Creative arts as a public health resource: moving from practice-based research to evidence-based practice

Abstract

There is growing international acceptance of the notion that participation in the creative arts can be beneficial for well-being and health. For over 30 years practical arts for health projects have been developed to support health care and promote health and well-being in communities. An increasing body of evaluation and research evidence lends weight to the value of such initiatives. However, the field of arts and health is complex and multi-faceted and there are challenges in moving beyond ‘practice-based’ research, towards building a progressive body of knowledge that can provide a basis for future ‘evidence-based’ practice in health care and public health. This paper reviews some of the population-level evidence from epidemiological studies on cultural participation and health, before considering research on active initiatives that draw on the creative arts in health care settings and communities to support health and well-being. The notion of a hierarchy of evidence is discussed in relation to arts for health initiatives and a plea is made for recognising the value of concrete case studies, qualitative research and the testimonies of participants and professionals alike in assessing both the value of creative arts activities and for understanding their impacts. Nevertheless, the need for robust controlled studies with precise measurable health outcomes is clear if we are to move towards the scaling up of arts interventions to achieve public health-level impacts from creative arts participation. A brief account of the current programme of research on singing and health that is underway at the Sidney De Haan Research Centre for Arts and Health is presented as a possible model for future research on arts and health.

INTRODUCTION

The need for robust evidence as a basis for practice in public health is incontestable. We need an understanding of the nature, scale, distribution and determinants of disease provided by epidemiology, and we need evidence on what works to promote health through rigorously evaluated intervention studies. But values and ethics are also a key driver in medicine and public health. As Marmot has argued in the reports on the social determinants of health for the World Health Organization (WHO)\(^1\) and the UK Government,\(^2\) changes to reverse the situation of growing health inequalities are possible and justifiable, not only on economic grounds but first and foremost on the basis of social justice.

In addition to a growing awareness of the role of social determinants of health, there is a renewed recognition that health is more than an absence of disease. This is clear with the emergence of a new ‘wellness’ agenda globally and in the UK,\(^3\) and an interest in the positive resources people have both personally and in their social and physical environments, which can help to promote a sense of well-being and even happiness. This is clearly reflected in the current WHO European review on health inequalities and the health divide\(^4\) where it is recognised that the determinants of well-being and the determinants of health overlap but are not identical and a call is made to identify the contribution of personal and...
social assets that can support health and well-being. In the same vein, the Mental Health Foundation identifies ten ways of promoting positive mental health, and the NHS Confederation and New Economics Foundation argue for using the ‘five ways to well-being model’ in initiatives to promote population mental health through the commissioning of ‘wellness services’. In this re-orienting in emphasis towards the positive, the need for evidence-based practice is central.7

Beyond what we know through scientific evidence and in addition to our commitments to social justice, there is a third principle that deserves consideration in thinking about public health. Gardner in his work on curriculum highlights the three central questions he believes education should address: what is true, what is good and what is beautiful? Medicine and public health as fields clearly have an ethical base and are driven by evidence – but what is the relevance of aesthetic considerations to the field of health? This is an important question to ask, given the lack of attention to the creative arts or to wider cultural issues in the report from the WHO Commission on the Social Determinants of Health. As Clift, Camic and Daykin acknowledge, consideration of the contribution of the arts and creativity to health may seem marginal given the levels of material poverty, lack of water and food security, lack of decent housing, and limited health care and educational opportunities, which are the major sources of poor health for many in the world today. Nevertheless, the arts can and do have a role to play in enhancing well-being and quality of life, even in the most disadvantaged of environments. It is striking that in the Citizen’s Inquiry into the Tottenham riots of August 2011, one factor identified as contributing to the riots was ‘the aesthetics of Tottenham’, and people surveyed named ‘unpleasant high street shops and unpleasant living conditions’ as a key cause of young people not respecting the community.

Over the last 30 years, there has been a growth of interest internationally in the role of the arts – in all their diversity – in both health care and in community-based public health and health promotion initiatives. In the UK, as such initiatives have grown and have increasingly been supported financially and recognised as important in policy and guidance documents, the demands for robust evidence have increased. Certainly, robust evidence becomes central to any effort to translate promising demonstration projects into sustained programmes of work through commissioning by the public sector. We may well be approaching a tipping point in this field as the critical mass of researchers interested in the field has increased; the scale and quality of the evidence available has improved and new specialist peer-reviewed journals to raise the profile of the field have been established.1 The growing number of systematic mappings and reviews of research on the contribution of the arts to health and social care is also a marker of the concern to provide evidence on the contribution of the arts to well-being and health.11

The recent review by the International Federation of Arts Councils and Cultural Agencies on the ‘arts sector and its contribution to other sectors’ (e.g. health) provides an indication of worldwide interest in the contribution the arts can play with respect to pressing health and social issues. The National Endowment for the Arts in the USA has also recently published a report on the role of the arts in human development, which presents findings from key studies supporting the contribution of the creative arts to lifelong well-being. The report acknowledges, however, that research evidence is limited and it calls for a new ‘national research agenda for the arts, lifelong learning, and individual well-being’.

THE CONCEPT OF ‘CULTURAL CAPITAL’
The creative arts need to be set within the wider cultural context of any society and the resources that different forms of cultural engagement can provide for health. It is well established that economic and non-material resources are linked with population health and risk of disease, and considerable attention has been given to the contribution of different forms of social capital (both bonding and bridging for example), with respect to health.14 In addition, Abel drawing on the work of Bourdieu, argues for the significance of cultural capital in relation to health and health inequalities. Cultural capital includes people’s social abilities and competence for action, including their perceptions, values, norms, cognitive and operational skills and takes three different forms: incorporated (e.g. values, skills, knowledge), objectivised (e.g. books and tools) and institutionalised (e.g. educational degrees, professional titles). With respect to health, these general notions of cultural capital provide a basis for identifying health-relevant cultural capital made up of all culture-based resources that are available to people for acting in favour of their health.

The notion of culture-based resources includes the creative arts, but clearly it goes well beyond this area of cultural life – to include education, the media, sports and leisure activities, travelling, holidays and much more. In addition, cultural capital is not simply based upon economic and social capital, but interacts with both in important ways. Key to Abel’s argument is the view that cultural capital in the form of health values, perceptions, health knowledge and behaviour norms provides the non-material resources needed to develop healthy lifestyle patterns and deal effectively with health issues on an everyday basis. Cultural capital depends upon economic and social capital but also constitutes those resources that influence individual and group priorities in the use of their economic and social resources for health – for example spending decisions with respect to well-understood factors affecting health and well-being, such as exercise, diet, consumption of tobacco and alcohol, and so on, as well as such decisions on valued forms of social participation and cultural engagement.

EPIDEMIOLOGICAL STUDIES ON LINKS BETWEEN CULTURAL ENGAGEMENT AND HEALTH

Before considering the intentional use of the arts in health settings or communities, it is important to recognise that people voluntarily engage with a
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A wide spectrum of creative arts in many different ways and at different levels. If we consider the music, film, television, digital and performing arts industries, we are concerned with major global businesses reaching global audiences of billions of consumers. Listening to recorded music, in particular through personal digital players, is increasingly understood to play important roles in people's daily lives, with potential health and well-being dimensions. More active engagement in cultural and arts activities, both by attending live cultural and arts events and more especially through direct participation in creative activities, is likely to have greater personal significance and stronger effects that may have health and well-being implications.

A number of large-scale epidemiological studies of cultural participation have been undertaken in Scandinavian countries and also in the USA to explore potential links between culture and health. The seminal epidemiological study of this kind was conducted in Sweden. A population sample of nearly 13,000 Swedes were interviewed in 1982–3 about their cultural activities and by the end of 1991 over 800 of them had died. An index of cultural participation (based on visiting the theatre, concerts, arts exhibitions, museums and sports events) was constructed, and three levels of participation defined (rarely, occasionally and often). The survival of participants in relation to these levels of participation was examined controlling for age, gender, education, income, long-term disease, smoking and physical exercise – all of which are likely to affect survival. The findings clearly showed an excess mortality associated with both rare and occasional cultural participation compared with the highest levels of participation, when taking these confounding variables into account. The same sample was followed up again after 14 years and a higher mortality risk was found for people who rarely engaged in cultural activities compared to those who did so frequently, again controlling for confounding factors. Further studies have shown that maintaining participation in cultural activities is important for self-reported health and that cultural participation appears to provide some protection against cancer mortality for people living in urban areas.

Building on these Swedish studies, a recent survey in the USA explored the links between participation in cultural activities and self-rated health in a sample of just under 1,500 participants aged 18–89 years old. Respondents were surveyed on the extent to which they had attended six types of cultural activity – art exhibitions, dance performances, opera or classical recitals, the cinema, live popular music, the theatre – over the previous year. The more cultural activities participants reported attending, the better their self-rated health when controlling for confounding demographic and socioeconomic variables.

A series of sophisticated epidemiological studies have also been conducted in Finland exploring the role of ‘leisure’ participation, including attendance at cultural events in relation to health. Initially studies were motivated by an attempt to explain the generally better health profiles and life expectancy of the minority Swedish-speaking Finns compared with the Finnish-speaking majority. Cultural and social activities were found to differ between the two language communities, with the Swedish speakers more active in social participation, including choir singing, than Finnish speakers, and these differences in social and cultural capital; with other economic and health factors held constant, appeared to explain the different health profiles. A more recent study also reports that leisure participation (including engagement in clubs and societies, cultural and sports activities, attending church, outdoor activities, cultural interests and hobbies) functioned as an independent determinant of survival for men, when confounding factors (age, smoking, alcohol, obesity, self-rated health, chronic illness) were controlled. For women the picture was more complex, as leisure participation predicted survival among women with health problems but not for healthy women. The authors concluded that health promotion programmes should not only focus on conventional risk factors but also on increasing opportunities for participation in a wide range of leisure and social activities.

A separate Finnish research team has explored the relationships between cultural participation and cause-specific mortality in the working-age population. High levels of engagement in cultural activities were found to predict lower all-cause mortality when controlling for co-factors likely to be associated with mortality (e.g. socio-economic status, work stress, chronic health issues). This link, however, was largely due to a strong association between cultural activities and lower likelihood of deaths from ‘external’ causes (suicide, accidents and crime). The authors suggest that participation in cultural activities may be associated with a healthier lifestyle and enhanced mental health and resilience in the face of life stresses.

More recently, a major Norwegian study, with over 50,000 participants, has explored the links between receptive and creative cultural activities and examined health, anxiety, depression and life satisfaction for men and women separately. Their findings show that, for women, receptive cultural participation (e.g. attending museums, art exhibitions, concerts, theatre, cinema, church and sports events) and creative participation (e.g. being part of a club or association, involvement in music, singing, theatre or dance, outdoor activities or sports) were associated with health benefits even when confounding factors (e.g. social status, chronic illness, smoking, alcohol use) were controlled for. For men, however, attending receptive rather than creative cultural activities was more strongly associated with all health and well-being outcomes.

MORE FOCUSED STUDIES ON THE BENEFITS OF VOLUNTARY ARTS PARTICIPATION

In addition to the epidemiological studies that have considered multiple forms of participation in cultural activities in relation to health and well-being, a growing body of evidence has examined the perceived benefits of voluntary
participation in creative arts activities – particularly instrumental music, dance and singing. Perhaps not surprisingly, given that individuals are choosing these activities, the picture that emerges is a highly positive one, with participants identifying a wide range of benefits, including contributions to health and well-being. A large-scale survey of choral singers in Australia, England and Germany has shown a high level of consensus that singing improves the sense of mental and physical well-being, even among people dealing with health and well-being challenges due to ill health, bereavement and stress in their personal lives. A major study of older people’s participation in community music activities has also highlighted the significance of such activities in promoting social engagement and a sense of well-being, with measures of well-being consistently higher among participants in community music activities than among older people engaged in other group activities (e.g. language classes, arts and crafts, yoga, social support and a book group). People who dance regularly also recognise the value of this activity for their psychological and social well-being as well as physical fitness.

RESEARCH AND EVIDENCE ON ARTS AND HEALTH INTERVENTIONS

A hierarchy of evidence in the field of medicine and health care is widely recognised, although this is not without its critics. Central to the evaluation of practical interventions designed to improve health are the following questions: do they work (their efficacy and effectiveness), does intervention A work more effectively than intervention B, and are interventions cost-effective? Robust controlled designs with clear outcome measures and health economic assessments are essential if such questions are to be answered, and systematic reviews of such studies are important in reaching considered decisions based on the body of available relevant evidence. Hurwitz, in a search of the Cochrane Library with arts-related medical subject heading (MeSH) terms in the title or abstract, found 27 Cochrane reviews and 49 other reviews of sensory arts therapies (music, art, dance and play), representing well over 1,000 randomised controlled trials. Such studies are mainly clinically focused taking place in health care settings, but a few controlled community studies with wider public health relevance have been undertaken. Hurwitz highlights the work of Cohen et al. on community singing for older people, showing evidence of improvements in physical well-being and morale and reductions in loneliness, doctor visits, falls and medication use. Two recent randomised clinical trials have also shown that regular singing can help improve the breathing and quality of life of people with chronic respiratory illness, and this approach could be scaled up on a community level with potential public health relevance.

Randomised controlled trials and systematic reviews are central to the development of evidence-based practice, but as Petticrew and Roberts note, there are many research questions that these cannot answer; questions such as: how does an intervention work; is it acceptable to potential participants; is it an appropriate intervention given participant needs; and are service users and other stakeholders satisfied with the intervention? Attention to qualitative issues of intervention integrity, the processes through which interventions work to achieve change and above all the experiences of participants, are all essential in gaining a rounded account of the potential value of creative arts interventions. Qualitative methods of data gathering, including observations, interviews and focus group discussions together with analytical techniques such as narrative, thematic and content analysis, are important tools for a deeper evaluation of arts-based interventions. Further research questions concerned not simply with the internal validity of experimental research designs and the qualitative dimensions of process and experiential outcomes, but with the ecological validity of studies and the extent to which the learning from research can be translated into practice and sustained, are also important to the development of the field and require a different kind of research at the level of organizational barriers and opportunities, policy and leadership.

Detailed case reports, with qualitative evaluations, are very important in this regard, and the arts and health field in the UK has generated a considerable grey literature of project descriptions often with end-of-project and retrospective evaluations based on participant experiences. Beyond this, ‘mapping’ exercises are invaluable in gaining a sense of the variety of activities drawing upon the arts. The survey undertaken by Secker and colleagues served to map arts for mental health projects across England. Devlin has gathered case studies of good practice in arts and health, and Aston has surveyed existing music for health projects, both in the UK. A major evaluation of creative arts interventions established as part of the Well London initiative has also been undertaken, highlighting the learning gained from practical experience of a diversity of arts projects set up in disadvantaged communities across London. The programme ‘Be Creative, Be Well’ is described by the authors as ‘one of the most ambitious grassroots arts and health programmes ever delivered in the UK’ (p. 8) and the evaluation served to ‘explore the range and depth of benefits potentially associated with artists working in close collaboration with local communities’ (p. 8).

In discussing evidence in relation to arts and health, it is important to recognise that the growth, scope and variety of practical initiatives in this field should, in itself, be regarded as important evidence of the feasibility, acceptability, flexibility and vitality of working through the creative arts in supporting health care and promoting health. Such activities would not happen and certainly would not continue to happen, if their value was not recognised and if the experiences of such initiatives on the part of artists, health professionals and participants did not point to tangible benefits. Of course, one can raise questions of placebo and expectation effects in connection with any form of intervention. However, the
consistency in reported benefits is so widespread and come from such a wide variety of contexts, art forms and participants that the claims for benefits have considerable face validity. We are not dealing with a situation of extraordinary claims requiring extraordinary evidence, nor are we dealing with forms of invasive treatments where there are risks to be weighed against possible benefits. The creative arts are on the whole benign and carry few if any risks to health. The experiences of people who feel they have benefited from participation in arts-based interventions for health deserve to be taken seriously, not as anecdotal evidence but as serious personal testimony.

The recent BBC2 Culture Show film on the value of art therapy for former armed services personnel suffering from post-traumatic stress disorder provides a case in point.24 Men receiving art therapy through the charity Combat Stress25 not only testified to the power of creative arts in helping them come to terms with their experiences and the consequences for their health and well-being, but reflected powerfully on how and why creating visual images can be more effective than talking therapies and conventional medicine. In addition, the considered personal assessments of health researchers and health professionals who witness the power of arts interventions also deserve to be taken seriously as evidence of the value of cultural and arts initiatives. Sarah Harper, who led the evaluation of the ‘Good Times’ programme for older people at the Dulwich Picture Gallery in London26 gives this assessment of the programme:

“The stories we have told in this report include some that were indeed life changing, some that talked of compassionate support, of the transformation of daily lives for older people and their families. Not only did it affect the older participants, but also very clearly the staff in the Gallery, and the professionals who took part. As one of the storytellers put it, the Good Times Programme “changed the way I think about my life.” ... Indeed, despite having worked with and alongside older people for 25 years, I found my own perceptions and understandings of later life change both professionally and personally just through my interaction with the Programme." (p. 5)

Filmed accounts of projects, including interviews with participants, can be very powerful in providing personal testimonies. Filmed documentary records can of course be subject to biases and can be edited to give a misleading impression – but then written reports can be subjected to exactly the same biases and we have to trust to the integrity of authors as much as film makers. The ‘Singing Hospitals’ project working in Birmingham Children’s Hospital, has produced a film that demonstrates how the musicians worked with sick children, parents and staff. This shows directly the impact that music and singing has on young people in the course of challenging treatments and gives supporting testimony from health professionals on the power of music to improve well-being. Here, for example, is Helen King, a play specialist, reflecting on the reactions of the children and the ways in which music helps to humanise medical treatment:

“They’re soothed, they’re relaxed, they are wanting to engage in treatments they might not have wanted to engage in before. Whereas so many of the treatments that may happen in hospital may be done to them, this is something they are in control of. I’ve been working on this unit for 22 years, and since the introduction of Singing Medicine, I have seen a real difference in our patients’ response to their treatment and their recovery.”

**EVALUATION AND RESEARCH IN ARTS AND HEALTH AS A BASIS FOR FUTURE PRACTICE**

As Clift et al. acknowledge, there are considerable difficulties involved in evaluating and researching arts and health practice, beyond qualitative documentation of participants’ perceived benefits. The key challenges relate to the inherently complex and subtle character of artistic endeavours and the wide spectrum of art forms. In addition, arts-based interventions might take place in a wide variety of different settings, with a diverse range of individuals, and in response to the whole spectrum of health issues and points of intervention. Theatre productions designed to raise awareness of sexual health issues among young people and the role of singing in helping to maintain voice quality in Parkinson’s patients both fall under the remit of ‘arts and health’ – but as interventions, each would require very different approaches to evaluation and it would be a challenge to see how the evidence from such studies could be synthesized to provide an evidence base for arts-on-prescription projects addressing enduring mental health needs. The field is complex and requires a substantial number of progressive research programmes. Research is needed, not simply to document and evaluate the benefits of arts and health projects, but to provide a foundation for the future planning and up-scaling of arts interventions that are more securely ‘evidence based’.

An illustration of what is needed is provided by the current work of the Sidney De Haan Research Centre for Music, Arts and Health on the potential value of group singing for health. All available research evidence on singing and well-being has been systematically mapped and reviewed on two occasions41 (for the most recent review) and a further update of the review is planned. These reviews did not follow the Cochrane model as it was clear that few studies undertaken were controlled, but the picture is changing and more stringent systematic reviews are needed to update those already completed. One Cochrane review has already emerged on singing and bronchiectasis,42 but it remains empty as no randomised controlled trials were found through a systematic search of the literature.

On the basis of these reviews, the De Haan Centre has undertaken large-scale surveys of members of existing choirs and choral societies to explore their perceptions of the benefits gained from singing as noted above, but has gone
beyond this work to help establish and to evaluate networks of singing groups for people with little or no previous experience of group singing. These projects have been designed to explore not only the general psychological and social benefits that can come from group singing, but also to assess more precisely the specific benefits that singing may have for individuals with enduring health challenges (e.g. with their mental health, their breathing and their speech).

The De Haan Centre has work closely with the charity Sing For Your Life in exploring the value of group singing for older and elderly people who are often affected by age-related health conditions, particularly dementia, and has identified clear benefits for physical, mental and social well-being in qualitative evaluations.43 This work has led to the setting up of the world’s first community-based pragmatic randomised controlled trial on group singing for people aged 60 and above, funded by the National Institute for Health Research, Research for Patient Benefit programme.44,45 Volunteers were randomly assigned to singing groups that ran weekly over a period of three months or to a ‘usual activities’ control. The principal outcome measure was the York SF12, which is validated for older people and provides measures of mental and physical health-related quality of life. The mental health scores of participants in the singing groups improved significantly over the control group at three months and the difference was maintained over a further three-month follow-up period. On the basis of the positive evidence emerging from the initial trial, the centre is now working with research partners across the UK to design and implement a multi-centre trial on singing and well-being for older people. Such a developing evidence base is seen as essential to encourage health and social care providers to consider the commissioning of singing-group provision for older people.

In addition to work with older people, the De Haan Centre is exploring the value of singing for groups of people with specific health challenges, and projects on singing and mental health, chronic obstructive pulmonary disease (COPD) and Parkinson’s are at different stages of development.48 Funding from the Eastern and Coastal Kent Primary Care Trust supported a network of singing groups across East Kent for people with a history of severe and enduring mental health issues. Seven groups met weekly over one year and a prospective evaluation took place using a validated and widely used clinical assessment questionnaire (CORE) supplemented by qualitative feedback.36 The CORE questionnaire provides an overall measure of ‘mental distress’ with an established clinical cut-off point and clinically significant change scores. Monitoring of the groups showed clear and linear improvements in CORE scores on three assessments over an eight-month period, and written accounts from participants demonstrated a wide range of benefits for improved mood, sense of achievement and social engagement. On the basis of the evidence gathered, further funding has been secured from the Kent and Medway Partnership Trust to maintain and develop the network of singing groups and to more fully integrate this provision within the work of the trust’s mental health access and recovery teams. The study has provided a good foundation for a randomised controlled trial, which is the next step needed to provide more robust evidence of the value of group singing for mental health.

As noted above, the potential value of singing for people with COPD has been shown in a limited number of small-scale controlled studies in health care settings.34,35 The current work of the De Haan Centre in this area is concerned with exploring the value of community singing groups for people with COPD. With funding from the Dunhill Medical Trust, a feasibility study is under way and a network of singing groups has been established, with over 100 volunteers with COPD. Participants have been assessed at baseline with spirometry and the St Georges Respiratory Questionnaire, and repeat assessments will be made on three further occasions over a period of 18 months. To date, we have clear evidence that creating singing groups for people with COPD is possible, and that participants have attended regularly and are enthusiastic about the activity. The final outcome from the study remains to be seen, but it should provide a secure foundation for deciding on the value of progressing to the next stage of designing a community-based pragmatic randomized trial.

Singing and Parkinson’s is also an area that has attracted some research and the De Haan Centre aims to build upon the existing body of evidence. To date, a pilot singing group for people with Parkinson’s has been running for over a year. The group is being monitored qualitatively and the feedback has been highly encouraging. Further formal evaluation, with a particular focus on the impact of regular singing on voice quality, is planned. As with the other applications of singing to health issues, there is some way to go before the health and well-being benefits of singing for people with this progressive neurological condition are sufficiently well established to claim that we have an evidence basis to singing group provision as part of Parkinson’s care.

CONCLUSION
Internationally and certainly in the UK, the last 30 years has seen a considerable growth of interest in the health and well-being benefits of cultural participation, and particularly engagement with the creative arts. Evaluation and research studies have documented these benefits in a systematic way, contributing to the growth of practice-based evidence. The challenge now in a public health context is to extend these research efforts into progressive research programmes that provide a robust body of knowledge for evidence-based practice. Only in this way will we potentially see the extension of small arts-for-health initiatives, which appear to be both effective and cost-effective, to a scale that has measurable public health benefits.
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References


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