, it may be off-putting to non-members on low incomes. While most members identify strongly with their local ARA, it appears that some ARA members feel that there is a communication gap between themselves and the national organisation. They would also like more communication between themselves and other local ARAs. It appears that the ARI is aware of the need to address these issues; it has set up structures, including putting in place a network of development officers to recruit new members and to support existing ARAs. The findings confirm that these structures need to be further developed.

5.8 Members' recommendations for ARI

This research provides a unique insight into how ARA members believe that Active Retirement Ireland should continue to develop into the future. There was much agreement across surveys, interview and focus groups that there was not enough communication filtering from the head organisation through to the ordinary members of ARAs. While there are mechanisms in place for this purpose (outreach officers, development officers and the regional structure itself), it appears that they do not in all cases work effectively. Reflecting the findings of Harvey (2012), members expressed considerable enthusiasm when speaking about their local ARA. There was a great sense of pride felt among members regarding the operation of their local ARA and the performance of their ARA's organising committee. However, for some members this sense of pride did not extend to being a member of the umbrella organisation Active Retirement Ireland. The qualitative research revealed that at least some members felt disconnected from Active Retirement Ireland and were largely unaware of how their own ARA fits into the larger structure. Some members were unaware of the role of ARI overall; nor did they appear to be aware of the regional structure.

Both members and non-members had a number of recommendations for attracting new members to Active Retirement Ireland:

- "Bring a buddy" scheme
- Name change
- Inviting people, e.g. tradesmen, to come along and share skills
- Include information about ARI in pre-retirement courses
- Further advertisement, locally and nationally

Members also had a number of other recommendations for improving the experience of being a member of ARI:

- Compile a directory of ARAs and their activities

- Promote more communication between well-established ARAs and developing ARAs with a view to sharing advice
- Promote more communication between ARAs in the same geographical areas

5.9 Priority issues for older people

Finally, there was a strong endorsement from members that Active Retirement Ireland should act as an advocate on priority issues for older people – this was one of ARI's strategic objectives. The main issues identified amongst members related to access to health care, defending against government cuts to entitlements generally (including medical cards and free travel) and pensions in particular, the need to combat ageism and to promote a positive view of ageing in Irish society, and the need to combat social isolation and to encourage more social contact for older people. It was apparent from this research that some members are unaware of Active Retirement Ireland's role in acting as an advocate for older people on such issues.

5.10 Conclusions and recommendations

The conclusion considers the research findings in the light of the research questions the study sought to address (listed 1-4 below) and the strategic objectives of ARI (5-7 below). This evaluation sought to establish:

1. What constitutes healthy ageing for older people?
2. What are the processes through which quality of life is enhanced?
3. Does involvement in a social organisation such as ARI promote a healthier lifestyle and/or lead to enhanced quality of life in older people?
4. What are the next steps for ARI in pursuing this aim?

It also considers whether ARI is achieving its strategic objectives:

5. To be an organisation the people would be proud to be part of locally, regionally and nationally.
6. To be a recognised voice for retired people on social, health, learning and economic issues in collaboration with other organisations.
7. To work towards becoming a self-sustaining organisation.

The first question was addressed by consulting key international and health guidelines which recommended that governments and non-governmental organisations should provide opportunities for older people to participate in social, physical, cultural and educational activities and to volunteer.

A review of the literature identified several activities and forms of engagement which have a demonstrably beneficial effect on the quality of life of older people including volunteering, meeting socially, physical programmes, educational and cultural activities.

It is clear that Active Retirement Ireland has succeeded in providing on a national scale a range of social, physical, cultural and educational activities which older people appear to find engaging and exciting and which address some of the international and national recommendations for health promotion for older people.

The main processes through which well-being is enhanced are through enjoyment of physical and cultural activities, feeling valued, having meaningful opportunities for social engagement, gaining enhanced confidence from learning new skills, and experiencing social solidarity.

It appears that, overall, ARI is achieving many of its strategic objectives to varying degrees. It has succeeded in becoming an organisation that people are proud to be part of locally, although it appears that it needs to do more to encourage people to be proud to be a member at regional and national levels. The organisation of more regional events and perhaps national competitions may assist in this.

ARI has largely succeeded, in the view of the majority of members, in becoming a recognised advocate for older people, although not all ARA members seem to be aware that it has adopted this role.

However, there are a number of challenges ARI needs to address if it is to fully achieve its strategic aims. The ARI as a national organisation needs to establish more presence and profile both with its existing members and with potential members. The expanded development team may assist with this task.

If ARI and its members wish to increase and diversify its membership, it needs to break down some of the stereotypes associated with older people and project a more vibrant image, perhaps through advertising. This resonates with members' broader recommendation that ARI should initiate a debate on ageism and promote a positive view of ageing.

It might attract new members by approaching workplaces, unions, etc. ARI might consider expanding its existing pre-retirement courses as a means of fundraising and profile-raising.

The evident positive impacts of the activities provided by ARI on the quality of life of older people and the relative lack of existing statutory psychosocial services provided by the government provides a rationale for sustaining and even increasing existing levels of government funding

Similarly, given the internationally recognised need to promote active ageing, there is a need for policy in relation to active ageing to be articulated in the forthcoming National Positive Ageing Strategy so that programmes of the kind provided by ARI may be underpinned by a solid policy approach and funding be guaranteed and sustained into the future.

Key recommendations

Key recommendations arising from the report are as follows:

1. Given its size and reach across the country and the benefits it offers to older people in terms of quality of life and psychological well-being, the role of ARI and ARAs should be embedded within the new National Positive Ageing Strategy as offering a new model of health promotion for older people. In fact, participating in ARAs should thus be regarded as an investment in healthy and active ageing – a means of producing health.

2. Existing levels of public funding to the national organisation should be sustained and enhanced, given the obvious health and quality of life benefits of being a member.

3. ARI needs to engage in documenting its activities to keep track of its full programme of work and also the contributions that it is making to individual lives and communities.

4. There is a need for ARI to ensure better information flows between itself and local ARAs, and between ARAs at a local and regional level.

5. ARI needs to increase and make more visible its role as an advocate for older people at national level.

6. The research reveals the following priorities for older people, for which they wish ARI to advocate at a national level: health; general advocacy for older people; entitlements including pensions; enabling older people to participate in the community; social contact, communication, security and transport.

7. ARI needs to diversify and expand its membership in terms of gender, age and social class if it is to be vibrant and sustained into the future.

8. ARI should engage in future research to establish assess from time to time whether benefits continue to be experienced by ARA members. It would be useful for ARI to develop and maintain a centralised membership list so that a representative sample of members could be included in the research.

Given the current economic climate of austerity, there is sufficient evidence to suggest that continuing to fund ARI as a national organisation is both beneficial and necessary. Given the health-promoting benefits associated with the type of programmes offered by ARI and the opportunities it provides for older people to contribute to society as organisers and volunteers, the organisation is making a significant contribution to Irish society.

Bibliography

ACREE, L. S., LONGFORS, J., FJELDSTAD, A. S., FJELDSTAD, C., SCHANK, B., NICKEL, K. J., MONTGOMERY, P. S. & GARDNER, A. W. (2006) Physical activity is related to quality of life in older adults. *Health and Quality of Life Outcomes,* 4(37).

ACTIVE RETIREMENT IRELAND (2011) *Strategic Plan 2012-2014*. Dublin: Active Retirement Ireland.

ACTIVE RETIREMENT IRELAND (2012) *About Us* Retrieved 28th September 2012 from http://www.activeirl.ie/2/about-us.html

AGAHI, N. & PARKER, M. G. (2005) Are today's older people more active than their predecessors? Participation in leisure-time activities in Sweden in 1992 and 2002. *Ageing and Society,* 25(6) pp. 925-942.

AGREN, G. & BERENSSON, K. (2006*) Healthy ageing: a challenge for Europe.* Stockholm: Swedish National Institute of Public Health.

ALDRIDGE, F. & LAVENDER, P. (2000) *The impact of learning on health*. Leicester: National Institute of Adult Continuing Education.

ANDERSSON, L. (1998) Loneliness research and interventions: a review of the literature. *Aging & Mental Health,* 2(4)**,** pp. 264-274.

AUSTRALIAN BUREAU OF STATISTICS (2010) Voluntary Work, Australia. Retrieved 16th April 2012, from http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/404350EEC6509985CA2579580013177A/$File/44410_2010.pdf.

BABCHUK, N. & BOOTH, A. (1969) Voluntary association membership: A longitudinal analysis. *American Sociological Review,* 34(1), pp. 31-45.

BARRETT, A., BURKE, H., CRONIN, H., HICKEY, A., KAMIYA, Y., KENNY, R. A., LAYTE, R., MATY, S., MCGEE, H. & MORGAN, K. (2011) *Fifty Plus in Ireland 2011: First Results from the Irish Longitudinal Study on Ageing (TILDA).* Dublin: TILDA.

BERKMAN, L. F., GLASS, T., BRISSETTE, I. & SEEMAN, T. E. (2000) From social integration to health: Durkheim in the new millennium. *Social Science & Medicine,* 51(6), pp. 843-857.

BLAKE, H., MO, P., MALIK, S. & THOMAS, S. (2009) How effective are physical activity interventions for alleviating depressive symptoms in older people? A systematic review. *Clinical Rehabilitation,* 23(10)**,** pp. 873-887.

BLANE, D., HIGGS, P., HYDE, M. & WIGGINS, R. D. (2004) Life course influences on quality of life in early old age. *Social Science & Medicine,* 58(11)**,** pp. 2171-2179.

BOND, J. & CORNER, L. (2004) *Quality of life and older people*. New York: McGraw-Hill International.

BORAWSKI, E. A., KINNEY, J. M. & KAHANA, E. (1996) The meaning of older adults' health appraisals: congruence with health status and determinant of mortality. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences,* 51(3), pp. S157-170.

BOULTON-LEWIS, G. M., BUYS, L. & LOVIE-KITCHIN, J. (2006) Learning and active aging. *Educational Gerontology,* 32(4), pp. 271-282.

BOURDIEU, P. (1986) The forms of capital. In RICHARDSON, J. (ed.) *Handbook of theory and research for the sociology of education*, pp. 241-258. New York: Greenwood.

BOWLING, A. (2007) Quality of life in older age - what older people say. Are we measuring the right things? In MOLLENKOPF, H. & WALKER, A. (eds.) *Quality of life in old age.* Heidelberg: Springer (Social Indicators Research Series, 31).

BREEN, C. (2011) *Focus on volunteering*. Dublin: Centre for Ageing Research and Development (CARDI).

BRENNER, H. & SHELLEY, E. (1998) *Adding years to life and life to years. A Health Promotion Strategy for Older People.* Dublin: National Council on Ageing and Older People.

BUTRICA, B. A., JOHNSON, R. W. & ZEDLEWSKI, S. R. (2009) Volunteer dynamics of older Americans. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences,* 64B(5), pp. 644-655.

CARO, F. G. & BASS, S. A. (1995) Increasing volunteering among older people. In: BASS, S. (ed.) *Older and active: How Americans over 55 are contributing to society*, pp. 71-96. New Haven, CT: Yale University Press.

CATTAN, M., HOGG, E. & HARDILL, I. (2011) Improving quality of life in ageing populations: What can volunteering do? *Maturitas*, 70(4), pp. 328-382.

CIECHANOWSKI, P., WAGNER, E., SCHMALING, K., SCHWARTZ, S., WILLIAMS, B., DIEHR, P., KULZER, J., GRAY, S., COLLIER, C. & LOGERFO, J. (2004) Community-integrated home-based depression treatment in older adults. *JAMA: The Journal of the American Medical Association,* 291(13)**,** pp. 1569-1577.

CLARY, E. G. & SNYDER, M. (1999) the motivations to volunteer: theoretical and practical considerations. *Current Directions in Psychological Science,* 8(5), pp. 156-159.

COHEN, G. (2009) New theories and research findings on the positive influence of music and art on health with ageing. *Arts & Health,* 1(1), pp. 48-62.

COHEN, G. D., PERLSTEIN, S., CHAPLINE, J., KELLY, J., FIRTH, K. M. & SIMMENS, S. (2006) The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults. *The Gerontologist,* 46(6), pp. 726-734.

CONROY, R.M., GOLDEN, J., JEFFARES, I., O'NEILL, D. & McGee, H. (2010) Boredom-proneness, loneliness, social engagement and depression and their association with cognitive function in older people: a population study. *Psychology, Health & Medicine,* 15(4) pp. 463-473

COOPER, R., KUH, D. & HARDY, R. (2010) Objectively measured physical capability levels and mortality: systematic review and meta-analysis. *BMJ: British Medical Journal,* 341;c4467 doi:10.1136/bmj.c4467

DAUGBJERG, S. B., KAHLMEIER, S., RACIOPPI, F., MARTIN-DIENER, E., MARTIN, B., OJA, P. & BULL, F. (2009) Promotion of physical activity in the European region: content analysis of 27 national policy documents. *Journal of Physical Activity & Health,* 6, pp. 805-817.

DAVIS, M. G., FOX, K. R., HILLSDON, M., SHARP, D. J., COULSON, J. C. & THOMPSON, J. L. (2011) Objectively measured physical activity in a diverse sample of older urban UK adults. *Medicine and Science in Sports and Exercise,* 43(4), pp. 647-654.

DAVIS-SMITH, J. & GRAY, P. (2005) *Active ageing in active communities: volunteering and the transition to retirement*. Bristol: Policy Press.

DE JONG-GIERVELD, J. & KAMPHUIS, F. (1985) The development of a Rasch-type loneliness scale. *Applied Psychological Measurement,* 9(3), pp. 289-299.

DENCH, S., and REGAN, J. (2000) *Learning in later life: motivation and impact*. Research Report RR183: London, Department for Education and Employment. Accessed, 26 October, 2012 http://www.employment-studies.co.uk/pubs/summary.php?id=rr183

DEPARTMENT OF HEALTH (2011) *Health In Ireland: key trends 2011* [Online]. Retrieved 25th September 2012 from http://www.dohc.ie/publications/pdf/key_trends_2011.pdf?direct=1

DEPARTMENT OF HEALTH AND CHILDREN & HEALTH SERVICE EXECUTIVE (2009) *The national guidelines on physical activity for Ireland*. Dublin: Department of Health and Children & Health Service Executive.

DEPARTMENT OF SOCIAL, COMMUNITY AND FAMILY AFFAIRS (2000) *White paper on a framework for supporting voluntary activity and for developing the relationship between the state and the community and voluntary sector.* Dublin: Stationery Office.

ERLINGHAGEN, M. (2010) Volunteering after retirement. *European Societies,* 12(5)**,** pp. 603-625.

ERLINGHAGEN, M. & HANK, K. (2006) The participation of older Europeans in volunteer work. *Ageing and Society,* 26(4)**,** pp. 567-584.

EUROSTAT (2011) *Population projections 2010-2060*. Retreived 5th May 2012 from http://epp.eurostat.ec.europa.eu/cache/ITY_PUBLIC/3-08062011-BP/EN/3-08062011-BP-EN.PDF

FERRANS, C. E. (1996) Development of a conceptual model of quality of life. *Research and Theory for Nursing Practice,* 10(3), pp. 293-304.

FORD, J., SPALLEK, M. & DOBSON, A. (2008) Self-rated health and a healthy lifestyle are the most important predictors of survival in elderly women. *Age and Ageing,* 37(2), pp. 194-200.

GABRIEL, Z. & BOWLING, A. (2004) Quality of life from the perspectives of older people. *Ageing and Society,* 24(5), pp. 675-691.

GALLAGHER, S. K. (1994) Doing their share: comparing patterns of help given by older and younger adults. *Journal of Marriage and the Family*, 56(3), pp. 567-578.

GLASS, T. A., DE LEON, C. M., MAROTTOLI, R. A. & BERKMAN, L. F. (1999) Population based study of social and productive activities as predictors of survival among elderly Americans. *British Medical Journal,* 319, pp. 478-483.

GOTTLIEB, B. H. & GILLESPIE, A. A. (2008) Volunteerism, health, and civic engagement among older adults. *Canadian Journal on Aging/La Revue Canadienne du Vieillissement,* 27(4), pp. 399-406.

GRAY, A. (2009) The social capital of older people. *Ageing and Society,* 29(5), pp.5-31.

GREAVES, C. J. & FARBUS, L. (2006) Effects of creative and social activity on the health and well-being of socially isolated older people: outcomes from a multi-method observational study. *The Journal of the Royal Society for the Promotion of Health,* 126(3), pp. 134-142.

HAO, Y. (2008) Productive activities and psychological well-being among older adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences,* 63(2), pp. S64-S72.

HARRIS, A. H. S. & THORESEN, C. E. (2005) Volunteering is associated with delayed mortality in older people: analysis of the Longitudinal Study of Aging. *Journal of Health Psychology,* 10(6), pp. 739-752.

HARVEY, B. (2012) *Including and involving a broader range of groups in Active Retirement Ireland*. Dublin: Active Retirement Ireland.

HASKI-LEVENTHAL, D. (2009) Elderly volunteering and well-being: a cross-European comparison based on SHARE data. *Voluntas*, 20(4), pp. 388-404

HEALTH DEVELOPMENT AGENCY (2000) *Art for Health: a review of good practice in community-based arts projects and initiatives which impact on health and well-being*. London: Health Development Agency.

HEALTH SERVICE EXECUTIVE (2012) *How physiotherapy works*. Retrieved 4th April 2012 from http://www.hse.ie/eng/services/flu/A-Z/P/Physiotherapy/How-physiotherapy-works.html

HENDRICKS, J. & CUTLER, S. J. (2004) Volunteerism and socio-emotional selectivity in later life. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences,* 59(5)**,** pp. S251-S257.

HYDE, M., WIGGINS, R. D., BLANE, D. & HIGGS, P. (2003) A measure of quality of life in early old age: the theory, development and properties of a needs satisfaction model. *Aging and Mental Health* 7, 86–94

IDLER, E. L., BOULIFARD, D. A., LABOUVIE, E., CHEN, Y. Y., KRAUSE, T. J. & CONTRADA, R. J. (2009) Looking inside the black box of "attendance at services": new measures for exploring an old dimension in religion and health research. *International Journal for the Psychology of Religion,* 19(1), pp. 1-20.

KEDDY, B. A. & SINGLETON, J. F. (1991) Women's perceptions of life after retirement. *Activities, Adaptation & Aging*, 16(2), pp. 57-65.

KLUSMANN, V., EVERS, A., SCHWARZER, R. & HEUSER, I. (2012) Views on aging and emotional benefits of physical activity: effects of an exercise intervention in older women. *Psychology of Sport and Exercise*, 13(2), pp. 236-242.

KNOCKER, S., (2002) Play and metaphor in dementia care and drama therapy, *Journal of dementia care*, 10 (2), pp 33-37.

LA SOUZA, M., LAUTERT, L. & HILLESHEIN, E. F. (2011) Quality of life and voluntary work among the elderly. *Revista da Escola de Enfermagem da USP,* 45(3), pp. 665-671.

LAUDER, W., MUMMERY, K., JONES, M. & CAPERCHIONE, C. (2006) A comparison of health behaviours in lonely and non-lonely populations. *Psychology, Health & Medicine,* 11(2), pp. 233-245.

LAUTENSHLAGER, N.T., COX, K. L., FLICKER, L., FOSTER, J., VAN BOCKXMEER, F., XIAO, J., GREENOP, K., ALMEIDA, O. (2008) Effect of physical activity on cognitive function in older adults at risk for Alzheimer disease. *Journal of American Medical Association*, 300(9), pp. 1027-1037.

LEE, H.Y., JANG, S.N, LEE, S., CHO, S.I., PARK, E.O. (2008) The relationship between social participation and self-rated health by sex and age: A cross-sectional survey. *International Journal of Nursing Studies*, 45(7), pp.1042-1054.

LEE, Y. (2000) The predictive value of self-assessed general, physical, and mental health on functional decline and mortality in older adults. *Journal of Epidemiology and Community Health,* 54**,** pp. 123-129.

LEVASSEUR, M., GAUVIN, L., RICHARD, L., KESTENS, Y., DANIEL, M. & PAYETTE, H. (2011) Associations between perceived proximity to neighborhood resources, disability, and social participation among community-dwelling older adults: results from the VoisiNuAge study. *Archives of Physical Medicine and Rehabilitation,* 92(12)**,** pp. 1979-1986.

LI, Y. & FERRARO, K. F. (2005) Volunteering and depression in later life: social benefit or selection processes? *Journal of Health and Social Behavior,* 46, pp. 68-84.

LI, Y. & FERRARO, K. F. (2006) Volunteering in middle and later life: is health a benefit, barrier or both? *Social Forces,* 85(1), pp. 497-519.

LIE, M. & BAINES, S. (2007) Making sense of organizational change: voices of older volunteers. *Voluntas: International Journal of Voluntary and Nonprofit Organizations,* 18(3), pp.225-240.

LUM, T. Y. & LIGHTFOOT, E. (2005) The effects of volunteering on the physical and mental health of older people. *Research on Aging,* 27, 31-55.

LUNN, P. & KELLY, E. (2008) *In the frame or out of the picture?* Dublin: National Economic and Social Forum.

MARTINEZ, I. L., KIM, K., TANNER, E., FRIED, L. P. & SEEMAN, T. (2009) Ethnic and class variations in promoting social activities among older adults. *Activities, Adaptation & Aging,* 33, pp. 96-119.

MCAULEY, E., BLISSMER, B., MARQUEZ, D. X., JEROME, G. J., KRAMER, A. F. & KATULA, J. (2000) Social relations, physical activity, and well-being in older adults. *Preventive Medicine,* 31(5), pp. 608-617.

MCGEE,H.,MORGAN,K., HICKEY,A., BURKE,H & SAVVA,G. (2011) Quality of life and beliefs about ageing. In BARRETT, A., SAVVA, G., TIMONEN, V. & KENNY, R. A. (eds.) *Fifty Plus in Ireland 2011: First Results from the Irish Longitudinal Study on Ageing (TILDA)*, pp. 265-293, Dublin: TILDA.

MCKENNA, A. (2009) Membership survey results: June 2009. Dublin: Active Retirement Ireland.

MCLAUGHLIN, D., VAGENAS, D., PACHANA, N. A., BEGUM, N. & DOBSON, A. (2010) Gender differences in social network size and satisfaction in adults in their 70s. *Journal of Health Psychology,* 15(5), pp. 671-679.

MCNAMARA, T. K. & GONZALEZ, E. (2011) Volunteer transitions among older adults: the role of human, social, and cultural capital in later life. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences,* 66B(4)**,** pp. 490-501.

MEHROTRA, C. M. (2003) In defense of offering educational programs for older adults. *Educational Gerontology,* 29, pp. 645-655.

MOEN, P., DEMPSTER-MCCLAIN, D. & WILLIAMS JR, R. M. (1992) Successful aging: A life-course perspective on women's multiple roles and health. *American Journal of Sociology*, 97(6), pp. 1612-1638.

MOONS, P., BUDTS, W. & DE GEEST, S. (2006) Critique on the conceptualisation of quality of life: a review and evaluation of different conceptual approaches. *International Journal of Nursing Studies,* 43(7), pp. 891-901.

MORROW-HOWELL, N. (2010) Volunteering in later life: research frontiers. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences,* 65B(4), pp. 461-469.

MORROW-HOWELL, N., HONG, S. I. & TANG, F. (2009) Who benefits from volunteering? Variations in perceived benefits. *The Gerontologist,* 49(1), pp. 91-102.

MIDDLETON, L.E., MITNITSK, I. A., FALLAH, N., KIRKLAND, S. A. & ROCKWOOD, K. (2008) Changes in cognition and mortality in relation to exercise in late life. *PLoS One*, 3(9), pp. 3124.

MULLINS, L. C., SMITH, R., COLQUITT, R. & MUSHEL, M. (1996) An examination of the effects of self-rated and objective indicators of health condition and economic condition on the loneliness of older persons. *Journal of Applied Gerontology,* 15(1), pp. 23-37.

MUSICK, M. A., HERZOG, A. & HOUSE, J. S. (1999) Volunteering and mortality among older adults: findings from a national sample. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences,* 54B(3), pp. s173-s180.

NEALON, J.P (2006) *Examining the different forms of social capital and their mobilisation to achieve desired outcomes within an Irish national community and voluntary organisation* Unpublished M. Litt. Thesis, National University of Ireland, Maynooth

NELSON, M. E., REJESKI, W. J., BLAIR, S. N., DUNCAN, P. W., JUDGE, J. O., KING, A. C., MACERA, C. A. & CASTANEDA-SCEPPA, C. (2007) Physical activity and public health in older adults:

recommendation from the American College of Sports Medicine and the American Heart Association. *Medicine and Science in Sports and Exercise,* 39(8), pp.1435-1445.

NETUVELI, G., WIGGINS, R. D., HILDON, Z., MONTGOMERY, S. M. & BLANE, D. (2006) Quality of life at older ages: evidence from the English longitudinal study of aging (wave 1). *Journal of Epidemiology and Community Health,* 60(4), pp. 357-363.

NEWALL, N. E. G., CHIPPERFIELD, J. G., BAILIS, D. S. & STEWART, T. L. (2012) Consequences of loneliness on physical activity and mortality in older adults and the power of positive emotions. *Health Psychology*. Advance online publication. doi: 10.1037/a0029413.

NÍ LEIME, A. & O'SHEA, E. (2008) *The Bealtaine festival: a celebration of older people in the arts*. Dublin: Age and Opportunity.

O'DWYER, C. & TIMONEN, V. (2009) Doomed to extinction? The nature and future of volunteering for meals-on-wheels services. *Voluntas: International Journal of Voluntary and Nonprofit Organizations,* 20, 35-49.

O'SHEA, E. and CONNOLLY, S. (2012) *Reforming health production in Ireland*. *The World Economy* doi: 10.1111/j.1467-9701.2012.01488.x

O'SHEA, E. (2006) An economic and social evaluation of the Senior Help Line in Ireland. *Ageing and Society,* 26(2), pp. 267-284.

O'SHEA, E. & NÍ LEIME, A. (2012) The impact of the Bealtaine arts programme on the quality of life, wellbeing and social interaction of older people in Ireland. *Ageing and Society,* 32(5), pp. 851-872.

OKAMOTO, K. & TANAKA, Y. (2004) Gender differences in the relationship between social support and subjective health among elderly persons in Japan. *Preventive Medicine,* 38(3), pp. 318-322.

OKUN, M. A. & MICHEL, J. (2006) Sense of community and being a volunteer among the young-old. *Journal of Applied Gerontology,* 25(2), pp. 173-188.

OUR LADY'S HOSPICE (2012) *Physiotherapy in the Community Reablement Unit*. Retrieved 2nd April 2012 from http://www.olh.ie/7-departments/49-physiotherapy/181-physiotherapy-in-the-community-reablement-unit.html?PHPSESSID=7bba470eb71ce0513b3347f3d0c36924

OXLEY, H. (2009) *OECD Health Working Papers, N0. 42, Policies for Healthy Ageing: An Overview*. Paris: OECD Directorate for Employment, Labour and Social Affairs Health Committee.

PARKINSON, L., WARBURTON, J., SIBBRITT, D. & BYLES, J. (2010) Volunteering and older women: psychosocial and health predictors of participation. *Aging and Mental Health,* 14(8), pp. 917-927.

PARSONS, G.R. & MASSEY, D.M (2003) A RUM model of beach recreation In Hanely, N., Shaw, D & Wright, R (eds.), *The New Economics of Outdoor Recreation*. Cheltenham, Edward Elgar

POWER, M., QUINN, K. & SCHMIDT, S. (2005) Development of the WHOQOL-Old module. *Quality of Life Research,* 14(10), pp. 2197-2214.

PUTNAM, R. (2001) Social capital: measurement and consequences. *Canadian Journal of Policy Research,* 2, pp. 41-51.

RAYMOND, É., SÉVIGNY, A., TOURIGNY, A., VÉZINA, A., VERREAULT, R. & GUILBERT, A. C. (2012) On the track of evaluated programmes targeting the social participation of seniors: a typology proposal. *Ageing & Society,* FirstView, pp.1-30.

ROY, K & ZIEMEK, S (2000) *On the economics of volunteering* ZEF Discussion Papers on Development Policy 26. Bonn*:* Center for Developmental Research

ROZARIO, P. A. (2006) Volunteering among current cohorts of older adults and baby boomers. *Generations,* 30(4), pp. 31-36.

RUSSELL, D. (1996) The UCLA Loneliness Scale (Version 3) reliability, validity, and factor structure. *Journal of Personality Assessment*, 66, pp. 20-40

SAVIKKO, N., ROUTASALO, P., TILVIS, R. S., STRANDBERG, T. E. & PITKÄLÄ, K. (2005) Predictors and subjective causes of loneliness in an aged population. *Archives of Gerontology and Geriatrics,* 41(3), pp. 223-233.

SCHARF, T., PHILLIPSON, C. & SMITH, A. E. (2005) Social exclusion of older people in deprived urban communities of England. *European Journal of Ageing,* 2, pp. 76-87.

SHMOTKIN, D., BLUMSTEIN, T. & MODAN, B. (2003) Beyond keeping active: concomitants of being a volunteer in old-old age. *Psychology and Aging,* 18(3), pp. 602-607.

SIRVEN, N. & DEBRAND, T. (2008) Social participation and healthy ageing: an international comparison using SHARE data. *Social Science & Medicine*, 67(12), pp. 2017-26.

SMITH, D. B. (2004) Volunteering in retirement: perceptions of midlife workers. *Nonprofit and Voluntary Sector Quarterly,* 33(1), pp. 55-73.

SUPAN, A., HANK, K. & JURGES, H. (2005) A new comprehensive and international view on ageing: introducing the Survey of Health, Ageing and Retirement in Europe. *European Journal of Ageing,* 2(4), pp. 245-253.

TANG, F., CHOI, E. H. & MORROW-HOWELL, N. (2010) Organizational support and volunteering benefits for older adults. *The Gerontologist,* 50(5)**,** pp. 603-612.

TIMONEN, V., KAMIYA, Y. & MATY, S. (2011) Social engagement of older people. In BARRETT, A., SAVVA, G., TIMONEN, V. & KENNY, R. A. (eds.) *Fifty Plus in Ireland 2011: First Results from the Irish Longitudinal Study on Ageing (TILDA).* Dublin: TILDA.

TIMONEN, V., DOYLE, M and O'DWER, C., Expanded but not regulated: Ambiguity in home care policy in Ireland, *Health and Social Care in the Community*, 20, (3), 2012, pp. 310 – 318.

UNITED NATIONS (2002) *Report of the Second World Assembly on Ageing: Madrid 8-12, 2002*.New York: United Nations.

VICTOR, C. R., SCAMBLER, S. J., BOWLING, A. & BOND, J. (2005) The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain. *Ageing and Society,* 25(6), pp. 357-375.

VON BONSDORFF, M. B. & RANTANEN, T. (2011) Benefits of formal voluntary work among older people. A review. *Ageing Clinical and Experimental Research,* 23(3), pp.162-169.

VON DEM KNESEBECK, O., WAHRENDORF, M., HYDE, M. & SIEGRIST, J. (2007) Socio-economic position and quality of life among older people in 10 European countries: results of the SHARE study. *Ageing and Society,* 27(2), pp.269-284.

WAHRENDORF, M., VON DEM KNESEBECK, O. & SIEGRIST, J. (2006) Social productivity and well-being of older people: baseline results from the SHARE study. *European Journal of Ageing,* 3(2), 67-73.

WARBURTON, J. & CROSIER, T. (2001) Are we too busy to volunteer? The relationship between time and volunteering using the 1997 ABS time use data. *Australian Journal of Social Issues,* 36(4), pp. 295-314.

WARBURTON, J. & MCLAUGHLIN, D. (2005) 'Lots of little kindnesses': valuing the role of older Australians as informal volunteers in the community. *Ageing and Society,* 25(5), pp. 715-730.

WARBURTON, J. & STIRLING, C. (2007) Factors affecting volunteering among older rural and city dwelling adults in Australia. *Educational Gerontology,* 33(1), pp. 23-43.

WARBURTON, J., TERRY, D. J., ROSENMAN, L. S. & SHAPIRO, M. (2001) Differences between older volunteers and nonvolunteers. *Research on Aging,* 23(5)**,** pp. 586-605.

WEERDESTEYN, V., RIJKEN, H., GEURTS, A. C., SMITS-ENGElSMAN, B. C., MULDER, T. & DUYSNENS, J. (2006) A five-week exercise program can reduce falls and improve obstacle avoidance in the elderly. *Gerontology,* 52(3), pp. 131–141.

WIGGINS, R. D., HIGGS, P. F. D., HYDE, M. & BLANE, D. B. (2004) Quality of life in the third age: key predictors of the CASP-19 measure. *Ageing and Society,* 24, pp. 693-708.

WHOQOL (1995) The World Health Organization quality of life assessment (WHOQOL): Position paper for the World Health Organization.*Social Science & Medicine*, 41 (10): 1403-1409.

WORLD HEALTH ORGANIZATION (2002) *Active ageing: a policy framework.* Geneva: World Health Organization.

WORLD HEALTH ORGANIZATION (2003) *Health and development through physical activity and sport.* Geneva: World Health Organization.

WORLD HEALTH ORGANIZATION (2004) *Global strategy on diet, physical activity and health.* Geneva: World Health Organization.

WU, A. M. S., TANG, C. S. K. & YAN, E. C. W. (2005) Post-retirement voluntary work and psychological functioning among older Chinese in Hong Kong. *Journal of Cross-cultural Gerontology,* 20(1), pp. 27-45.

Appendix A

Table 1: Number of affiliated Active Retirement Associations from 1994-2012

Year	*Total No. ARAs*	*% Increase*
1994	96*	-
1999	145*	+51%
2005	355*	+145%
2009	470**	+32%
2012	550***	+17%

*Nealon (2006) **McKenna (2009) ***Active Retirement Ireland (2012)

There has been a steady increase in the number of associations affiliated with ARI since data became available from 1994. As is evident from Table 1, the largest increase in association numbers occurred between 1999 and 2005, when the number of associations more than doubled in size. Since this the rate of increase has slowed but the number of affiliated associations continues to grow.

Table 2: Marital status of respondents

Marital Status	*Chairs*	*Members*	*Total*	*Males*	*Females*
Married	56%	49%	53%	73%	48%
Living With Partner	1%	0%	1%	1%	1%
Widowed	32%	36%	34%	17%	39%
Divorced/Separated	4%	3%	4%	3%	4%
Single	7%	12%	9%	6%	10%

Table 3: Living arrangements of respondents

Living Arrangement	*Chairs*	*Members*	*Total*	*Males*	*Females*
Living With Spouse	51%	40%	47%	64%	40%
Living With Spouse and Other Family Members	6%	8%	7%	7%	7%
Living with Family Members Other Than Spouse	11%	6%	9%	2%	11%
Living With Others (Not Family)	1%	2%	1%	0	2%

Living Alone	31%	44%	36%	27%	40%

Table 4: Age group and level of education

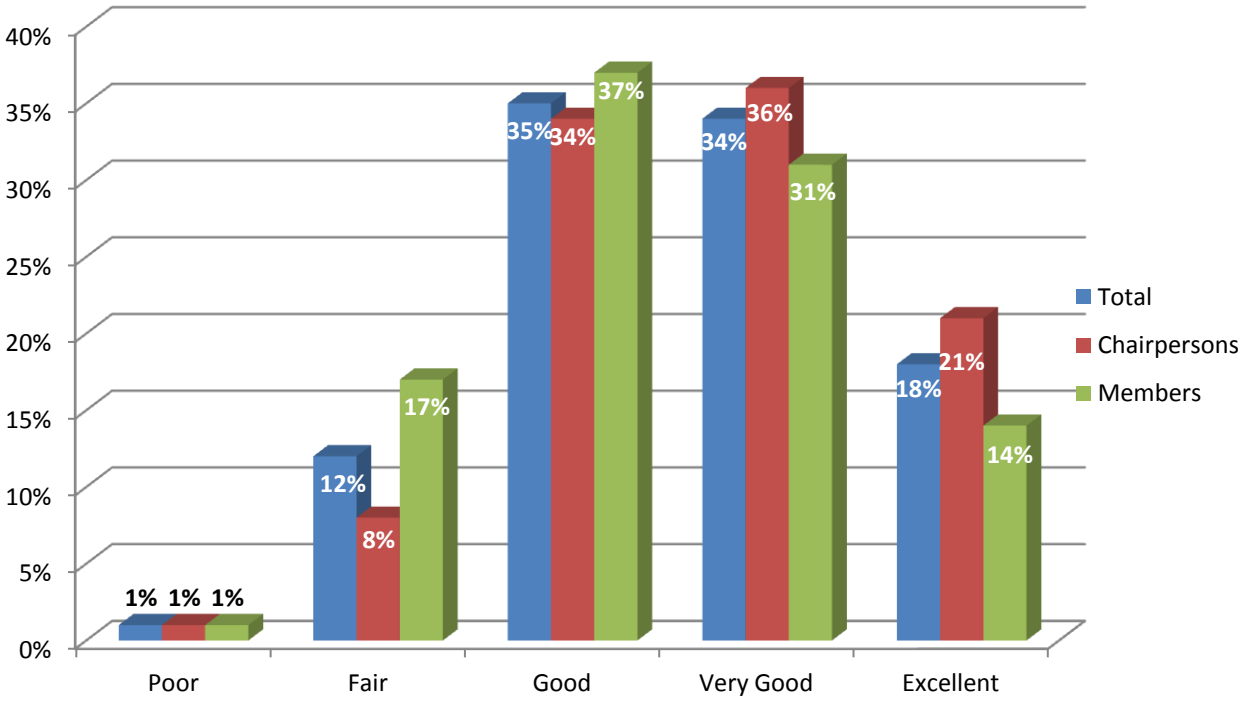
Education Type	*Age Groups*			
	55-64	*65-74*	*75-84*	*85+*
Primary	27%	20%	28%	43%
Secondary	44%	43%	41%	29%
Third-Level	25%	26%	17%	21%
Diploma/Trade	4%	8%	11%	-
Other	-	2%	3%	7%
None	-	1%	-	-

Table 5: Occupation of respondents based on the NACE categories*

NACE Rev.2 Economic Sector	*Total*	*Males*	*Females*
Agriculture, Forestry and Fishing	24 (6%)	15 (14.5%)	9 (3%)
Industry	19 (5%)	11 (10.5%)	8 (3%)
Construction	4 (1%)	4 (4%)	-
Wholesale and Retail Trade	17 (4%)	3 (3%)	14 (5%)
Transportation and Storage	7 (2%)	5 (5%)	2 (1%)
Accommodation and Food Service Activities	14 (4%)	4 (4%)	10 (3%)
Information and Communication	10 (3%)	5 (5%)	5 (2%)
Financial, Insurance and Real Estate Activities	1 (.25 %)	-	1 (.25%)
Professional, Scientific and Technical Activities	15 (4%)	12 (11.5%)	3 (1%)
Administrative and support services activities	56 (14.5%)	14 (13%)	42 (15%)

Public Administration and defence	26 (7%)	12 (11.5%)	14 (5%)
Education	39 (10%)	9 (9%)	30 (10%)
Human Health and Social Work Activities	49 (12.25%)	4 (4%)	45 (15.75%)
Other NACE activities	107 (27%)	5 (5%)	102 (36%)
	388	103(100%)	285 100%)

Figure 1: Self-rated health compared to that of peers



Appendix B: Selected organisations providing social programmes for older people

Age Action is a charity that promotes positive ageing and better policies and services for older people. Their main activities are:

- Advocacy and campaigning on behalf of all older people
- Information service
- Reference library
- Publications, including the monthly Ageing Matters in Ireland
- Conferences, seminars, and education and training programmes
- National and international pilot projects to promote innovation and good practice
- Development aid and education
- Research and evaluation
- Fundraising, including charity shops
- Liaison and co-operation with other organisations
- Liaison and co-operation with other countries
- Services, including Care & Repair Programme, University of the Third Age (U3A), Intergenerational Activities, and Getting Started (programme teaching older people how to use computers).

Age Action Ireland receives funding from a variety of sources including the HSE, Google, Irish Aid, charitable foundations and their own fundraising efforts.

Age & Opportunity is the national not-for-profit organisation that promotes opportunities for greater participation by older people in society through partnerships and collaborative programmes. They run a number of programmes that provide a focus for the different ways in which we promote participation and tackle barriers that prevent it. Programmes include:

- Bealtaine – the national festival celebrating creativity in older age.
- Creative Exchanges – using the arts to transform the experience of residents and staff in care centres for older people.
- Go For Life – promoting greater participation by older people in sport and physical activity.
- AgeWise – raising awareness of ageism among policy-makers and service providers whose work affects the lives of older people.
- Ageing with Confidence – helping people to explore their own ageing in a positive way to maintain health and well-being.
- Get Vocal – strengthening the voice of older people in Irish society.

As a not-for-profit organisation, Age & Opportunity receives core funding from the Health Service Executive (HSE). Each programme is then supported by a particular funding and support mechanism. Major ongoing funders for particular programmes include:

- For Bealtaine, the Arts Council
- For Go For Life, the Irish Sports Council
- For Get Vocal, Atlantic Philanthropies.

The Alzheimer Society of Ireland: As the major dementia-specific service provider in Ireland, The Alzheimer Society's network includes over 120 dementia-specific services such as day care centres, home care services, carer support groups, social clubs, a national respite centre and an advocacy service. The Alzheimer Society of Ireland also operates the Alzheimer National Helpline Service offering information and support to anyone affected by Alzheimer's or dementia. The Alzheimer Society of Ireland comprises over 2,500 members, 300 volunteers and over 700 full- and part-time staff. There are also six regional offices and a network of branches around the country.

The Carers' Association is Ireland's national charity for and of family carers in the home. Their mission is to provide family carers with emotional and practical supports; to promote the interests of family carers and those receiving care in the home through effective partnership, lobbying and advocacy; and to gain recognition and social justice for carers' invaluable contribution to Irish society. Services and supports include:

- A national care line
- support groups
- advocacy and lobbying
- home respite service
- Information
- Membership
- resource centres and outreach services
- Training.

The Carers' Association receives their core funding from the HSE.

'Friends of the Elderly' is a volunteer based Irish charity that aims to alleviate social isolation and loneliness amongst older people in Ireland through friendship. Their work includes the following: Care of the Older Person Course; Visiting Programme; Friendship Call Service; Run for Us; The Wednesday Club; Grandparent's Day; Life and Times Biography; Holidays; Advocacy Assistance; Social Activities; and intergenerational activities through schools. Friends predominantly rely on fundraising efforts, donations from the public and donations from the corporate sector. They also receive a small amount of government funding.

The Irish Association of Older People is a voluntary and membership-based organisation that provides information and promotes and encourages activities that improve the lives of older people. They:

- Publish a quarterly newsletter "Getting On", which keeps the membership up-to-date on best policy and practice.
- Participate in conferences and seminars at local, national and European level.
- Meet both formally and informally with local and national groups, and with them organise focus groups addressing specific issues.
- Advocate on behalf of older people based on the principles of respect, dignity and choice with the overall aim of informing, enabling and empowering.

Men's Shed is any community-based, non-commercial organisation that is open to all men where the primary activity is the provision of a safe, friendly and inclusive environment where the men are able to gather and/or work on meaningful projects at their own pace, in their own time and in the company of other men, and where the primary objective is to advance the health and well-being of the participating men. They receive a very small amount of government funding.

The National Widows' Association was founded in 1967. There are 30 branches throughout the country and their activities are many and varied including outings, social gatherings, holidays seminars, educational talks and demonstrations.

Older and Bolder, which began in 1996, is an alliance of eight NGOs (Active Retirement Ireland, Age & Opportunity, The Alzheimer Society of Ireland, The Carers' Association, The Irish Hospice Foundation, the Irish Senior Citizens' Parliament, the Older Women's Network (no longer in existence) and the Senior Help Line) that champions the rights of all older people and seeks to combat ageism, acting as a catalyst for:

- Supporting older people, through our member organisations, as active participants in shaping an Ireland that promotes the welfare and quality of life of all citizens.
- Positively influencing and shaping beliefs and values, attitudes and opinion regarding ageing and older people.
- Valuing the role of older people in the community and understanding the diversity of older people, including those with a disability.
- Promoting an age-friendly society where decisions are informed by the expressed needs and preferences of older people and evidence-based research.

Older and Bolder is funded by Atlantic Philanthropies.

Senior Citizen's Parliament is primarily an advocacy association which represents the views of older people and makes pre-budget submissions to the government on a range of issues including health-care, long-term care, pensions, transport and security. It provides a forum for older people to air and share their views and to interact with each other.

Third Age is a national voluntary organisation celebrating the third age in life when people may no longer be in paid employment, but can remain healthy, fulfilled and continue to contribute to society. The third age provides programmes and services at a national and regional level. National programmes include Senior Help Line, a confidential listening service for older people by trained older volunteers; Fáilte Isteach, a community project with older volunteers welcoming new migrants through conversational English classes; and the National Advocacy Programme, established in 2008 to provide an independent advocacy service for older people in long-stay nursing home care. Regional programmes include intergenerational programmes and an "Eating Well Into the Future" programme run in conjunction with the HSE.

Appendix C: Questionnaire for Members and Chairpersons

Active Retirement Ireland

Self-Completion Questionnaire

Irish Centre for Social Gerontology

National University of Ireland, Galway

Thank you for taking the time to complete this survey regarding **your** membership with Active Retirement Ireland. This survey is in collaboration with Active Retirement Ireland and the Irish Centre for Social Gerontology. This survey involves questions regarding **your** experiences and **your** membership with Active Retirement Ireland It also includes some questions about you, your age, education, employment and general health.

In this survey some questions require you to tick the box and others may ask you to write in your answer. The information you provide in this survey will be treated with the strictest confidence and it will not be possible to identify you in any way in the final report. We are solely interested in **your** opinions as a member of Active Retirement Ireland.

We appreciate you taking the time to complete this questionnaire and if you have any questions regarding this survey you can call **Aoife Callan** at **091 495740** or email her at aoife.callan@nuigalway.ie

Date Issued	Date Returned	Date Added

Section A: Introduction

1. Do you hold a position within your local Active Retirement Association (ARA)?

Yes	No

1.a Please specify your role with your ARA_____

1.b If yes, did you receive training for your role with your ARA? Yes ____ No____

1.b.1 If yes, did you receive ARI committee skills training? Yes ____ No____

2. How many hours, on average, a month do you spend involved with Active Retirement Ireland? Please specify the total number of hours per month:

_____

3. How long have you been a member of Active Retirement Ireland?

Less than 3 months	Between 3-12 months	1-2 years	3-5 years	More than 5 years

4. What age were you when you joined Active Retirement Ireland? _____

5. How often do you, yourself, participate in each of the following physical activities with your ARA, if at all?

	1 to 3 times a week	Once a month	Once every three months	Once a year	Do not participate
Swimming					
Walking					

Go For Life					
Bowls					
Other Please specify					

6. How often do you, yourself, participate in each of the following social activities with your ARA, if at all?

	1 to 3 times a week	**Once a month**	**Once every three months**	**Once a year**	**Do not participate**
Tea dances					
Short holidays					
Day tours					
Coffee mornings					
Other					

7. How often do you, yourself, participate in each of the following cultural activities with your ARA, if at all?

	1 to 3 times a week	**Once a month**	**Once every three months**	**Once a year**	**Do not participate**
Visits to museums					
Attend the opera					
Attend the theatre					
Visits to art galleries					
Bealtaine					
Other					

8. How often do you, yourself, attend each of the following learning or educational activities with your ARA, if at all?

	1 to 3 times a week	**Once a month**	**Once every three months**	**Once a year**	**Do not participate**
Computer skills training					
Mobile phone training					
Arts and crafts					
Guest speakers at meetings					
Information sessions on important issues					
Other					

9. Sometimes members may take a temporary break for a period of time in participating in their regular activities with their Active Retirement Association. In the last year, have you taken a break from participating in your regular activities with Active Retirement?

Yes	**No**

9.a. If yes, please provide a brief explanation of why you took a temporary break. For example, it may be due to health, personal reasons or a different reason.

_____

9.b. Why did you return to your Active Retirement Association?

_____

10. Are you currently a member of or engaged in voluntary work with another organisation(s) (**not** associated with the ***Active Retirement Ireland***)?

Yes	**No**

10.a If yes, please select from the following list the organisation(s) that you are involved in:

Senior help line	
Credit Union	
St. Vincent DePaul	
Meals on Wheels	
Tidy towns	
GAA club	
Other (please specify)	

10.b If **yes**, in a typical **month**, how many hours do you spend on these activities **outside** of ***Active Retirement Ireland****?*

_____

Section Two: Reasons for joining your Active Retirement Association

11. How important were the following reasons in your decision to join your Active Retirement Association? (If none of the statements reflect your reason(s) for joining ***Active Retirement Ireland***, please write your reason(s) in the box provided below).

	Very unimportant	**Unimportant**	**Don't Know**	**Important**	**Very Important**
To help other people					
To learn new skills					
To meet new people					
To meet a new partner					
To engage in more exercise and physical activities					
To engage in more cultural activities					
To engage in more social activities					
To be a part of the Active Retirement organisation					
To be a part of the community					

To feel useful or needed					
To motivate me to leave the house					
I was asked by a friend/acquaintance					
A friend or friends were already members					
My partner was already a member					
Because I was lonely					
Other (please state)					

Section Three: Your membership with Your Active Retirement Association

This section contains statements about **your** membership with **your** local Active Retirement Association.

12. To what extent do you, yourself, agree or disagree with the following statements about your own participation in your Active Retirement Association.

	Strongly Agree	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**
My life has become more fun / exciting since joining ARA					
I have lots more energy since joining ARA					
My physical health has greatly improved since joining ARA					
My ARA membership makes me feel valued					
I don't believe my ARA membership has enlarged my circle of friends and acquaintances					
I believe my ARA membership gives me a sense of being needed					
I believe joining ARA has been a waste of my time					
Since joining my ARA, I feel better					

about myself					
	Strongly Agree	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**
I used to feel more lonely before joining my ARA					
My ARA membership gives me a reason to get up in the morning					
I enjoy life a lot more since joining ARA					
Since joining ARA, I don't engage with other community activities outside of ARA as much					
Since joining ARA, I have become a lot more active and independent					
I want my ARA to better incorporate my needs into their activities					
I believe my ARA membership really benefits the local community					
My ARA membership has given me the confidence to do more things by myself					
I have met most of my current friends through my ARA membership					
I find it difficult to get my ARA to listen to my suggestions and opinions					
Since joining ARA, I have access to new activities that I would not had access to otherwise					
I've learnt lots of new skills and knowledge since joining ARA					
My ARA membership has made me more aware of issues for older people in Ireland					
I am proud of being a member of my					

ARA					
I feel I can freely choose the activities I want to participate in					

13. Do you, yourself, have any suggestions about how membership for participants in your Active Retirement Association could be improved?

Section Four: About Active Retirement Ireland

In this section, we are interested in **your** opinions about Active Retirement Ireland (ARI) as a national organisation.

14. Do you, yourself, think ARI is a strong advocate / recognised voice for older people in Ireland?

    Yes_____ No_____

    Why or Why not? Please provide a brief explanation of your answer

    _____

    _____

15. What do you, yourself, think are the three priority issues for ARI to get involved in on behalf of older people in Ireland?

    1)_____
    2)_____
    3)_____

16. Do you, yourself, think ARI as a national organisation adds value to your local Active Retirement Association? Yes _____ No_____

Please provide a brief explanation for your answer:

_____

_____

17. Do you have any suggestions for how ARI could be improved nationally?

_____

Section Five: About You

18. The next questions are how you feel about different aspects of your life. For each one, please say how often you feel that way.

	Often	**Some of the time**	**Hardly ever or never**
How often do you feel you lack companionship?			
How often do you feel left out?			
How often do you feel isolated from others?			
How often do you feel in tune with the people around you?			
How often do you feel lonely?			

19. The next question involves a list of statements that people have used to describe their lives or how they feel. How often do you feel this way? Please tick the box that is most appropriate to you for each statement.

	Often	**Sometimes**	**Rarely**	**Never**
My age prevents me from doing the things I would like to				
I feel that what happens to me is out of my control				
I feel free to plan for the future				
I feel left out of things				
I can do the things that I want to do				
Family responsibilities prevent me from doing what I want to do				
I feel that I can please myself what I can do				

My health stops me from doing the things I want to do				
Shortage of money stops me from doing the things that I want to do				
I look forward to each day				
I feel that my life has meaning				
I enjoy the things that I do				
I enjoy being in the company of others				
On, balance, I look back on my life with a sense of happiness				
I feel full of energy these days				
I choose to do things that I have never done before				
I feel satisfied with the way my life has turned out				
I feel that life is full of opportunities				
I feel that the future looks good for me				

Section Six: Socio-Economic Questions

20. Sex. *Please tick the appropriate box*.

Male	Female

21. What age are you? *Please tick the appropriate box.*

45-54	55-64	65-69	70-74	75-79	80-84	85+

22. What is your current Marital Status? *Please tick the appropriate box.*

Married	Living with partner	Widowed	Divorced/separated	Single

22.a. If married / living with partner: is your partner also a member of ARA?

Yes _____ No_____

23. Which of the following best describes your current living arrangements? *Please tick the appropriate box.*

Live with spouse/partner only	**Live with spouse/partner plus other family member(s)**	**Live with family member(s) (other than spouse/partner)**	**Live with others (not family)**	**Live alone**

24. What is the highest level of education that you have attained? *Please tick the appropriate box.*

None	**Primary level**	**Secondary level**	**Third level**	**Trade/diploma**	**Other**

25. Which of the following **best** describes your employment situation? *Please tick the appropriate box.*

Employed part-time	
Retired	
Unemployed	
Permanently sick or disabled	
Looking after home or family	
In education or training	
Other	

26. Please provide a brief description of your occupation which best describes your main occupation for the **majority** of your life:

_____

27. In general, how often do you get together with friends, neighbours or relatives and do things like go out together or visit each other's home? *Please tick the appropriate box*

Once a week	2 or more times a week	Less than once a month	Once a month	A couple of times a month

28. Did you vote in the last general election?

Voted	Did not vote	Don't know

29. About how often, if at all, do you go to religious meetings or services?

Never	Once or twice a year	Every few months	Once or twice a month	At least once a week	More than once a week

30. Do you provide regular, unpaid personal care/support for a family member or friend with long-term illness, health problems or disability? *Please tick the appropriate box.*

Yes, 10 hours or less a week	Yes, between 11 and 20 hours a week	Yes, more than 20 hours a week	None

31. How would you rate your own current health status? *Please tick the appropriate box.*

Excellent	Very Good	Good	Fair	Poor

32. Compared to other people of the same age as you, how would you rate your own current health status? *Please tick the appropriate box.*

Excellent	Very Good	Good	Fair	Poor

33. Please say how much you agree or disagree with the following statements:

	Strongly Agree	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**
I am satisfied with my life.					
Throughout my life, I have always had a positive attitude.					

Thank you for taking the time to complete this questionnaire.

If you have additional comments or feedback regarding this survey or Active Retirement Ireland, please fill them in below.