EDITORIAL

Gone viral: a new vocabulary for public health

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Honorary Editor

'*I'm forever blowing bubbles*'.

Popular song for over a century

Long before West Ham football fans appropriated it, a song from 1919 was linked to a poster advertisement for soap, the most popular image being a painting of a child blowing bubbles by Pre-Raphaelite artist John Millais. Past songs from challenging times were played more frequently in the early months of the Covid-19 pandemic. Later, by then accustomed to new terms such as 'lockdown', 'social distancing' and 'shielding', the 'support bubble' was introduced. This is my personal favourite, encompassing the combined need for support and isolation for the most vulnerable people in society. I am not so keen on the word 'bubbling' in this context, although 'distancing' as short hand for keeping apart seems a useful addition. Meanwhile, governments around the world protested that they were 'following the science', my least favoured phrase associated with Covid-19. Not that science is to be ignored, far from it, but practitioners of public health know better than most that science can be fallible and must be tempered by experience – and common sense – in the field. The vocabulary of epidemiology raced into popular use as politicians spoke about the 'R number', 'flattening the curve' 'antigen tests' and 'herd immunity'. Quarantine became a familiar term and inspired a cocktail, probably one of many, given reports of increased alcohol consumption. Some Covid neologisms may not stand the test of time, despite the 'covidiots' (people ignoring health advice) and the 'zoom fatigue' associated with long virtual meetings. War and weather metaphors became far more common as this virus 'stormed' in, forcing us to confront the 'new normal' and to 'beat' this enemy. At the same time, there was a rise in conspiracy theories and rumours or myths about causes, prevention and treatment. Prevented by sunshine? If only. Treated by drinking bleach? Of course not, but colleagues reported that they received genuine queries on both.

Bubbles by Sir John Everett Millais, 1886: copyright to this painting was bought in 1890 and used to sell Pears' soap. The advertisers inserted a bar of soap, much to Millais' annoyance. The boy's resemblance to a footballer in the 1920s is said to have inspired the West Ham anthem (https://upload.wikimedia.org/wikipedia/commons/8/8b/Bubbles_by_John_Everett_Millais.jpg).

The invented terms and word play are not simply a temporary phenomenon: at times of crisis, they help people to articulate worries and to create collective reference points. There is no doubt of the huge damage that the enforced isolation has done to mental health, care of chronic conditions and the economy that funds our health and social services. People are speaking of the 'BC' [before Covid] world. Post-lockdown societies are emerging a lot poorer, probably unhealthier and going around with masks uselessly hanging around their chins, underlining the fact that masks are uncomfortable and often not used to beneficial effect. The evidence of linguistic creativity should be compared with new behaviours that have quickly come into place, as well as the ways used to promote them. We often heard about 'adult conversations' with the Government, a contrast with 'baby steps' taken to control or relax measures. The advice that people would want to act responsibly was worthy, but at odds with the experience of investigating and controlling UK outbreaks. A lot depends on personal perception of risk, with no amount of nanny state orders or nudging distance lines having much influence on some individuals. Good long-term effects of the pandemic on public health would be a better appreciation of the history of what did and didn't work and, most of all, much more emphasis on surveillance and early testing to detect another surge of this or other infections. Let's not forget, too, the role of public toilets in promoting good hygienic behaviours and reducing the spread of infection: park and street urination has soared in recent months while even fewer toilets have been available.

This is my last editorial for the journal and I would like to thank the RSPH for trusting me with this role, made possible with the help of an excellent editorial team, editorial boards and supportive publishers. I first worked with this remarkable organisation some 30 years ago, when I became editor of the then house journal. It has been often a challenge but always a pleasure to be involved with the development of *Perspectives in Public Health* from its beginning. I am leaving it in good hands with Joanna Saunders taking over as editor and two deputy editors to deal with our increasing submissions and the 'new normal' world. So little to celebrate out there at present, but this journal will find it, with encouraging research on arts and health in this issue, thanks to guest editor Theo Stickley. Champagne sellers, at least, are pleased by increased sales lately. Bubbles, anyone?

Arts, health and wellbeing across the age span

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The inspiration for this Special Issue was the 2017 publication *Creative health: The arts for health and wellbeing*. This was a significant report produced by the All-Party Parliamentary Group on Arts, Health and Wellbeing[1] with a view to making recommendations to improve policy and practice. For many of us who have worked in the field of arts and health, in either research or practice, this was a momentous publication and is replete with references to the now considerable evidence supporting the effectiveness of arts interventions across the age span. The report may well have influenced the Arts Council England's 10-year strategy that has recently been released.[2] It is a reassuring step that the UK government recognises the need for increased funding in order for the arts and culture sector to continue its contribution to public health. The strategy includes the following statement:

> *Over the next decade, Arts Council England will focus on ensuring that everyone has the opportunity to develop and express creativity throughout their lives. We will help grow and champion opportunities for people from every place, and at every stage, from preschool to older age, to take part in creative activities in their communities* ... (which) *... supports health and wellbeing.*

This strategy too provides an emphasis on the importance of age-specific needs. Many of us here in the UK have bemoaned the erosion of the arts in our educational system for children in recent years, while at the same time witnessing an increase in mental health difficulties among this age group.[3] Similarly, in the last ten years, greater emphasis has been placed on the need for increased awareness of the social needs of the poor, elderly and most vulnerable in society, while at the same time public funds have been reduced for marginalised groups.[4] This has become more exposed with the coronavirus pandemic.

It is indeed a moment in time to celebrate the increased societal awareness of the value of creativity and the arts to health and wellbeing, and its potential for public health. Social awareness, however, is the first step towards social change, and policy, practice and research are facilitators of that change.

It has been seven years since the Royal Society for Public Health (RSPH) published '*Arts, Health and Wellbeing Beyond the Millennium: How Far Have We Come and Where Do We Want To Go?*'.[5] In this report, the RSPH demonstrated its commitment to promoting health and wellbeing through the arts and a multitude of creative enterprises. Over the period since the report was published, the RSPH has been active in this area of research and practice, and this activity has included the creation of a Special Interest Group on Arts, Health and Wellbeing. The group has hosted numerous conferences and webinars, collaborating with the Culture, Health and Wellbeing Alliance in many events and initiatives.

The last Special Issue of *Perspectives* that focused on Arts, Health and Wellbeing (January 2018) comprised papers presented at the Culture, Health & Wellbeing International Conference in 2017. The timing of this current Special Issue is to coincide with the call for abstracts for the third of these conferences in 2021. There is a website link at the end of this Editorial if you would like to find out more about the conference and indeed how and when it will be held, as with most other large events it has been subject to change.

Since the last international conference, interest in this field has grown rapidly both nationally and internationally, in particular the development of social prescribing, which is also recognised in the new Arts Council Strategy. Furthermore, the Culture, Health and Wellbeing Alliance was launched in March 2018 and has over 4000 members. Again, the web address follows this article and is free to join.

To return now to this current issue addressing arts, health and wellbeing across the age span, we have included articles about young people, older people and those in between. The coronavirus pandemic has been devastating for communities around the world. One of the ways that people have uplifted one-another is through the arts, both online and by singing from balconies and front doors. One of the research articles in this issue by Elisabette Corvo and her colleagues at Canterbury Christchurch University reports on a singing project for older people in Rome. Being Italian herself, I asked her for some observations on this wonderful singing phenomenon that was reported in the media, early in the outbreak of the virus:

Italians reside mainly in apartment blocks, where the use of windows and balconies have become important as a means of social contact, in order to see each other, to give courage and support. Immediately music and singing became a way of feeling connected. The use of popular songs, as well as the national anthem demonstrated communities' need for connection.

People arranged to meet up on their balconies at a specific time in the day to sing together maintaining a social distance but creating an emotional fusion. This period has evidenced the power of singing and of music to overcome barriers and to limit the feelings of loneliness, fear and despair, which may affect whole communities.

Corvo et al.'s paper (p. 263) makes a valuable contribution to the research evidence for the mental health benefits of singing among older people.

In compiling this Special Issue, we were overwhelmed with the number of submissions relating to arts activities with older people, which is very heartening. One study we have included (Dadswell et al.: p. 286) reports on arts practices in care homes in the UK. The COVID-19 pandemic, certainly in the UK, has brought care homes to the headlines more than ever before. From a Public Health perspective, very important lessons need to be learnt from these dreadful experiences. As care homes reflect and rebuild, one focus may be upon improving the quality of residents' experiences. In many countries, innovative, creative and artistic practices are being developed in environments that can sometimes be so bleak. We have also been able to include an article specifically reporting the use of arts among people with dementia (Ponsillo: p. 252). In addition, this issue covers arts activities among children (Barnes: p. 254) and students (Phillip: p. 260), as well as adults of all ages (Holt: p. 270; Jenkins: p. 249; Moss: p. 259; Thomson: p. 277; Yoeli: p. 257). We look forward to another Arts & Health special issue of *Perspectives* in the not too distant future.

If you are interested in joining the RSPH Special Interest Group on Arts, Health and Wellbeing, visit https://www.rsph.org.uk/membership/special-interest-groups/join-our-arts-and-health-group.html

If you would like to find out more about the third Culture, Health & Wellbeing International Conference, visit: https://www.culturehealthwellbeing.org.uk/

Furthermore, if you would like to join The Culture, Health and Wellbeing Alliance, visit https://www.culturehealthandwellbeing.org.uk/join-us

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cpd ARTICLE

The July CPD paper was 'Knowledge, attitudes and eating habits red and processed meat among gym users: a cross-sectional survey' by F Bert et al.

Answers: 1c, 2a, 3a, 4a

Obesity in the age of COVID-19

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Obesity has been a key area of focus for RSPH and indeed the public health community as we have witnessed the concerning increase in the prevalence of overweight and obesity among the UK population over the past few decades.[i] The public and professional narrative as to how we address this has ranged from individual responsibility ('eat less and move more'), to greater acknowledgement of the social determinants of health, such as the role of the obesogenic environment in influencing weight.

In early 2019, the Royal College of Physicians and other medical experts went a step further by calling for obesity to be recognised as a disease.[ii] The theory was that disease status could lead to weight management services and obesity prevention strategies being given the attention and funding they deserve, thereby helping to reduce the rate of obesity in the population and limit the strain on the health service borne from the many health conditions caused or exacerbated by overweight and obesity.

RSPH explored whether obesity should be recognised as a disease through 2019 and early 2020; we engaged with the public through national polling and analysed the international picture and evidence from countries where disease recognition has occurred to some degree. Our forthcoming publication is a review of this evidence, with mixed results. Although there are valid arguments for and against recognising obesity as a disease,[iii] the evidence from international precedents and our own research is far from unequivocal on what the real-world outcomes of disease recognition would be. Could the allure of greater funding actually come to fruition, or could we see a negative consequence such as greater stigmatisation of people living with obesity?

The international representation did not present a clear picture. Although some countries that recognised obesity as a disease, including the US and Canada, have seen more training for healthcare professionals and more funding, this is by no means the norm. In some instances, disease recognition had not changed the perception of obesity and those living with it. For instance, healthcare professionals in Portugal reportedly view obesity as a behavioural problem.[iv] Fundamentally, in every country we looked into, the rate of obesity had continued to increase following disease recognition.

The view from the public was also split: when polled last year, just over one-third (38%) were in favour of disease recognition, while a similar number (36%) did not support disease recognition. The research also revealed that less widely accepted views within public health circles about the degree to which individuals are responsible for weight, are still common among the public.

What was clear from the evidence review was the need to focus on prevention, weight management and reducing stigmatisation. We concluded that further research is needed to fully explore the implications and practicalities of disease recognition in the UK.

Then COVID-19 made the situation more acute – not only for society as a whole, but also for professionals working on obesity and health. The pandemic brought into sharp focus further, serious consequences of overweight and obesity on population health outcomes. It is well known that obesity increases a person's risk of having Type 2 diabetes, heart disease, cancer, and a host of other conditions,[v] but suddenly there was a new danger.

As more data about the pandemic became available, it emerged that obesity is a risk factor for becoming seriously ill with COVID-19. One study of nearly 17,000 patients hospitalised with COVID-19 in the UK found that those with a body mass index (BMI) in the obese range (above 30) had a 33% greater chance of dying from COVID-19 than those who were not obese.[vi] The Public Health England review into disparities in the risk and outcomes of COVID-19[vii] also highlighted the increased risk of adverse outcomes for people with obesity.

Prime Minister Boris Johnson went through his own battle with COVID-19 citing this experience, along with his personal weight, as the driver behind a reinvigorated intention to approach obesity in a much more interventionist manner.[viii] This revelation came less than one year after Mr Johnson announced plans to re-evaluate 'sin taxes' if elected Prime Minister, including a review of the overwhelmingly successful Soft Drinks Industry Levy (SDIL).[ix]

Clearly, the severity of the consequences of living with overweight and obesity, and the urgency to act now because of the risk posed by COVID-19, is a powerful force. The UK Government's COVID-19 Recovery Strategy made reference to

obesity, stating, 'the Government will invest in preventative and personalised solutions to ill-health, empowering individuals to live healthier and more active lives'.[x] This objective is similar to the intended aim of recognising obesity as a disease – improved prevention and treatment.

The disease recognition debate is taking on even greater importance in light of the increased public and political oxygen being given to the issue. Health is a form of resilience and part of the foundation required for a functioning society, yet public health has not been treated that way. Put succinctly by the President of the Association of Directors of Public Health, Jeanelle de Gruchy,

> *the NHS is fundamentally just not set up to focus resources on [illness] prevention. Yes it's one of the best healthcare systems in the world, but its main focus is still on acute hospital care. And that's where the money goes*.[xi]

If there is indeed a renewal of some political appetite to take serious action in this space, then those working in public health have a duty to do all they can to ensure this energy is directed towards meaningful and structural change. While some of the Government's plans in the new obesity strategy focus on lifestyle factors, obesity is a multifaceted issue and solving it requires a whole-systems approach. It is vital to build on the momentum generated by this public health crisis to produce long-lasting effective change. That may involve recognising obesity as a disease and should certainly include challenging the food and advertising systems further. It must also involve the Government recognising that children living in the most deprived areas are more than twice as likely to be obese as those living in the least deprived areas,[xii] and that tackling public health issues like obesity goes hand in hand with tackling social deprivation as a whole. Disease recognition may help make this reframing successful, so is a question with extra importance.

This opportunity must be seized, so that it becomes a watershed moment for obesity and public health. For too long we have talked about the need for bold, urgent action and greater funding – now there is an apparent political will and greater public awareness, we must ensure the Government and key stakeholders follow through with their plans to rebuild a better, fairer, healthier society.

Notes

i. https://commonslibrary.parliament.uk/research-briefings/sn03336/
ii. https://www.rcplondon.ac.uk/news/rcp-calls-obesity-be-recognised-disease
iii. Should obesity be recognised as a disease? *Perspect Public Health* 2019; **139**(5): 215–6.
iv. https://www.sciencedirect.com/science/article/abs/pii/S0033350615000098
v. https://www.nhs.uk/conditions/obesity/
vi. https://www.medrxiv.org/content/10.1101/2020.04.23.20076042v1
vii. https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes
viii. https://www.thetimes.co.uk/article/boris-johnson-to-launch-war-on-fat-after-coronavirus-scare-flgswhmvx
ix. https://www.rsph.org.uk/about-us/news/rsph-bitterly-disappointed-with-boris-proposal-to-halt-sugar-levy.html
x. https://www.gov.uk/government/publications/our-plan-to-rebuild-the-uk-governments-covid-19-recovery-strategy
xi. https://www.theguardian.com/society/2020/may/20/jeanelle-de-gruchy-nhs-not-set-up-preventing-illness-coronavirus-public-health
xii. https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-obesity-physical-activity-and-diet/england-2020/part-4-childhood-obesity-copy

Improving children's social and emotional health by dramatising their stories

In this article, Jonathan Barnes summarises children's perceived outcomes of a Speech, Language and Communication Arts intervention experienced four years ago.

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Speech Bubbles (SB) is a drama-based programme designed to address barriers in Speech, Language and Communication (SLC) among 6- and 7-year-olds.[1,2] It is founded on evidence that hearing and honouring children's invented stories provokes their participation and builds skills in confidence, listening and oracy.[3] Over a 30-week programme, groups of ten children with speech, language and communication difficulties tell and act out one story each week, sympathetically led by trained theatre practitioners and teaching assistants. In 2019, SB worked with 1260 children in 64 schools.

Schools make compelling claims about SB's effectiveness.[4] The programme, evaluated in 2015, suggested that about 80% of children made measurable speech, language and communication and behaviour improvements,[5] but there has been no study of longer term impact until the pilot evaluation summarised below.

80% of children made measurable speech, language and communication and behaviour improvements

After gaining permission from parents and school, six 11-year-olds volunteered to share on video memories of their involvement with SB four years ago. In their first years of schooling, these children experienced a wide range of challenges: English was their second or third language, they had other learning difficulties, were painfully shy, mute or unable to control language. In the words of one anonymised child:

> *.... I sat in the corner like yeah they used to always say to me like, 'put your hand up if you have an answer', but I never used to do it because I was too shy I was going to get it wrong ...* (Child 1)

SB claims to promote confidence and involvement among such children, so that learning, listening and contributing can flourish. All SB sessions follow a common pattern:

1. Ten children with SLC difficulties arrive in a room with a teaching assistant.
2. In a circle they chant SB's binding values with actions: kindness/ gentleness, turn-taking, good listening and good acting.They then:
3. 'throw' their names into an imaginary bucket in the centre of the circle, using funny, quiet or loud voices,
4. join in warm-up/imagination exercises to get into theatre-making mode,
5. are reminded of the features of a good story: characters, a place, a happening and a 'good ending',
6. practice scenes from the week's chosen story, deciding with voices and bodies how to make settings like jungles, cities, shops, castles, unicorns or, dragons.
7. Next they: make a masking-tape 'story square' stage on the floor,
8. listen and act out the story in the story square as theatre practitioner slowly reads it, line by line, (different children take lead roles in each section of the story).
9. One child stays behind to tell the theatre practitioner next week's story.
10. The story is written down verbatim – no corrections, additions or prompts.

All interviewees remembered SB enthusiastically. Discussions were videoed and their words transcribed as they described their experiences. Quotations capture the impact of children's involvement:

> *... at first I wasn't really listening, It felt like it was going to take years to get to my turn, but ... I realised that everyone was listening to me so that I should listen back to them because they're giving me their time and attention and I am giving them mine.* (Child 5)

> *I liked the square – no I didn't actually like it- I loved it, because we could explain our ideas and make up our own stories and express ourselves … .* (Child 4)

Children consistently remarked on confidence built through the SB sessions:

SB upgraded myself to be confident in class and out of class. When I am doing a question I [now] can get up in front of the whole class and answer it without thinking 'I don't want to do this anymore', – it's like sharing your opinion because it's your question or your answer – it made me understand and speak out'. (Child 3)

They remembered the warm-ups and individual stories in great detail, frequently using words like *imagination, emotion* and *expression*:

... now I want to listen more things and learn, I have more imagination now than before and use it in any type of writing, it's improved my writing. (Child 5)

All claimed improvements to listening skills, speaking and participation and linked these to developments in social and personal well-being:

... you should do good listening to them because you want them to listen to you ... [SB] made me listen to others in class and share my ideas more, put my hand up more, share your ideas more with everybody. (Child 2)

All claimed improvements to listening skills, speaking and participation

They ascribed improved relationships to SB too. Often using the pronoun *we*, children said SB had helped them become, '*happy to speak*' or '*have fun with others*', in class or playground, '*SB made me talk more and have conversations with people*', (Child 4). All remembered specific SB values, specially singling out the importance of being *gentle, kind, sharing* or *taking turns*.

Each child illustrated significant changes in their lives triggered by SB:

I was always the quiet one, now I am always laughing and loud. (Child 2)

We really like drama or acting now. (Child 3 and Child 6)

School records show that over their primary years these children with SLC difficulties made significant progress in confidence, storytelling, listening, relationships and participation. It would be premature, to claim these improvements resulted purely from SB. Numbers were small and not necessarily representative, children self-selected, but they unequivocally *believed* that SB had made all the difference to them. These volunteers had constructed narratives that underpinned their perceptions of good social and educational health. Their recollections consistently described anxious beginnings in school, an atmosphere of security established by the SB team and imagination, activity, fun, friendship, shared values, story-making and story-sharing linked to the process. Having their stories truly heard had changed them. Each autobiographical narrative culminated in eloquent descriptions of a contributing, socially and psychologically healthy self.

This pilot evaluation raises important questions for researchers:

- How far should teachers help children construct positive narratives about their mental and social health?
- Are the arts particularly conducive to provoking and sustaining such narratives?
- What is the relationship between children's positive narratives and their long-term social/psychological health?

CONFLICT OF INTEREST

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

FUNDING

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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'It's clever, but is it Art?'

In this article, Yoeli and McLusky speak to the fact that while there is no solid definition or explanation for the arts, when in the context of an Arts in Health initiative, it is important to know how the arts are distinguished from arts psychotherapies and the allied health professions.

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> We have learned to whittle the Eden Tree to the shape of a surplice-peg,
>
> We have learned to bottle our parents twain in the yolk of an addled egg,
>
> We know that the tail must wag the dog, for the horse is drawn by the cart;
>
> But the Devil whoops, as he whooped of old: 'It's clever, but is it Art?'[1]

The Devil is right to ask. In *The Conundrum of the Workshops*,[1] which both marvels at and worries about the extent of human progress, Kipling reflects the concern prevalent within his era that scientific advancement might one day render obsolete the human affinity for the arts. In evaluating the present-day arts in health (AiH) movement, this worry remains valid.

The question *but is it art?* is vital to the AiH movement because the arts (i.e. music, the visual arts, drama, literature, dance, multimedia, and the diverse and varied emerging new art forms) are what render AiH distinct from the arts psychotherapies (art therapy, psychodrama, music therapy, etc.) and allied health professions (physiotherapy, occupational therapy, nursing, etc.), and in their distinctiveness, uniquely beneficial to health. If a so-called AiH initiative fails to incorporate an element which can truly be considered art, it will fail to deliver those unique health benefits that the arts provide. In recent years, an increasing scarcity of funding opportunities and the continued demand for evidence-based practice has led the AiH movement to work in increasingly close collaboration and partnership with medical and rehabilitative services.[2] This professionalisation and medicalisation of AiH practice, is inadvertently threatening the extent to which AiH should be considered art.

What *is* art, then? When posed within a worldview which propounds the philosophical virtue of *art for art's sake*[3] or of intrinsic value,[4] this question has little meaning: the arts just *are*, and thereby require no definition, explanation or justification for their existence or utility.[5] When framed within a neoliberal worldview, in which AiH initiatives are required to provide clinical evidence of their effectiveness to ensure their financial viability, this question nevertheless requires an answer.[6] Public health policy tends to describe the arts as a means of generating *cultural capital*,[7] a concept defined as the use of non-economic strategies to promote social mobility and to combat inequality.[8]

The AiH movement embodies the concept of *art for art's sake* through the ways in which it distinguishes itself from

the arts psychotherapies and the allied health professions. Both the arts psychotherapies and allied health professions are essentially task-orientated in their aim to treat symptoms, improve wellbeing, promote coping and produce behaviour change. AiH, however, is fully process-driven, aiming simply to generate a genuine and meaningful artistic experience through painting, singing, ballet or the many other art forms through which AiH operates.

As AiH becomes increasingly drawn into professional healthcare provision, there has been an increasing move to appropriate specific artistic techniques as therapeutic manoeuvres. Some of the vocal exercises used by singers have been employed to teach mindfulness for people experiencing anxiety,[9] for example, and some ballet movements have been used to promote posture and balance in stroke survivors, often to significant clinical effect. Whenever artistic techniques are removed from their context and stripped of their creative potential in this way, they may lose their meaningful *art for art's sake* element of creative self-expression – and thereby may no longer be art. AiH most readily preserves its artistic quality when delivered by a dedicated and practicing artist who is able to facilitate its activities from a creative rather than a therapeutic perspective.

AiH ... is fully process-driven, aiming simply to generate a genuine and meaningful artistic experience

ISSN 1757-9139 DOI: 10.1177/1757913920922274

The concept of the AiH movement as a means to combat inequality predates the concept of *cultural capital* and is indeed integral to the history and heritage of the AiH movement itself.[10] Until approximately the turn of the millennium, AiH initiatives were grounded primarily in community-owned, socially engaged and often anti-establishment artistic practices aiming to improve the wellbeing of communities through their advocacy for social and economic inclusion and justice.[11] To some extent, this AiH activism continues within artistic subcultures such as Forum Theatre,[12] and within mental health settings.[13] However, the growing alliance between AiH and mainstream health services has generally encouraged AiH initiatives to advance less subversive and more apolitical views. Whenever art is stripped of the creative freedom needed to contribute to *cultural capital*, it risks no longer being art.

Nevertheless, the presence and role of the practicing artist facilitating AiH activities within healthcare provision remain inherently radical. Healthcare professionals are expected to relate to their patients in highly regulated and tightly boundaried ways. Artistic practitioners, by contrast, are in this regard unconstrained; they are by definition *Outsiders* to mainstream health provision and thereby possess the radical freedom to relate to participants in a creative, equalising and often subversive manner.[14] Artistic practitioners facilitating AiH activities can radically dignify and empower their participants by elevating each to the status of artistic co-producer, a status far removed from the benevolent, yet distancing, professional gaze.[15] In so doing, artistic practitioners facilitating AiH activities can enable their participants to create and to co-create their own authentic art. This art, having originated through the participants' unique and radical relationship and collaboration with the AiH practitioner-artist, carries an inherent social and political message. Through this message, this art thereby makes a valuable contribution to *social capital*.

Artistic practitioners facilitating AiH activities can radically dignify and empower their participants

The role of the facilitator – the practitioner who delivers the AiH interventions – thereby emerges as central to the question facing the contemporary AiH movement. As AiH becomes increasingly integrated within medical or rehabilitative services, this article argues that AiH initiatives will only fulfil their therapeutic potential when facilitated by practicing artists, distinct in their role from healthcare professionals. As AiH practitioners become increasingly aligned with the medicalised thinking of their professional colleagues, they must nevertheless remain true to their heritage as agents of radical empowerment and social change, and as advocates of the inherent value of the artistic process.

FUNDING

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Wellcome Trust (103339/Z/13/Z).

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The arts may not always be good for us.

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Publication date

01-01-2020

Published in

Perspectives in Public Health;140 (5)

The arts may not always be good for us

Perspectives in Public Health 2020 140 (5)

http://dx.doi.org/10.1177/1757913920917540

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In this special issue we celebrate the arts and how beneficial they can be for our health, however, it is important to remember that, like anything, we must engage with them in a safe and consensual way. Hilary Moss discusses the ways in which the arts can be experienced negatively.

Although my life's work has revolved around promoting the health and wellbeing benefits of engaging in the arts, I also know that music can be harmful. The arts and health field tends to reinforce myths that need to be challenged, for example, that engaging in the arts does not necessarily make you a better person or always make you feel better. Music that is too loud, played repetitively or is politically offensive has previously been used as a form of torture and in concentration camps.[1]

Unfortunately, in my practice as a musician and music therapist, I have listened to descriptions by service users of well-meaning visiting musicians who have played at their bedside out of tune, too loudly, without asking permission and at an inappropriate time – in other words, musicians who have done harm, thinking they have done something good.

In 2019, Dingle et al.[2] published a fascinating paper detailing the state of the field in singing and health research. Eighteen eminent researchers collaborated to produce a series of knowledge statements, issues and recommendations for future research regarding singing, health, and well-being. Current initiatives in my own research team in Ireland are reflective of international concerns.[3,4] Singing is known to have many health and wellbeing benefits, and a large body of highquality work is growing in this area. The study by Dingle et al.,[2] along with the recent award-winning World Health Organization (WHO) report[5] on arts and health, is an example of rigorous, highquality research in arts and health. However, what is rarely written about is the propensity for singing and music (and indeed any of the arts) to do harm or cause injury. Among hundreds of peer reviewed papers on the health benefits of singing, only one was found in a recent review which offered negative associations with singing.[6]

The beauty of music and arts in healthcare settings lies in their sensitive, appropriate use by highly qualified artists who adhere to standards of practice and ethical conduct. We need more guidance such as Dingle et al.[2] to ensure that the arts are integrated into healthcare settings by qualified professionals and as part of a multidisciplinary team approach. The arts can certainly improve health and well-being and are a powerful form of health promotion. In order to ensure sensitive, appropriate and optimum use for service users, staff, and informal carers, we need to be willing to explore and identify when the arts do not work or are used inappropriately and be prepared to do something about it.

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Community singing, wellbeing and older people: implementing and evaluating an English singing for health intervention in Rome

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Keywords
singing; older people; wellbeing; Italy; England

Abstract

Aim: The aim of this research was to explore the transferability and effectiveness of the English Silver Song Clubs model for older people in a different social and cultural context, that is, in the capital city of Italy, Rome.

Methods: A single condition, pretest, post-test design was implemented. Participants completed the following two questionnaires: EuroQoL-5 Dimension (EQ-5D) and York Short Form (SF)-12.

Results: After the singing experience, participants showed a decrease in their levels of anxiety and depression. An improvement was also found from baseline to follow-up in reported performance of usual activities. The English study showed a difference between the singing and non-singing groups at 3 and 6 months on mental health, and after 3 months on specific anxiety and depression measures. This study (Rome) shows similar findings with an improvement on specific anxiety and depression items.

Conclusion: Policy makers in different national contexts should consider social singing activities to promote the health and wellbeing of older adults as they are inexpensive to run and have been shown to be enjoyable and effective.

INTRODUCTION

One of the most important demographic changes globally is the increased number of older people in national populations throughout the world. According to the United Nations,[1] between 2015 and 2030 the number of older people (above 60 years of age) is projected to grow by 56%. In 2015, 47 million individuals were living with dementia, with serious impacts on national health systems, and this number is projected to increase to 75 million by 2030, and 132 million by 2050.[2]

Quality of life and wellbeing are a substantial part of health. In the literature, there are two main concepts of wellbeing – hedonic wellbeing identified as the pursuit of pleasure and avoidance of pain or 'as the presence of positive affect and the absence of negative affect'[3] and eudaimonic wellbeing, which focuses on self-realization and can be defined 'in terms of the degree to which a person is fully functioning'.[4]

Several recent systematic reviews have been conducted on the health and wellbeing benefits of singing, especially for older people. These highlight some methodological weaknesses in research on this issue, but nevertheless show that singing has potential for promoting wellbeing. Gick[5] employed a sophisticated framework drawing on a health psychology perspective in a review of 37 studies. She concluded that the corpus of research is diverse and many studies have methodological limitations. In the quantitative studies, these include lack of control groups, small sample sizes and selection bias, while in the qualitative studies there are problems of lack of clarity in sample recruitment and data analysis. Nevertheless, Gick[5] concludes, 'Notwithstanding the methodological shortcomings, taken together, there is inconclusive but promising evidence for some potential benefits of singing to health and well-being' (p. 197).

Clark and Harding[6] have reported a systematic review of the literature on active singing interventions for therapeutic benefit, in which a

SAGE Publications
ISSN 1757-9139 DOI: 10.1177/1757913920925834

rigorous quality screening process was employed to consider only studies which were judged methodologically sound. In total, 14 studies were considered suitable for the review, 11 of which were quantitative in design and 3 qualitative. The authors concluded that of the 11 quantitative studies, three demonstrated significantly improved psychosocial measures following the active singing intervention and three additional studies showed improvements for both the singing intervention and active control. The three qualitative studies, however, suggested that 'singing may have some less tangible benefits that were not captured in the quantitative data'.[6]

A systematic review focused on the link between lung function and singing is reported by Lewis et al.[7] The review was conducted by analysing research using singing as therapy for chronic respiratory problems, including chronic obstructive pulmonary disease (COPD), bronchiectasis, interstitial lung disease, asthma or sleep apnoea. This systematic review aimed to evaluate the efficacy of singing in comparison to standard care or a control treatment. Among the six studies selected after the application of the inclusion and exclusion criteria, there were four randomized controlled trials (RCTs) and two cohort studies. The studies analysed show that singing is able to improve the conditions of participants more in terms of quality of life than on a physical level, nevertheless in the study reported on patients with asthma[8] there was an improvement in peak expiratory rate and breathlessness and improvements in mood and quality of life. Results described by the review, despite the limitations already stated by the authors, appear to support the value of singing as an activity which can improve the health status of individuals.

More recently, a systematic review focused on the use of singing for mental health and wellbeing was conducted by Williams et al.[9] In total, 13 studies were analysed, which included seven longitudinal studies and six qualitative studies. The quantitative studies showed a range of improvements in the mental conditions of the participants, in terms of lowering depression[10,11] or improvement of the levels of clinical distress.[12] Qualitative studies reported themes concerning a general improvement in emotional and social wellbeing including the development of the sense of group identity and belonging. Along with these positive results some negative issues concerning performance stress also arose from the studies analysed. As in the case of lung function studies, singing proved to be a valuable tool for improving the mental and physical health of individuals of all ages.

An important issue addressed by Price and Whitfield[13] was to compare and contrast the impacts of a 'singing for health' group open to older people with a variety of health challenges associated with aging, compared with the outcomes of singing groups setup to support individuals with specific conditions (e.g. COPD,[14] mental health challenges[15] and Parkinson's disease).[16] This study and review found that the physical and mental benefits achieved by the different groups were very similar, which adds robustness to the evidence on singing and its impact on wellbeing. However, participants of the generic group clarified their preference for participating in a more diverse group rather than a health-related one, as this gave them the opportunity to meet a variety of people, with different backgrounds and with different health issues.

Currently, only two studies have been conducted in Italy on the value of singing for older people, with a focus on people with mental health issues[17] and Parkinson's disease.[18] The study carried out by Tavormina[17] examined the role of singing to improve the recovery of patients with mental illness and showed that singing (in some cases in association with psychotherapy and drugs) improved participants' lives and aided re-integration into society. Di Benedetto's[18] study was focused on improvement in speech and communication. A total of 20 individuals suffering from Parkinson's disease reported improvements in their quality of speech and breathing following engagement in group singing. The study presented here, in contrast, is a timely exploration of the value of singing for older Italian people living in the community, without a focus on specific health conditions.

This study adopted a model of group singing developed and evaluated by researchers in the Sidney De Haan Research Centre for Arts and Health in England.[19,20] Qualitative data drawn from participants in 'Silver Song Clubs' showed clearly a range of social, psychological and physical benefits associated with singing, and these provided the basis for conducting an RCT of singing groups for older people living independently in the community.[21]

In the Coulton et al.[21] study, more than 250 participants were assessed at baseline and then randomized into community singing or a non-treatment control. The singing intervention consisted of weekly singing over 3 months, after which participants in both arms were assessed again. A further assessment was carried out after a further 3 months, during which no singing took place. Results from this study showed statistically significant differences 6 months after randomization as measured by the York SF-12 questionnaire[22] with improved mental health-related quality of life in the singing group compared with the control. In addition, at 3 months, immediately on completion of the intervention, differences were observed on the York SF-12[22] mental health subscale and on the Hospital Anxiety and Depression Scale (HADS)[23] measuring both anxiety and depression.

METHODS

The aim of this research was to explore the transferability and effectiveness of the Silver Song Clubs model for older people in a different social and cultural context, that is, in the capital city of Italy, Rome.

Three singing groups were set up in three different areas of Rome and weekly sessions of about 2 h of singing were held for 12 weeks. Participants completed a questionnaire before the start of the experience, then at the end of 12 sessions and again after 3 months as follow-up. Two standardized questionnaires were used, which had previously been used by Coulton et al.[21] in an English RCT: the EuroQol-5 Dimension (EQ-5D)[23] which measures health utility and the York Short Form (SF)-12 which measures health-related

quality of life and wellbeing.[22] The EQ-5D is made up of five items and a rating scale (1–3) for assessing five aspects of health, and the York SF-12 is made up of 12 items to assess mental and physical wellbeing (see Table 1 for the content of the items).

The Italian version of the EQ-5D was used, supplied directly by the owner of the questionnaire. The algorithm used to create the scores of EQ-5D is based on English-speaking populations but has been validated for the Italian population by Savoia et al.[24] and subsequently also by Balestroni and Bertolotti.[25] The text of the official Italian translation and validation of the original SF-1226 was employed but laid out according to the format of the York SF-12.[22] The York version is a modification of the SF-12 with minor changes made to individual items because older people were found to have difficulties in correctly completing the original version. The transformation of the instrument did not affect the validity of the original SF-12 questionnaire but simply made it easier to use. In light of this and the need to use the same tools as those of the English RCT, an Italian version of the York SF-12 was created. This is supported by the fact that the SF-12 has been validated in Italy[26,27] and the York SF-12 is equally reliable in detecting quality of life and is recommended for use with older populations.

In establishing singing groups, the main aim was to replicate the Silver Song Club model as closely as possible, so that the feasibility of the approach could be established. The final choice of the three areas where the singing sessions were set up was determined by considering the following three main aspects:

- The demographic features of the area;
- The interest of older people in participating in the research; and
- The willingness of senior centres to be involved as a venue for singing groups.

Each of the groups ran for 12 weekly sessions of approximately 2 h, with a mid-session break for refreshments. Sessions for two groups were held during the late afternoon (after 4 p.m.), and for one group in the morning.

During each session up to eight songs were sung. Songs were chosen before the session started by the facilitators and the researcher, and generally, in each session one or two songs were chosen by the participants.

Two facilitators with experience in leading singing groups across different ages were recruited, to direct the singing groups. The choice of the songs was guided by the advice from the two musicians/facilitators on traditional and well-known songs that would be familiar to older people, linked, for instance, to the time of their youth.

This health promotion model was 'translated' to fit better into Italian culture to be transferred to Italy from England, informed by the knowledge of Italian culture of the first author, who suggested the elements that could be copied and those which could not be included in the Italian cultural context. The elements replicated in full were the number of sessions (12), the length of the sessions (approximately 2 h) and the pattern of sessions (singing/break/singing). The aspects changed were mainly the times of the sessions, the break (shorter) and repertoire.

The research received ethical approval from Canterbury Christ Church University Ethics Committee. No formal ethical approval system was in place for the research to be carried out within the centres, but permission was granted by each of the managers of the social centres where the singing groups were held. This was helped by a letter of support from the Department of Public Health and Infectious Diseases, Sapienza University, Rome. Written informed consent was obtained from all participants; data were held securely according to University policies and data protection laws.

RESULTS

A total of 45 participants were involved in the singing experience, 41 of whom took part in the entire research, filling in all three questionnaires. The project lasted for 12 sessions and participants attended regularly giving verbal feedback. Like the English group,[21] the Italian sample was rather heterogeneous with respect to demographic features. The sample was predominantly female, split into two numerically similar age groups, one between 60 and 74 years old ($n = 23$) and the other 75 years onward ($n = 22$), and both had a similar situation with respect to living arrangements (living alone ($n = 24$) vs. living with partner, children or relatives ($n = 21$)).

The picture which emerged from the questionnaires is that the sample had good mental health status with poorer physical status, and the summary measures of health status remained very similar over the course of the study.

Table 1 reports the mean values and standard deviations for the York SF-12 and EQ-5D items and total scores. For the York SF-12, two-component scores provide an indication of physical and mental wellbeing. These scores were derived using the same algorithms as employed in the English Silver Song Club trial (and validated for the Italian population) to ensure comparability. For the whole English sample, the physical component mean was 39.4 and the mental component mean was 49.4. The Italian sample was slightly lower in terms of physical wellbeing (39.1) and reported slightly higher mental wellbeing (50). For the EQ-5D, the items are weighted to give a health utility score with 1 indicating 'perfect health' and 0 representing 'death'. For the total English sample, the EQ-5D score was 0.74 and the value for the Italian sample is very similar. The total scores did not show a statistically significance change over the course of 3 months of singing, but there are suggestive changes in two individual items, which may indicate some improvements in mental wellbeing in the combined sample across the three singing groups. Both of these items relate to feelings of depression/anxiety, which appear to be lessened after the singing compared with the baseline assessment.

Table 2 shows that no changes were apparent for the period between baseline and the second follow-up (24 weeks/6 months). However, Item 3 of EQ-5D (usual activities), showed a marginally significant improvement: mean

Table 1

York SF-12 items and components and EQ-5D items and tariff at baseline and end of singing – mean scores (standard deviations)

York SF-12 items and components	*Baseline*	*After singing*	t
1. General health rating	3.22 (0.74)	3.31 (0.76)	–1.43
2. Moderate activities limited by health	2.36 (0.65)	2.42 (0.66)	–0.83
3. Climbing stairs limited by health	2.33 (0.67)	2.42 (0.66)	–1.16
4. Regular activities accomplished less	3.76 (1.13)	3.82 (0.96)	–0.62
5. Any kind of work limited by health	3.71 (1.20)	3.76 (0.96)	–0.33
6. Accomplished less depression/anxiety	3.93 (1.03)	4.16 (0.77)	–1.70*
7. Worked less carefully depression/anxiety	4.07 (1.01)	4.02 (0.81)	0.37
8. Pain interfered with normal work	3.69 (1.15)	3.78 (0.90)	–0.78
9. Felt calm and peaceful	2.49 (1.25)	2.47 (0.92)	0.11
10. Had a lot of Energy	2.36 (1.05)	2.49 (0.94)	–0.90
11. Felt downhearted and low	3.62 (1.13)	3.67 (0.91)	–0.29
12. Health interfered with social activities	4.00 (0.95)	3.93 (0.84)	0.49
Mental wellbeing component	50.16 (12.42)	50.02 (8.51)	0.09
Physical wellbeing component	38.95 (5.56)	38.93 (6.12)	0.02
EQ-5D items and health tariff			
1. Mobility	1.31 (0.47)	1.36 (0.48)	–.070
2. Self-care	1.02 (0.15)	1.07 (0.25)	–1.43
3. Usual activities	1.24 (0.48)	1.20 (0.41)	0.70
4. Pain/discomfort	1.80 (0.63)	1.78 (0.56)	0.23
5. Anxiety/depression	1.53 (0.63)	1.36 (0.53)	2.07**
EQ-5D tariff	0.71 (0.29)	0.74 (0.24)	–0.78

For SF-12 Items 1, 9 and 10, higher scores: poorer health; test–retest correlations range from .25 to .85. For EQ-5D, test–retest correlations range from .39 to .60.
*$p < .10$; **$p < .05$ (two-tailed).

values at baseline were 1.27 and 1.15 after follow-up, with a paired sample *t* value of 1.95 and probability (two-tailed) of .058.

DISCUSSION

In this study, the sample was involved in three rounds of questionnaires, baseline (before the start of the singing experience (t_0)), after 12 weeks of singing activity (end of the singing experience (t_1)) and at further follow-up (after 12 weeks from the end of the singing activity (t_2)). The improvement in some items of the questionnaires is encouraging and supported the informal feedback from participants who repeatedly stressed the 'need' for a greater number of sessions or alternatively, an additional and longer experience.

The results obtained should be considered with caution as the sample is small, and it is difficult to generalize. The goal of this study, however, was primarily

Table 2

EQ-5D items and tariff at baseline and follow-up – mean scores (standard deviations)

EQ-5D items and health tariff	*Baseline*	*Follow-up*	t
1. Mobility	1.32 (0.47)	1.22 (0.42)	1.43
2. Self-care	1.02 (0.16)	1.02 (0.16)	0.00
3. Usual activities	1.27 (0.50)	1.15 (0.36)	1.95*
4. Pain/discomfort	1.80 (0.64)	1.83 (0.54)	–0.22
5. Anxiety/depression	1.54 (0.64)	1.44 (0.50)	1.07
EQ-5D tariff	0.70 (0.30)	0.75 (0.23)	0.28

*$p < .10$ (two-tailed).

to explore the effectiveness and transferability of this model in Italy. The intention was to take the model, trying to change it as little as possible, except to fit into Italian cultural expectations (e.g. time of day of the sessions and repertoire). The real strength of the model lies in its intrinsic transferability, as singing is a universal human activity and singing groups are simple to set up and can operate at low cost.

In general, transplanting good practice from one national context to another comes with challenges, and may not be straightforward or easy, as different sociocultural dimensions must be given careful attention. The European Union is endeavouring to provide guidance to all member states in strengthening public health and health promotion. According to the Ottawa Charter for Health Promotion, health promotion can only make sense as a 'global' phenomenon.[28]

Although the guiding principles for health promotion can be universal, detailed planning of practical activities must always take account of the particular national and cultural context. According to Azarmina et al.,[29] to transplant a model of health promotion or social policy from one context to another, 'an account for diverse social, economic, policy and practical factors' (p. 373) should be made. Furthermore, if an intervention has a good impact in one setting this does not mean that it will have the same or a similar impact in a different context.[30] Potential interventions must be adapted linguistically and culturally to meet local norms and practices and then their effects tested through evaluation.

The English model was developed, as mentioned, in the south-east of England in a series of small towns and villages close to Canterbury, a small city (population approximately 145,000). The Italian model was developed in Rome (population approximately 2,750,000). The sociocultural differences and contrasts between a big city and small one should be considered, beyond the differences between nations.

In this study, the indications of a reduction in anxiety and depression observed are very encouraging because depression has negative effects on health and preventing depression is one of the major objectives of the World Health Organization (WHO)[31] and national public health authorities.[32] There are currently 151 million people suffering from depression globally and, in the WHO projections,[2] it is considered to be a major cause of disability in the future. Furthermore, the fact that the changes were found in both questionnaires employed, helps to reinforce the validity of the finding. Although there was an improvement in the self-perceived level of anxiety and depression immediately following the intervention, this was not found after a further 3 months in the follow-up. This suggests that the benefits experienced during singing declined after the intervention ended, which further suggests that a longer intervention might have a more lasting effect. The significant improvement during the period baseline to 6-months follow-up in the performance of 'usual activities' is interesting. The improvement in dealing with 'usual activities'[33] effectively means greater independence[34] which is of particular significance in the older population.

The York SF-12 and EQ-5D scores discussed were calculated using the same algorithms as employed in the English Silver Song Club trial to ensure comparability. For the whole English sample, the mean physical component was 39.4 and the mean mental component was 49.4. The Italian sample was slightly lower in terms of physical wellbeing, and reported slightly higher mental wellbeing. For the total English sample, the EQ-5D score was 0.74, which is close to the value for the Italian sample which was 0.71. The most interesting finding in comparing the two studies is that the English study showed a significant difference between the singing and non-singing groups at 3 and 6 months on mental health, and after 3 months also on specific anxiety and depression measures. The findings from this study are similar, therefore, in showing some reductions in anxiety and depression items.

The participants involved in the research carried out a number of activities. They went to the place where the sessions were held (physical activity), had contact with peers and did something enjoyable (social life) before, during and at the end of the session and, finally, their cognitive ability was stimulated in reading, singing and following the director's indications. It is known that all these activities impact on health and, in particular, the health and wellbeing of older people.[35–37] Specifically, social engagement can help to reduce depression,[38] an effect which is supported by the results obtained in the Italian study as well as by those in the English one.

Singing groups can promote hedonic wellbeing, stimulating pleasure and positive mood[4] as well as eudaimonic wellbeing, that focuses on the development and growth of human potential[39] in terms of personal growth and positive relations with others.[4] In the literature on wellbeing, there is general agreement that both hedonic and eudaimonic wellbeing have positive connections with physical health.[40]

CONCLUSION

This study has made a contribution in showing that a model of health promotion for older people through singing, developed in small towns and villages in England, can be successfully transferred to urban contexts in Italy. First, it was demonstrated that a model of health promotion based on singing can be implemented in a different European context, with similar results; and second, that the model is potentially cost-effective. The investment required for each group is not substantial, while the effects could be significant in terms of health gained by older people who are the biggest users of the health system.

In conclusion, simple arts activities such as singing can have a major impact on the health and wellbeing of older people. It is, therefore, crucial that policy makers take into account social activities to promote the health and wellbeing of older adults based on arts and singing in particular.

ACKNOWLEDGEMENTS

The authors thank the Sidney de Haan Research Centre, which funded the study and the Department of Public Health and Infectious Disease of Sapienza University, Rome for their support during the research.

CONFLICT OF INTEREST

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

FUNDING

The author(s) received no financial support for the research, authorship and/or publication of this article.

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Tracking momentary experience in the evaluation of arts-on-prescription services: using mood changes during art workshops to predict global wellbeing change

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Keywords

experience sampling; wellbeing; art-on-referral; mood; social prescribing

Abstract

Aims: To measure the immediate impact of participating in arts-on-prescription workshops on multiple dimensions of mood and to evaluate whether improvement in mood is a mechanism for change, predicting improvements in global wellbeing before and after participation in arts-on-prescription programmes.

Methods: The evaluation drew upon the experience sampling method, asking participants to complete a six-item mood questionnaire at the beginning and end of each workshop in a 12-week-long arts-on-prescription programme. Participants also completed a measure of global wellbeing at the beginning and end of the programme.

Results: Multilevel modelling was used to test hypotheses since the data were hierarchical (with 1491 mood reports nested within 66 participants). There was a significant improvement in global wellbeing across participation in the arts-on-prescription programme. After each art workshop there was a significant increase on all dimensions of mood: hedonic tone (contentment); tense arousal (calmness); and energetic arousal (alertness). There was also a significant improvement in these dimensions of mood, over time, upon arrival at the art workshops each week. Furthermore, reduction in tense arousal after art workshops significantly predicted changes in global wellbeing.

Conclusion: The findings suggest that a reduction in tense arousal (feeling less nervous, anxious and stressed) is a crucial component of arts-on-prescription services and make a direct link between experiences during art workshops and changes in global wellbeing for the first time. This strengthens the evidence base for arts-on-prescription and suggests that tracking experience across interventions is a useful evaluation tool, with much potential.

INTRODUCTION

There is increasing impetus to develop the evidence base for what has been called 'arts-on-prescription' or 'arts-on-referral', using the arts in primary care both to improve the mental health of patients and to reduce the burden on the National Health Service (NHS).[1–3] This article reports on an evaluation of arts programmes run by Bristol Arts on Referral Alliance. The evaluation builds upon previous research using pre–post designs, which suggest that arts-on-prescription can improve wellbeing,[4–8] but is novel in that it draws on the experience sampling method,[9] tracking reports of momentary wellbeing over the course of arts-on-prescription programmes. The aim is to evaluate the extent to which dimensions of mood (hedonic tone, tense arousal and energetic arousal) are affected by art-making, how these change over

ISSN 1757-9139 DOI: 10.1177/1757913920913060

time, and whether this predicts any long-term changes in wellbeing. A further aim is to test a novel evaluation tool (mood tracking) that is easy to deliver and useful for inferring mechanisms of change.

Arts-on-prescription forms part of the wider remit of social prescribing, where doctors, nurses or other primary care professionals prescribe non-clinical activities with the expectation that this will improve the health and health behaviours of participants, including the arts, as well as gardening, cookery, healthy eating advice, nature walks and sport.[3,10,11] Three benefits of social prescribing have been outlined,[3] which are not mutually exclusive: improved mental health; improved community wellbeing; and improved social inclusion. This model draws on a holistic definition of health that is impacted by social cultural factors.[12] With an increasing burden on General Practice (GP), and since it is claimed that one in five visits to GPs are due to social rather than medical reasons,[11] social prescription is being explored as a route to reducing the financial burden of patient care, decreasing visits to GPs.[1] Indeed, in England, the NHS Long Term Plan aims to make social prescribing available at every GP practice.[11,13] It is important to evaluate whether such interventions can improve wellbeing, since the primary driver for its use should be patient benefit.[11] Evidence for the efficacy of such interventions is especially pressing since the costs of mental healthcare are expected to surge in the next 10 years,[14] and the World Health Organization predict that by 2030, depression will be the main global cause of health loss.[2]

Art is not prescribed as an alternative to other forms of treatment, but as a supplement.[4] People are usually referred by a primary care professional due to stress and anxiety, depression and low mood, to help with symptoms of chronic pain and/or to improve self-esteem and reduce loneliness.[3] Art-on-prescription is not a form of psychotherapy, and individuals participate in visual art and craft activities, in small groups, led by a skilled arts practitioner rather than an arts therapist.[3,15] Typically, this consists of attending a weekly art-workshop, for about 2 hours, for 10 to 12 weeks, after which there may be an opportunity to join 'move on' art groups.[5] Activities are structured according to individual need and interest, and may include clay work, watercolour, mixed media, drawing, print work, collage, felting, and so on. The emphasis is on process and enjoyment, exploring art materials in a safe, non-judgemental space, rather than solely on the development of artistic skill, a process in which the artist facilitator plays a key role.

Research on art and health more generally supports the view that art making is associated with a broad range of benefits such as: decreased depression, anxiety and stress; and increased engagement, meaning (eudemonic happiness), empowerment, connection with others and self-esteem.[9,15,16] Research on the impact of community art groups suggests an improvement in wellbeing over the duration of the workshops, in both pre–post designs and a waiting list control study.[16–18] However, specific research on arts-on-prescription is more limited and consists of only a few research papers.[4–8,19–24]

Quantitative outcomes, using pre–post designs, suggest that arts-on-prescription can improve wellbeing (assessed with global wellbeing scales at the beginning and end of art programmes, usually the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)).[6–8] Qualitative outcomes, from both comments on evaluation forms and interviews, suggest that participants feel that they benefit through connecting with and being with others, 'losing themselves' in the art activities (and thereby being distracted from pain or anxieties) and forming positive identities (of self-confidence, agency, empowerment and positive self-regard in relation to 'being an artist').[20–22,24] Furthermore, econometric work suggests that arts-on-prescription can reduce the financial burden on primary care.[19,25]

Despite these encouraging findings, overall, the evidence base is weak.[1] The quantitative work has focused mainly on one cohort (Artlift), there is a lack of control groups (and randomised allocation to conditions), meaning that wellbeing change could be attributed to uncontrolled factors, and attrition rates are not accounted for in analyses.[1,26] A further limitation relates to a lack of process evaluation, examining markers of change across the course of art workshops.[26] Due to the ethical and practical complexities of 'wait-list' and other control groups in primary care, this study focused on this latter issue, piloting a new method of evaluation that measured aspects of wellbeing *throughout* arts-on-prescription programmes.

It has been suggested that evaluations of arts interventions could profitably draw upon the experience sampling method and the use of state measures to capture the immediate impact that attending art workshops might have.[9] This study built upon this suggestion, using a form of event-contingent sampling, where mood was assessed before and after each art workshop of a 12-week-long course. This approach draws on current recommendations for wellbeing measurement, using both global, evaluative retrospective scales and in-the-moment measures.[27] Retrospective scales tend to measure beliefs about wellbeing, rather than actual experience. We forget nuances of our affective life and make errors in our recall (e.g. being biased to remember positive moods across a week-long period).[28,29] Measuring immediate experience can be a more reliable measure of wellbeing (but also has its own set of limitations, being temporary, contextual and labile). Based on best practice recommendations,[27,30] both global and immediate aspects of wellbeing (mood) were measured in this study.

It was hypothesised that (1) global wellbeing scores would increase over the course of the art programmes, replicating previous findings;[6–8] (2) immediate measures of mood (calmness, alertness and contentment) would increase after taking part in each art workshop;[9] (3) mood would improve over the course of the art programmes; and (4) that improvements in mood during the art workshops would predict improvements in global wellbeing.

METHODS

Participants

This article uses data collected from three arts-on-prescription groups over a 2-year period (September 2017 to July 2019). Arts-on-prescription was delivered by two artists (Julie Matthews and Barbara

Disney). Julie Matthews led two groups and Barbara Disney led one group. The data were contributed by 66 individuals (58 female), aged between 25 and 75 (mean age = 47) years, who were referred for a number of reasons, usually multiple, but predominantly due to anxiety and depression, as well as social isolation and chronic pain. A high proportion of participants identified as 'White British' and as being unemployed. Thirty participants attended for one 12-week-long programme, and 36 were given a 'repeat prescription' and completed two terms.

Design

This was a multilevel, repeated-measures design, with mood reports (level one – 'the experiential-level'), and wellbeing scores, nested within participants (level two – 'the person-level'). The dependent variables were mood (hedonic tone, tense arousal and energetic arousal) and global wellbeing. Predicting factors were time, either (1) pre and post each art workshop; or (2) repeated measurement points across the duration of the arts-on-prescription programmes.

Materials

Short Mood Scale (SMS)

A six-item scale, based on a three-factor model of the structure of mood, and longer versions of the scale, measuring: hedonic tone (feeling happy and cheerful rather than sad or depressed); tense arousal (feeling anxious, tense and stressed rather than relaxed or calm); and energetic arousal (feeling active and energetic rather than sleepy and sluggish).[31,32] Each item was presented with a line between two 'opposites' (content vs discontent; unwell vs well; agitated vs calm; relaxed vs tense; tired vs awake; and full of energy vs without energy). This line was 8.4 cm long and had a mark (a short perpendicular line) at the neutral mid-point, and marks at the ends of each line to denote extreme points clearly. This scale was designed to repeatedly sample individuals' mood and has been found to be reliable and sensitive to individual change.[31,33]

WEMWBS

A 14-item scale enquiring about psychological wellbeing over the previous 2 weeks, including connection to others, self-esteem, positive affect and clarity of cognition.[34] The scale has excellent psychometric properties and is responsive to change (a minimum 'meaningful change' being one of three points across measurement points). A score of 40 or below has been interpreted as indicative of probable depression, and 44 or below of possible depression.[34]

Procedure

Each programme consisted of 12 weekly art workshops, led by a skilled arts and health practitioner. Participants were gently introduced to a range of art techniques and ideas to help them explore their own creativity and were supported to learn and explore new artistic skills at their own pace throughout the programme. Participants were invited to take part in the evaluation in the first workshop, read a participant information sheet about what this comprised, and signed a consent form. They were asked to complete the WEMWBS at the start of the programme, before a half-term break, on their return from this break and at the end of the programme. Participants were also invited to complete the SMS at the start and end of each art workshop. They were given a separate paper mood scale at each point, and forms were collected immediately to avoid direct comparison of scores. All data were contributed anonymously. No names or other identifying details were recorded on forms. Data were cross-referenced with a unique code generated through responding to two questions on each form: 'the first two letters of your mother's first name' (e.g. Carol = CA) and 'your birth date' (e.g. 31 for 31 May). The evaluation was given ethical approval by the University of the West of England's Ethics Committee (reference number: HAS.17.07.197).

RESULTS

Screening the data and analysis

Because the data are nested, multilevel modelling was used to account for the lack of independence of data.[35,36] Multilevel modelling also allows for partial data across repeated-measurement points, which was the case in this study. The data consisted of 1491 mood reports (pre- and post-art workshops), with a mean of 23 mood reports per participant (ranging from 4 to 34), and 204 wellbeing scores (a mean of 3 per participant, ranging from 2 to 7). The impact of missing data on analyses was assessed and found to be negligible. Multilevel modelling has the further advantage of enabling random slopes analyses, where, for example, differential increases in wellbeing can be predicted by other variables (e.g. enjoyment of art workshops). Residuals of mood and wellbeing were normally distributed, meeting requirements for multilevel modelling. Following standard recommendations, between-person predictors were centred around grand mean scores.[36]

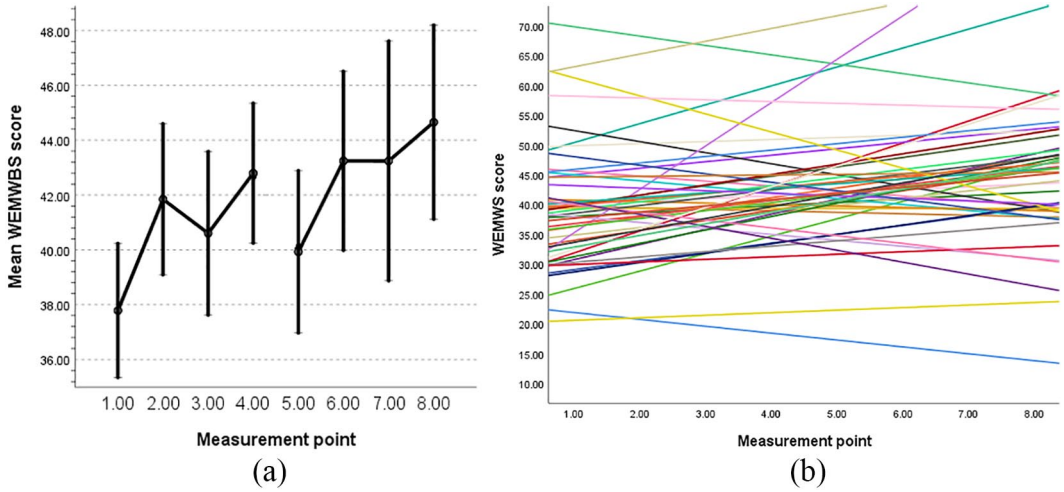
Wellbeing scores across the art programmes

The first hypothesis was that wellbeing would significantly increase over time. Mean wellbeing levels are illustrated in Figure 1 and indicate that across the first 12-week programme, wellbeing increased from 37.79 to 42.80, a mean increase of 5.01 units (above the minimum of 3 units indicative of 'meaningful change'). For people returning for a second programme, wellbeing continued to improve, on average, rising from 39.93 to 44.66 (a mean increase of 4.73). It is of note, as illustrated in Figure 1(a), that mean wellbeing scores decreased after a break from the arts programme (e.g. from 42.80 to 39.93 (a difference of –2.87), between programmes). The mean interval between programmes was 4.2 weeks (29 people having a 3-week-long interval and 7 people a 9-week-long interval between referrals due to the summer holidays).

A multilevel model was conducted, with a random intercept (allowing intercepts to vary by participant). Wellbeing was the dependent variable and change in wellbeing was predicted with a fixed factor of time, which had eight levels: the start and end of each 12-week-long programme (term 1 and term 2), and before and after a mid-term break (within

Figure 1

Changes in global wellbeing for each level of time. (a) Estimated mean global wellbeing scores (with 95% confidence intervals) across attendance at two arts-on-prescription programmes. (b) Spaghetti plot showing individual changes in wellbeing over time.



Measurement points are 1–4 are for programme 1, where 1 = baseline; 2 = before half terms (6 weeks); 3 = after half term; and 4 = end of the 12-week programme. Measurement points 5–8 are for programme 2.

each programme). Wellbeing scores significantly changed as a function of time $\beta = .85$ (standard error (SE) = .20; 95% confidence interval (CI) = 0.45, 1.25; df = 164), $p < .001$. As can be seen in Figure 1(b), which plots individual changes in wellbeing, not all individuals had upward slopes as predicted. Hence, random slopes were enabled in the model. However, this variation in slopes was not statistically significant ($\beta = .35$, SE = .35; 95% CI = 0.05, 2.28; $p = .29$). Pairwise contrasts suggested that the significant changes in wellbeing were mostly between baseline levels (at the start of term one) and subsequent time points: at the end of the first 6 weeks ($t = -3.18$, $p = .002$); the end of the first programme ($t = -4.24$, $p < .001$); and the end of the second programme ($t = -3.89$, $p < .001$). There was also a significant increase in wellbeing from the start of the second programme to its end ($t = -2.49$, $p = .014$). None of the decreases in wellbeing reached statistical significance, the biggest decrease being between the end of term one and the start of term two, which was non-significant ($t = 1.96$, $p = .052$). The hypothesis that wellbeing scores would significantly increase over time was accepted.

Mood scores before and after the art workshops

It was hypothesised that after engaging in an arts-on-prescription workshop participants would report feeling more content, calm and energetic. Multilevel models were conducted, with each dimension of mood as a dependent variable, and with 'pre' and 'post' wellbeing as a fixed factor. For each of the three dimensions, mood was significantly improved after the art workshop compared to baseline mood scores. Participants reported being significantly more: calm and relaxed ($F_{(1264, 1)} = 488.87$, $p < .001$); alert and energetic ($F_{(1269, 1)} = 221.21$, $p < .001$); and content and well ($F_{(1269, 1)} = 247.05$, $p < .001$). The largest effect was for a reduction in tense arousal (feeling more calm and relaxed after art workshops). The hypothesis that participation in arts-on-prescription workshops would be associated with improved immediate subjective wellbeing was accepted (Figure 2).

Changes in baseline mood over time

The second hypothesis regarding mood was that immediate subjective mood, on arrival at the art-workshop each week, would increase over the course of participation in the art programmes. Multilevel models were conducted ($N = 66$), with baseline mood as dependent variables and with time as a fixed predictor (chronological week numbers across period of participation: 1–24). Mood was significantly predicted by time, for all three dimensions: hedonic tone (contentment) ($\beta = .03$, SE = .013, $p = .013$; 95% CI = 0.007, 0.06); tense arousal (relaxation) ($\beta = .04$, SE = .014, $p = .006$; 95% CI = 0.01, 0.07); and energetic arousal (alert) ($\beta = .04$, SE = .015, $p = .012$; 95% CI = 0.009, 0.07). This suggested that not only global wellbeing but also immediate subjective wellbeing, feelings of contentment, calmness and alertness improved over the referral time-frame.

Cross-level interactions between mood and wellbeing over time

The final hypothesis was that dimensions of mood (shifts into a positive mood after art making) would predict changes in long-term wellbeing. By adding cross-level interactions to the initial wellbeing model (for hypothesis 1), it was tested whether the relationship between wellbeing and time differed significantly according to participants' average increase in mood

Figure 2

Mean mood scores before and after art workshops.

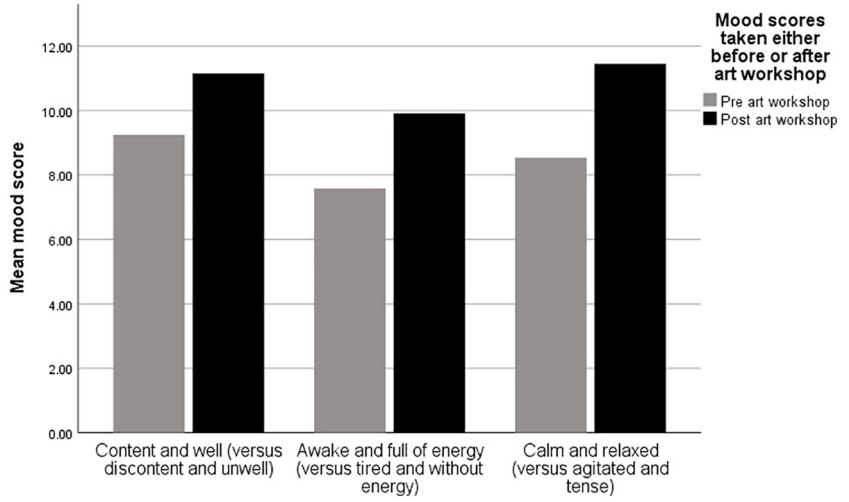
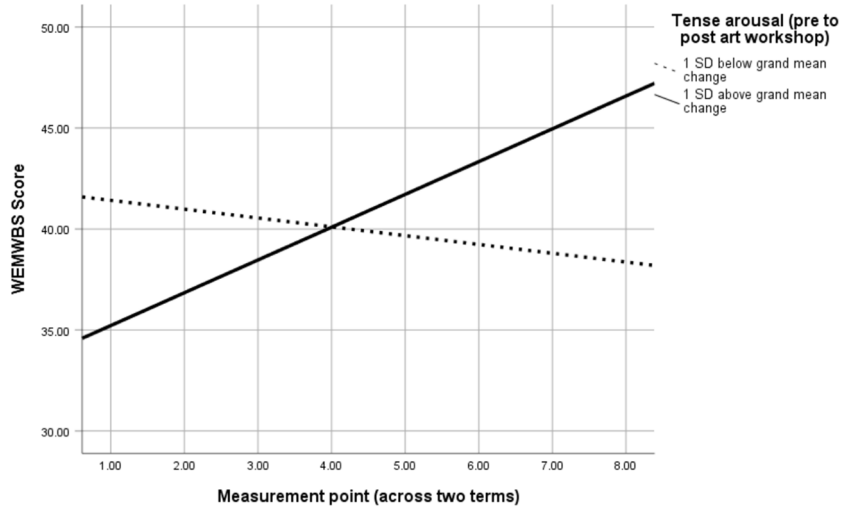


Figure 3

Association, with lines of best fit, between wellbeing change and time according to person-level mean reductions of tense arousal during art workshops.



during the art workshops. Reporting a larger reduction in tense arousal after art making was associated with increases in global wellbeing over time ($\gamma = .41$, SE = .17, $p = .019$; 95% CI = 0.07, 0.76). However, changes in energetic arousal and hedonic tone were not significant predictors ($\gamma = -.01$, SE = .07, $p = .84$; 95% CI = –0.16, 0.136; and $\gamma = -.29$, SE = .24, $p = .22$; 95% CI = –0.76, 0.18, respectively). As illustrated in Figure 3, there was an increase in global wellbeing scores over time only for those participants who reported a large reduction in tense arousal after the art workshops. The final hypothesis was partially met: reduction in tense arousal during art workshops predicted increases in wellbeing over the course of the arts-on-referral programmes.

DISCUSSION

The current research was innovative in that it applied mood tracking to the evaluation of an arts and health intervention for the first time. This approach enabled the immediate affective response to attending art workshops to be examined as a mechanism driving wellbeing change. The findings suggest that tracking immediate experience is a useful tool in the evaluation of public health interventions.

The significant increase in global wellbeing over the course of arts-on-prescription workshops supports previous research.[5–8] Wellbeing (WEMWBS scores) was generally low at baseline (at a mean level indicative of probable depression, below 40), but was increased to levels above this threshold after participation in one programme. These findings support the efficacy of arts-on-referral programmes for improving wellbeing. However, it is not known what factors might be required to maintain such increases in wellbeing after the cessation of the arts programmes, and longitudinal research is required to explore this.

The most important outcome from this study was the examination of the immediate impact of art making on mood and its relationship with wellbeing change. Mood is conceptualised as multidimensional, with orthogonal factors with different physiological underpinnings: hedonic tone (contentment and happiness); tense arousal (stress and anxiety); and energetic arousal (alertness and wakefulness).[31,32] For example, previous research, sampling moods in everyday life, has reported that physical activity improves both energetic arousal and hedonic tone (but not tense arousal).[37] In this study, participating in art workshops was associated with significant improvement on all three dimensions of mood. However, reduction of tense arousal appeared to be most important for global wellbeing. Participants who reported a larger increase in relaxation and calmness after the art workshops, had a larger increase in wellbeing across the arts-on-referral programmes. Increases in feelings of wakefulness and contentment did not have this effect. This finding is important because it suggests that reduction of tense arousal (agitation, tension, stress and anxiety) is one potential mechanism

by which arts-on-prescription improves wellbeing, and suggests that engagement with visual arts and crafts is an appropriate prescription for people experiencing anxiety and depression. It provides a direct link between experience during the art workshops and wellbeing change (limiting the interpretation that change could be attributed to non-controlled factors or reporting biases). The finding also concurs with experimental research suggesting that art-making reduces stress and cortisol levels.[38] Further research could seek to replicate and extend understanding of this effect and explore issues such as why some participants may not have had a relaxation response to the art workshops; how this response could be optimised in art workshops; and whether participants also use art making as a tool to manage anxiety in everyday life.

In addition to exploring the impact of mood change pre and post each art workshop, analyses of mood scores on arrival showed significant increases over time. Participants reported feeling more content, calm and energetic across the 12-week-long arts-on-prescription programmes. This supports the increase in global wellbeing and could be interpreted as being indicative of improved immediate subjective experience in everyday life. However, an alternative interpretation is that participants may have been feeling more relaxed in the art group only. Future work could sample mood at random points in everyday life, drawing on the experience sampling method,[9] in order to explore how long such boosts in mood last outside the safe space of the arts-on-prescription room and group. Such an approach has been used recently to explore the treatment impact of psychological interventions.[39]

The findings of this study support the use of the arts-on-prescription as an effective intervention, reducing tense arousal and improving the wellbeing of participants referred with anxiety and depression. Nevertheless, the study had several limitations. In order to be minimally invasive, only mood was measured. However, other aspects of experience could also contribute to wellbeing change, such as feelings of mastery, connection to others or states of absorbed concentration in art making.[9,15,18,19] Furthermore, it is possible that the completion of mood measures could be affected by demand characteristics. Participants may expect to feel better at the end of the workshops and mark the form accordingly. However, it is unlikely that response biases could explain either the interaction between mood and wellbeing scores, or change in mood across the art programmes, since this would require the memorisation of complex scoring patterns. Finally, it would be useful in future work to assess the impact of the number of sessions attended on wellbeing change, as well as to evaluate the efficacy of arts-on-prescription for different reasons for referral.

Future research could develop the approach outlined in this article, using computerised experience sampling methods to explore the impact of arts-on-prescription on wellbeing in everyday life, both across and beyond the referral time-frame. There is also the potential to track physiological data with this approach to augment self-report data.[40] However, perhaps the most crucial issue is to further explore who arts-on-prescription works best for, and why. For example, in relation to the current findings, what factors contributed to some people finding the art workshops relaxing, and others, not? Mixed methods approaches could be useful here, for example, interviewing people with different relaxation responses about their experiences of arts-on-prescription. Finally, it would be useful to apply theoretical models about why and how arts-on-prescription might work to future research (e.g. stress reduction, distraction and social models). Appropriate state variables (such as absorption and social connection) could be included, but also further potential global outcomes, both for the individual (e.g. social isolation, being better able to manage care) and health and care system (e.g. reduced consultations with GPs).[11]

CONCLUSION

The current research supports the efficacy of arts-on-prescription programmes for improving the wellbeing of people referred for anxiety, depression and social isolation.[5–8] The use of a mood tracking component, drawing upon the experience sampling method,[9] was demonstrated to be a useful tool for the evaluation of public health interventions, helping to understand processes of change. This study found improvements in immediate subjective experience after art workshops (contentment, wakefulness and calmness), experiences that are crucial components of psychological wellbeing.[27,30] Reductions in tense arousal during the art workshops significantly predicted global wellbeing change, making a direct link between experiences during art workshops and subsequent wellbeing for the first time. This strengthens the evidence base for arts-on-prescription and helps to suggest mechanisms for its efficacy. However, more complex theoretical and empirical work on mechanisms for change is required, as well as understanding of the longitudinal impact, of the arts-on-prescription.

ACKNOWLEDGEMENTS

The authors thank Julie Matthews and Barbara Disney, the artists who led the arts-on-prescription workshops, through the CreativeShift service for Bristol Arts on Referral Alliance. The project also benefitted from student volunteer research assistants who helped to input data; thanks for this work go to: Susannah Disley, Flora Strange, Sophie Ashton and Abigail Rickards.

CONFLICT OF INTEREST

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

ETHICAL APPROVAL

This study was approved by the University of the West of England's Research Ethics Committee (reference number: HAS.17.07.197).

FUNDING

The author(s) received no financial support for the research, authorship and/or publication of this article.

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Art, nature and mental health: assessing the biopsychosocial effects of a 'creative green prescription' museum programme involving horticulture, artmaking and collections

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Keywords

creative activities; green prescriptions; mental health service user; mixed methods; museum intervention; psychological wellbeing; social prescribing

Abstract

Aims: To assess the biopsychosocial effects of participation in a unique, combined arts- and nature-based museum intervention, involving engagement with horticulture, artmaking and museum collections, on adult mental health service users.

Methods: Adult mental health service users (total $n = 46$ across two phases) with an average age of 53 were referred through social prescribing by community partners (mental health nurse and via a day centre for disadvantaged and vulnerable adults) to a 10-week 'creative green prescription' programme held in Whitworth Park and the Whitworth Art Gallery. The study used an exploratory sequential mixed methods design comprising two phases – Phase 1 (September to December 2016): qualitative research investigating the views of participants ($n = 26$) through semi-structured interviews and diaries and Phase 2 (February to April 2018): quantitative research informed by Phase 1 analysing psychological wellbeing data from participants ($n = 20$) who completed the UCL Museum Wellbeing Measure pre–post programme.

Results: Inductive thematic analysis of Phase 1 interview data revealed increased feelings of wellbeing brought about by improved self-esteem, decreased social isolation and the formation of communities of practice. Statistical analysis of pre–post quantitative measures in Phase 2 found a highly significant increase in psychological wellbeing.

Conclusion: Creative green prescription programmes, using a combination of arts- and nature-based activities, present distinct synergistic benefits that have the potential to make a significant impact on the psychosocial wellbeing of adult mental health service users. Museums with parks and gardens should consider integrating programmes of outdoor and indoor collections-inspired creative activities permitting combined engagement with nature, art and wellbeing.

INTRODUCTION

The wide-ranging benefits of social prescription on psychological health have been well established.[1,2] Consequently, there is a growing impetus for social interventions that support psychosocial health outcomes, such as community-based referral to non-clinical provision involving creative and cultural activities, physical exercise or educational opportunities.[3,4] Given that a fifth of consultations with a general practitioner (GP) are for psychosocial rather than medical problems,[5] social prescribing has

ISSN 1757-9139 DOI: 10.1177/1757913920910443

become an important means by which healthcare professionals can 'seek to address the non-medical causes of ill health with non-medical interventions' (p. 5).[3] As an illustration of current interest in the UK in non-medical interventions, a new independent not-for-profit organisation, the National Academy of Social Prescribing, has been set up by the Secretary of State for Health and Social Care. The Academy's mission is to develop and advance social prescribing to promote health and wellbeing at local and national levels.[6]

As part of the National Health Service (NHS) Long Term Plan, NHS England has published a summary guide to social prescribing, regarded as a key component of Universal Personalised Care – the choice and control that people have over the way their care is planned and delivered.[7] As part of its Long Term Plan for the next 10 years, NHS England aims to recruit over 1000 trained social prescribing link workers within primary care networks by 2020/2021 and to integrate social prescribing into the personalised care remit with the objective of referring 900,000 people to such schemes by 2023/2024 (p. 25).[8] Furthermore, social prescribing in general practice, described as the use of referral and signposting to non-medical services in the community, is listed as one of 10 high impact actions needed to release time for GP care.[9] Other high impact actions related to social prescribing include active signposting that provides patients with a first point of contact to direct them to an appropriate source of help, such as web and app-based portals, and supporting people to play a greater role in their own health.

Arts on Prescription has a long history in the UK and the evidence base continues to grow, demonstrating a range of psychosocial outcomes that include supporting mental health recovery; combatting social isolation for people with mild to moderate anxiety and depression; as well as increased levels of empowerment and improved quality of life.[1,10] A review of Arts on Prescription studies illustrated a body of evidence indicating that participation in creative activities can promote health and wellbeing, quality of life, levels of empowerment and social inclusion, and positively impact people with mental ill-health.[10] Furthermore, the authors proposed that creative arts contribute to the health of the wider community, not just the individual. There is also good evidence to show that creative engagement in museums supports health and wellbeing, quality of life, social inclusion and lifelong learning. An extensive Museums on Prescription study, that carried out 12, 10-week programmes of museum-based sessions in seven central London and Kent museums with 115 participants, found significant wellbeing improvements.[3] Participants in the study, who were aged 65–94 and considered to be at risk of social isolation, rated highly the experiences of feeling absorbed and enlightened by the sessions and commented on the opportunities afforded by the museum activities to meet new people, learn new information and develop new skills.

Another type of social prescribing, 'green prescription' where outdoor spaces are used to improve health and wellbeing, is beginning to gain momentum, with a potential for impact across the life span.[11] Green prescriptions work under the same premise as social prescriptions, focusing on therapeutic engagement with nature-based interventions. A Scandinavian systematic review of 38 nature-assisted therapy programmes located three main types of intervention: horticultural therapy, wilderness therapy and unspecified nature-assisted therapy.[12] The authors found small but robust evidence to suggest that these different types of nature-based therapies were relevant public health interventions. Effects of these therapies included psychological, social and physical goals across diverse patient groups, with reduced measurable symptoms of disease in some cases, for instance, obesity and schizophrenia. An Australian review, using an expert elicitation process, categorised 27 distinct nature-based interventions.[13] Interventions were split into two categories: those that aimed to promote general wellbeing and prevent chronic health conditions through interaction with nature and those that aimed to treat specific physical, mental or social health and wellbeing issues through behavioural and environmental change. The review found that a key characteristic of nature-based health interventions is that a single intervention can potentially improve wellbeing across a range of domains. Nature prescriptions can promote physical activity leading to positive health outcomes, while contact with nature can have an additional restorative effect on mental wellbeing. As such, nature prescriptions can have significant impact as not only do they have multiple effects, they may have potential in terms of protective factors. Across both reviews, the authors called for more research to investigate the effectiveness of such programmes to promote their wider usage across public health.

A 2013 review evaluated the published literature on nature-based activities and found reliable evidence of the positive effects of gardening for mental health. The evidence included reduced symptoms of depression and anxiety, and a range of self-reported benefits across emotional, social, physical, occupational and spiritual aspects of the lives of mental health service-users.[14] Studies focused on mental health outcomes give further insight into the multiple effects of nature-based interventions that go beyond the benefits of contact with nature or physical exercise. Indeed, an additional potential positive effect of nature-based interventions is that they tend to be designed as social activities and therefore have the potential to mitigate social isolation and enable engagement with a person's community.[15] Qualitative studies further consolidate understanding of the psychotherapeutic mechanisms for how nature prescriptions can impact wellbeing, and mental health in particular. The social and occupational dimensions of activities are strongly associated with feelings of belonging allied with decreasing isolation and increasing social inclusion for people experiencing mental health issues.[16] In addition, as meaningful activities with opportunities for knowledge and skills developments, nature-based

interventions help to consolidate self-reliance and bolster self-esteem;[17] factors known to improve individual psychosocial wellbeing.[18] Conversely, poor self-esteem can be an indicator for the development of mental health disorders.[19] Improvements in self-esteem can be supported by programme designs that enable self-expression, personal growth and connectedness (with self and others) through meaningful occupation.[20]

The current UK-based study utilised the trend by museums and art galleries starting to use their outdoor spaces with a wider focus on wellbeing activities.[3,21] Since these activities are designed and delivered by museums, they are able to utilise the unique characteristics of their sites to bring together horticulture and gardening with creativity and culture. This article sets out to examine the potential of such a combination in a mental health intervention with adults, an area of practice not yet investigated. The current research was situated in a park adjoining an inner-city art gallery. It focused on a group project of dual engagement in green activity outdoors (including planting and clearing) and creative, arts-based activities indoors responding to collections with broad links to nature themes (including painting, print making and ceramics). The study was developed as a part of a larger research initiative called *Not So Grim Up North*, a collaboration between researchers at University College London and two museum partners, the Whitworth Art Gallery and Manchester Museum, part of the University of Manchester, and Tyne and Wear Archives and Museums. The current study reports on a project called 'GROW: Art, Park & Wellbeing', delivered by the Whitworth Art Gallery since 2015. The aim of this study was to explore the health and wellbeing outcomes derived from engagement in a combined programme of horticulture and creative, arts-based activities. In this sense, the study is unique and original in considering the dual effects of indoor and outdoor spaces, and the combination of arts- and nature-based activities. It was hypothesised for the quantitative phase of the study that measures of wellbeing would increase significantly reflecting positive improvements, such as social inclusion, that might be identified in the qualitative phase.

METHODS

Design

The project used a two-stage design following exploratory sequential mixed methods (p. 16),[22] where qualitative data collected in Phase 1 (September–December 2016) shaped quantitative data collection in Phase 2 (February–April 2018). Phase 1 used participant observation and in-depth, semi-structured interviews (Supplemental Appendix 1) derived from ethnographic methods to capture data in nature-based interventions.[23] Qualitative data comprised researcher and facilitator observation, interviews with participants ($n=10$ at programme-end; $n=1$ at 3- and 6-month follow-up), facilitators ($n=2$) and volunteers ($n=1$); and structured diary entries from participants ($n=12$) and facilitators ($n=2$). Phase 2 used a quantitative within participants design with an independent variable of pre- and post-intervention (Weeks 1 and 10) and dependent variable of psychological wellbeing score on the UCL Museum Wellbeing Measure,[24,25] specifically the positive generic wellbeing measure with high reliability (Cronbach's alpha = .81).

Participants

Phase 1 participants ($n=26$) and Phase 2 participants ($n=20$), with a mean age of 53 and age range of 26 (44–70 years), comprised 60% White, 30% Black and 10% Mixed race, with approximately equal numbers of males and females. They were recruited on the basis of accessing local mental health or social services through a community mental health nurse or day centre providing support to vulnerable and disadvantaged adults. Attendance across the project was varied with no single participants attending all 10 sessions of the programme. A different group of participants took part in each phase. Participant attrition reduced the Phase 1 sample size ($n=16$: males = 8); Phase 2 sample size remained constant ($n=20$: males = 11).

Materials

Materials included the participant information leaflet, consent form, museum activity schedule, interview protocol, weekly diaries with guideline questions and the UCL Museum Wellbeing Measure, a positive mood scale where participants rate each of six mood items (Active, Alert, Enthusiastic, Excited, Happy and Inspired) on a 5-point scale (1 = 'I don't feel'; 2 = 'I feel a little bit'; 3 = 'I feel fairly'; 4 = 'I feel quite a bit'; and 5 = 'I feel extremely').[24,25]

Procedure

Ethical approval was obtained for the research (Health Research Authority Ethics ID 199643). Participants were referred to the dual programme of outdoor horticultural activities and indoor nature-based creative activities, and were sent the museum schedule, consent form and information leaflet in advance of the programme. Informed consent was obtained by the research team prior to the start. The programme was coordinated by the Whitworth Gallery Cultural Park Keeper and delivered by a horticultural specialist, an arts tutor and a museum volunteer. The groups met in Whitworth Park and used the museum spaces to connect the indoors with the outdoors and nature. The 2-h sessions, comprising talks, demonstrations and practical activities, were held on consecutive Tuesdays over 10 weeks. A typical session started with a 15-min briefing prior to group work, with a 15-min break halfway through followed by group or individual work. Outdoor sessions comprised practical demonstrations followed by hands-on activities (e.g. using and maintaining garden tools, then cutting back herbaceous perennials) whereas indoor sessions included gallery visits or object handling followed by producing creative responses (e.g. looking at texture in an artwork, then using textured painting techniques to produce studies of parkland trees). Participants, facilitators and researchers kept weekly diaries with guideline questions to record their experiences. In Phase 1, participants and staff were interviewed at programme end with one participant interviewed at 3- and

6-month follow-up (not discussed here due to the small sample). In Phase 2, measures were completed before Session 1 and after Session 10. Data were anonymised and stored in a secure database.

RESULTS

For Phase 1, qualitative findings were derived from inductive thematic analysis of participant and facilitator diaries and interviews,[26] using NVivo v11, and for Phase 2, quantitative findings resulted from statistical analysis of pre–post intervention scores from UCL Museum Wellbeing Measure,[24,25] using IBM SPSS v25.

Phase 1: qualitative findings

An inductive approach was chosen as there are no other published studies on combined arts- and nature-based programmes. The inductive thematic analysis involved a six-phase approach consisting of familiarisation with interview transcripts and diaries, generation of initial codes, searching for themes among codes, reviewing themes, defining and naming themes and producing qualitative findings.[26] Three themes were inductively generated: building a sense of community, decreasing social isolation and supporting self-esteem. These themes worked together in shaping the collective experience of the intervention. As one participant elaborated,

> *I did feel a lot happier, every time I finished the session. I felt a sense of achievement very much so, self-esteem. . . a sense of belonging as well and doing something that refers to myself and especially with other people. It just made me feel not only more solid within my beliefs in myself and what I can do but a lot more connected, because it was done in a group session as opposed to a one-to-one.*

Examples of participant responses from across each of the three themes (Tables 1, 2 and 3) are discussed in turn below.

Sense of community

Across interviews, participants described how the programme had fostered a sense of community over the 10 weeks that had helped them to feel relaxed and enjoy the programme, as many commented that they were nervous on first arrival. Participants noted how the sense of community was facilitated by a number of related characteristics of the programme, first from knowledge and reassurance of taking part in activities with other people with shared experience of mental health difficulties:

> *It was very important to relate to people, that we had a common ground factor and that was our mental health experiences. Any other art group that wasn't focused around mental health, I would never be able to have the same chats and the same connection and the same understanding and empathy.*

This shared understanding of each other played a key role in building a sense of community in the programme. Although mental health was not discussed explicitly in the sessions, participants were aware that they shared a tacit understanding of mental health experiences. Support and sharing tended to happen spontaneously during breaks or activities on participants' own terms. Positive engagement was enhanced by facilitators and museum staff who recognised that participants were more than just their diagnosis.

Second, the programmes provided new, hands-on skills in both horticulture and arts-based practice, and this learning appeared to contribute to building a sense of community. In both set of activities, there were opportunities to learn together and further a common goal (e.g. planting) and for individual achievements (e.g. painting in response to a museum object or artwork). This unique combination of group and individual activities appeared to be key to producing positive outcomes for participants. As one participant reflected,

> *We all come together didn't we so . . . so at the end of it we all come as one. We were all together singly. Like the flowers, I suppose.*

Decreasing social isolation

Another effect of the intervention was related to enabling participants to gain motivation and a positive reason to leave their homes. Some participants led relatively isolated lives, while others reported spending a great deal of time at home alone, linked to unemployment and/or current mental health issues. Participants felt that the intervention gave them routine and structure with an opportunity to engage positively with others, which in turn decreased the sense of social isolation and was felt to support wellbeing and the potential of recovery. As one participant explained,

> *if you give people structure, then they don't . . . they won't get bored you see, and also it gives them some meaning, as well. And, especially if they are interacting with other people, that also helps people in their recovery, if people have to recover from something. Or, even maintaining wellbeing, interacting with others. I mean, nobody's isolated, you know, because then that's not helpful to the wellbeing*.

The programme could also be said to have an effect beyond the sessions as it gave participants something positive to look forward to during the week.

Self-esteem

Another key area related in interviews was the development of self-esteem through the programme. Several participants noted this in relation to becoming more outgoing as the session progressed, for example:

> *I've come out my shell which is really major, do you know what I mean? 'Cos usually I just curl up and feel sorry for myself and not go anywhere.*

Self-esteem was derived through social interactions around group activities outdoors where participants would help and support one another in activities (e.g. helping someone to dig), as well as supporting each other through informal, social discussion around the activities,

Table 1

Codes and quotes associated with building a sense of community

Theme	Codes	Quotes
Building a sense of community	Groups forming Connections Shared experience Learning Positive mood Green Space Art	'Like I say, the [...] group that came mostly seemed kind of happy and, bubbly and connected with each other anyway from the beginning right through to the end'. (Facilitator) 'Enjoyed mixing with group, growing with them'. 'So how we feel and how we're affected and so how our diagnosis or experiences of mental health issues might affect us and how we feel and how we act. So, quite important and still conversations that you wouldn't normally have . . .' 'What I've learnt here, especially the herbs and the gardening, I loved that'. 'Outside it's a kind of big park, so you have . . . it's just being close to nature in some ways. So, it feels alright, it's great'. 'Yes, because we were working . . . yes, the physical connection with the earth, the soil, I didn't think I would like that at all, but it's got an amazing satisfaction. I felt a lot more able to understand my mother being so fond of gardening after the sessions, or other people who are gardening obsessed'. 'I learned about art as I say and how to produce prints and how to dry some flowers. How to have the nature and the flowers and the nature itself can be, can be a source of art and inspiration for art'.

Table 2

Codes and quotes associated with decreasing social isolation

Theme	Codes	Quotes
Decreasing social isolation	Connections with group members and facilitators Routine and structure of getting out the house	'I always see a couple of the people at the group. Yeah. And hopefully when the group opens again, I'd like to return'. 'I found out I could work as well in a team . . .' 'It's just a feeling of doing something in a group really. It's basically that, doing an activity in a group which gave me a little bit, improved my confidence a little bit as the weeks went by'. 'Yes, yeah. It's just a bit, just a tiny bit easier being with strangers, just a tiny bit though. But yeah it's helped me a bit'. 'I liked getting up in the morning. I liked the fact that I had something to do'. 'It has provided some structure and an opportunity to be in a group with others while doing something interesting'.

both giving participants a sense of purpose. This was further enabled by the facilitation that modelled inclusive, supportive practice. As one participant summarised,

> *This is the point, if you're being supported, listened to, helped, it gives you self-confidence and self-worth and you try to do the same thing for [other participants].*

Self-esteem was also derived from the new learning and skills development about art and horticulture. One participant reflected on how they felt proud that their work could be enjoyed by other visitors to the museum park:

> *I felt very useful because I was helping the nature first and then I was going to make some people happy when they come out and they look very nice in in the spring. And people will enjoy it, enjoy the flowers that I put down on the ground.*

Phase 2: quantitative findings

Pre–post intervention UCL Museum Wellbeing Measure total scores (out of 30) and individual mood item scores (each out of 5) were analysed using descriptive and inferential statistical tests. Descriptive statistics showed that mean

Table 3

Codes and quotes associated with supporting self-esteem

Theme	Codes	Quotes
Supporting self-esteem	Confidence Agency and ability Purpose Meaningful occupation Motivation Participation	'While I was doing the course, my self-esteem has been sort of raised considerably to what it was'. 'Confidence really. The confidence to get out and about again. To meet new people. It was really a kick up the backside to get out'. 'I was feeling a bit nervous, a bit scared, not realising, it wasn't anything really to worry about. So, actually taking part helped my confidence a lot more'. 'Doing something I felt was worthwhile and sort of taking on board the praise I'd been getting from them, and, sort of just getting out of bed and coming here is a sort of reward in itself'. 'I've come out my shell which is really major, do you know what I mean? 'Cos usually I just curl up and feel sorry for myself and not go anywhere. Instead, I've been coming here, trying to get out the house, trying to get a life, there's only so much you can do with my illness, you know, but, it's great. I love it'. 'Connected with other people and, and in the process you find. . . you learn about yourself also. Because it's a group – other people become sort of a mirror and only in, in social situations a person can learn about himself'. 'I can do things that I like'. 'Don't need to be negative. I can do'. 'I am able to help others'. 'If you are participating in life, that is interacting to other living beings, and then that enhances you. It doesn't make you less in any way, you know, maintaining or enhancing [wellbeing], yeah'.

Table 4

Descriptive and inferential statistics for wellbeing

	N	Mean (SD)	*t* (df)	*p*
Preintervention wellbeing	20	16.70 (6.42)		
Postintervention wellbeing	20	25.30 (4.58)		
Pre–post wellbeing improvement		8.60	6.96 (19)	<.001

SD: standard deviation; df: degrees of freedom.

total scores for wellbeing increased postintervention compared with preintervention (Table 4, Figure 1). An inferential statistical paired *t* test on approximately normal data showed that the pre–post increase in wellbeing was highly significant, $t(19) = 6.96$, $p < .001$, one-tailed. Scores for each of the six mood items (Active, Alert, Enthusiastic, Excited, Happy and Inspired) were examined separately (Table 5). There was no missing data. Each of the separate mood items increased highly significantly postsession compared with presession and *t* tests showed no significant differences between individual mood items. The largest improvement across the intervention was for the word 'Excited' closely followed by 'Inspired' (Figure 2).

DISCUSSION

The aim of the study was to explore the health and wellbeing outcomes derived from a combined programme of nature-based horticulture and arts-based responses to museum collections as part of a creative green prescription. As Phase 1 produced a range of positive responses, it was hypothesised for the quantitative analysis, Phase 2 of the study, conducted two years later with another group of participants, that psychological wellbeing would increase significantly and reflect positive improvements identified initially through thematic analysis.

Thematic analysis of participant and facilitator interviews in Phase 1 revealed three main themes: building a shared sense of community, decreasing social isolation and supporting self-esteem. Each of these interacted to form the collective experience of the intervention; the sense of community supported a decrease in social isolation while self-esteem was boosted through social interaction. The sense of community was enabled by knowledge of shared experience but notably, this was not the main focus of the programme; rather, it was the types of activity and the non-clinical indoor and

Figure 1

Pre–post intervention wellbeing improvement (error bars ± 1 standard deviation (SD)).

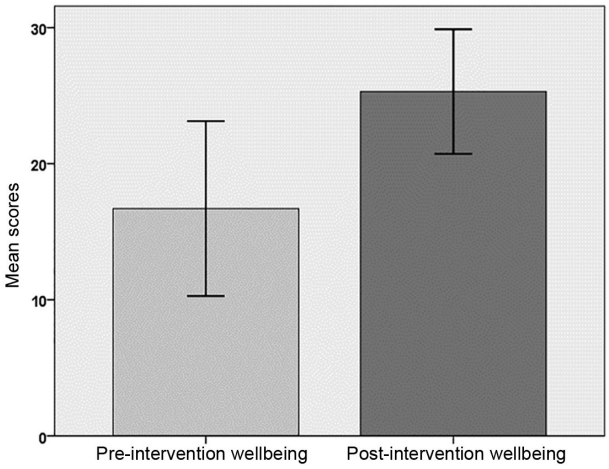


Table 5

Descriptive and inferential statistics for individual mood items

	N	Mean (SD)	*t*	df	*p*
Preintervention Active	20	2.65 (1.18)			
Postintervention Active	20	4.10 (0.91)			
Pre–post Active improvement		1.45	5.90	19	<.001
Preintervention Alert	20	2.70 (1.26)			
Postintervention Alert	20	4.10 (0.91)			
Pre–post Alert improvement		1.40	5.98	19	<.001
Preintervention Enthusiastic	20	2.95 (1.19)			
Postintervention Enthusiastic	20	4.10 (0.97)			
Pre–post Enthusiastic improvement		1.15	4.72	19	<.001
Preintervention Excited	20	2.10 (1.07)			
Postintervention Excited	20	4.20 (0.70)			
Pre–post Excited improvement		2.10	5.94	19	<.001
Preintervention Happy	20	2.95 (1.05)			
Postintervention Happy	20	4.35 (0.75)			
Pre–post Happy improvement		1.40	6.29	19	<.001
Preintervention Inspired	20	2.55 (1.20)			
Postintervention Inspired	20	4.50 (0.83)			
Pre–post Inspired improvement		1.95	7.94	19	<.001

SD: standard deviation; df: degrees of freedom.

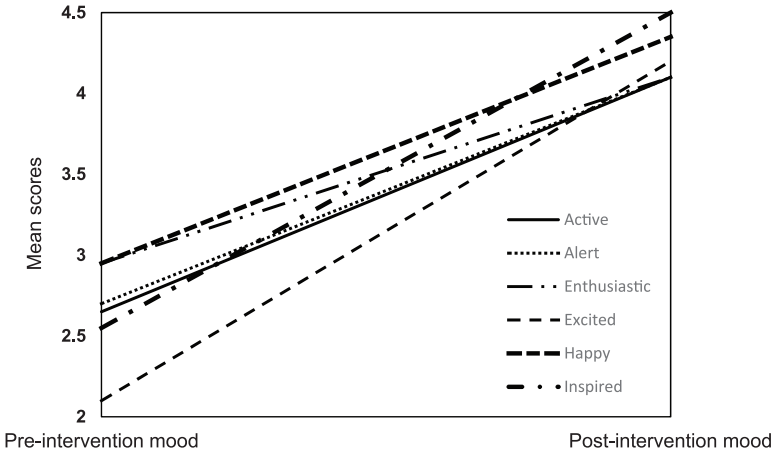
outdoor spaces of the museum that supported a sense of community first and foremost. The new learning gained from the programme, across both nature and arts topics, also contributed to a shared sense of community and individual self-esteem, thereby reducing feelings of isolation commonly reported by participants before the start of the project.

Although mental wellbeing was not mentioned explicitly by all participants, most of the themes they expressed had positive outcomes with many related to improvements in quality of life and individual, psychological wellbeing; consequently, it was appropriate to use the positive mood UCL Museum Wellbeing Measure for Phase 2 of the study.[24,25] Furthermore, support for self-esteem and allied confidence, agency, ability and sense of purpose are theorised to improve individual psychosocial wellbeing.[15] It was interesting that all of the six mood items on the Wellbeing Measure increased significantly after the 10-week programme, particularly 'Excited' and 'Inspired', that linked into the overall creative and outdoor experience of the intervention. These increases in positive mood, specifically in enthusiasm, inspiration, excitement and happiness, are conjectured to have arisen through the social, interactive and creative content of the programme. 'Active' also contributed to overall wellbeing, which could be related to the physical elements of the programme, in particular the outdoor horticultural activities. As such, and drawing on the wider literature, it can be speculated that the combined programme also had some physical health benefits, though these were not measured directly.

As a creative green prescription for adults with mental health issues, this study focused on engagement with a dual, arts- and nature-based intervention, and found predominantly positive biopsychosocial outcomes. Findings from the research need to be interpreted tentatively, however, due to the small sample size and the lack of a control group experiencing life as usual without the intervention. The unique aspect of this

Figure 2

Pre–post intervention individual mood item improvement.



programme was its delivery across two different environments, the park and the museum spaces. A future study, therefore, might compare the effects of a single intervention, arts- or nature-based with the effects of a combined programme. Currently, it can only be speculated that there were specific synergies between the dual aspects of the intervention, most notably in the creative and multisensory engagement,[27] that are likely to have supported positive outcomes alongside the social aspects of the project and the opportunities for new learning.

Within the literature, both arts- and nature-based interventions independently have been found to mitigate social isolation and enable engagement with a person's community.[3,10,11] In this study, these activities were effectively combined to produce similar outcomes. At the same time, there is some indication that this unique combination of physical and creative activities, and the outdoor and indoor museum spaces, may allow for additional benefits, as participants were able to engage in individual and group pursuits. Another aspect of note from this study is the sharing of past and current experiences of mental health that appeared to enhance social ties. While this intra-group sharing did not necessarily improve participants' relationships with people outside of their groups in the wider community, it could provide an area for further study.

A strong theme from this study was that the intervention bolstered self-confidence and self-esteem, aligning with other research.[14] Given that poor self-esteem can be an indicator for the development of mental health disorders,[16] it seemed pertinent that participants with mental health issues in this study should benefit from improved self-esteem. In addition, a challenge with common mental health disorder (anxiety and depression) is that it can co-occur with other factors such as social isolation, because people are reluctant to leave their homes, which in turn can lead to a lack of physical exercise from not going out. From this perspective, it is relevant to highlight the large significant pre–post increase in the feeling of being active, as shown in the UCL Museum Wellbeing Measure mood item analysis.

While there is limited previous research comparing arts- and nature-based interventions, these two forms of social prescribing appear to bring about similar health and wellbeing benefits, and further research is warranted to explain the underlying neuro-biopsychosocial mechanisms.[27] Similarly, the creative and multisensory aspects of these seemingly different types of activity need to be better understood, as do the connections between creativity, health and wellbeing, especially in relation to the neuro-biopsychosocial mechanisms underpinning creative health.

CONCLUSION

The *Creative Health* report argues that the arts and creativity can encourage a healthy lifestyle, aid recovery and support major health and social care challenges including ageing, long-term conditions, loneliness and mental health.[28] Research on engaging with nature shows similar advantages,[11,12] and here we report on the benefits of an intervention that includes both arts- and nature-based activities. Given the positive improvements for the two groups of participants in this study, held in a museum with adjacent parkland, it appears that green prescriptions, combining creative arts- and nature-based activities, have the potential to significantly impact the lives of adult mental health service users. Museums with outdoor spaces need to recognise the health, wellbeing and quality of life benefits in green prescribing, and the opportunities for combining creative outdoor and indoor activities using their spaces and collections.[27] The advantages that museums with outdoor spaces have over single green environments, such as forests or farms, is that they are not necessarily restricted by weather conditions, as collections-inspired activities can be continued indoors. Findings from this study link to the body of research on social prescribing,[1] where community referral can be used to support psychosocial outcomes.[2,3] Further research exploring interconnections between creativity, arts, nature, health and wellbeing outcomes is warranted to fully explain the dual, and potentially synergistic, benefits of creative arts and green prescriptions.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the Whitworth Art Gallery's Cultural Park Keeper, Francine Hayfron and the Arts for Health Manager, Wendy Gallagher; also the horticultural specialists and museum volunteers who supported the programmes, the community mental health and day centre staff who referred participants to the project, and in particular the participants who consented to take part in the research.

CONFLICT OF INTEREST

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

ETHICAL APPROVAL

Research and data collected from the Not So Grim Up North project and was approved by the University College London Ethics Committee (Study Ref.: 8297/001), and the Health Research Authority (IRAS IC 199643).

FUNDING

The author(s) disclosed receipt of the following financial support for the research, authorship and/or publication of this article: This study was conducted as part of the Not So Grim Up North project funded by Arts Council England (2015–2018; Grant: 29250851). The GROW Project and the Whitworth Gallery's creation of the Art Garden has been funded by Jo Malone, London.

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SUPPLEMENTAL MATERIAL

Supplemental material for this article is available online.

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The impact of participatory arts in promoting social relationships for older people within care homes

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Keywords
loneliness; older people; participatory arts; social isolation; social relationships

Abstract

Aims: Loneliness and social isolation negatively affect wellbeing and quality of life. Despite the proximity of others, older people living in care homes often experience loneliness and social isolation. The impact of participatory arts on wellbeing is widely acknowledged; however, relational impacts have received less attention. This article explores the impact of participatory arts in care homes on the social relationships between older people and older people and care staff.

Methods: 'Creative Journeys', an initiative led by Essex County Council, provides opportunities for older people living in care homes to participate in arts activities. In this study, three arts organisations (reminiscence arts, seated dance, and orchestral music participation) delivered participatory arts in three homes. Stage 1 of the research comprised mixed-methods case studies in each home. Stage 2 involved an online survey across care homes in Essex to provide a broader perspective, with follow-up interviews in three further homes, and a focus group with the arts organisations. Findings presented here focus on the qualitative data around the impact of participatory arts on the social relationships in care homes between older people and older people and care staff.

Results: Participatory arts enhanced social relationships between older people and between older people and care staff in care homes. Through engagement in shared experiences leading to increased communication and interaction, participatory arts facilitated social connectedness between residents, and changed the relationship dynamics between older people and care staff, thus promoting reciprocity.

Conclusion: Participatory arts enable older people to express themselves creatively, and make meaningful contributions to their social relationships. Policy makers and those working in the care sector should consider including participatory arts as an integral and necessary component of quality care for older people living in care homes.

INTRODUCTION

When older people move into residential care homes, they often experience loneliness and social isolation. Loneliness is a subjective experience with feelings of emptiness and rejection,[1] due to the number of relationships a person has, or the quality of those relationships not meeting their expectations.[2] In contrast, social isolation is an objective circumstance where a person has a small social network, or is separated from their network.[1] Loneliness and social isolation are clearly linked, but do not always present together; for example, a person may be isolated due to a small network but protected against loneliness by a few deep and meaningful relationships.[3] The direct consequences of loneliness are both social and emotional,[4,5] but loneliness and social isolation can also be detrimental to health, wellbeing and quality of life.[6] A recent literature review found the most prevalent health outcome of loneliness in old age was depression, while for social isolation it was cardiovascular problems.[7] In 2018, the UK Government launched the first Loneliness Strategy,[8] which implicitly addresses aspects of social isolation too. Similarly, the Campaign to

ISSN 1757-9139 DOI: 10.1177/1757913920921204

End Loneliness aims to tackle loneliness and social isolation particularly in older people.[9]

As people age, they may be more susceptible to experiencing loneliness and social isolation due to the loss of social networks through life transitions such as retirement, bereavement, reduced mobility and health deterioration.[6] Moving into a care home marks another life transition. Currently, 4% of those aged above 65 years and 16% of those aged above 85 years are living in care homes in the UK.[10] Despite the proximity of others, people living in care homes are twice as likely to experience loneliness compared with people living in the community.[11] Reasons for moving to a care home include poor physical health and/or cognitive impairments, which can create barriers to interaction between residents,[12] and establishing meaningful interpersonal relationships can be difficult.[13,14] Previous research has explored the importance of building relationships in care homes, and the different types of relationships that can develop;[15–17] the current research turns attention towards how these relationships can develop and be supported.

The impact of participatory arts on the wellbeing of older people is widely acknowledged.[18,19] The Creative Health Report[20] states that the arts can 'help meet major challenges facing health and social care' (p. 4) including ageing, loneliness and social isolation. However, there is little research that investigates how participatory arts may promote social relationships and therefore reduce loneliness and social isolation. A recent review of the literature identified that the arts promoted a sense of belonging to an artistic community and contentment with social lives, addressing discrepancies between desired relationships and reality.[3] Arts also facilitated interactions and enhanced social capital, helping to strengthen existing relationships and build new ones. Finally, arts enabled older people of all capacities to engage in meaningful social participation and make a valued contribution to their relationships and communities, indicating the potential of participatory arts to alleviate loneliness and social isolation experienced in care homes.

Introducing participatory arts in care homes presents an opportunity for residents to engage in 'meaningful activities', as recommended by the National Institute of Health and Care Excellence.[21] In terms of social relationships, it has been found that participatory arts programmes provided opportunities for meaningful social contact, support and friendship, improved relationships between people living in care homes, and fostered a better sense of social cohesion and community for those with dementia in care homes.[22] More recently, outcomes of improved communication, increased socialisation, and a better atmosphere have been identified.[23] These findings are significant given the central importance of relationships in the lives of residents.[13,24,25] However, none of these studies focused specifically on social relationships or social wellbeing, and most considered only one art-form. In contrast, the study reported here explored the impact of participatory arts across different art-forms on the social relationships between older people, and between older people and care home staff, within Essex care homes.

METHODS

'Creative Journeys' is an initiative led by Essex County Council's (ECC) Culture and Community Engagement Team providing opportunities for older people living in care homes to participate in a range of arts activities. Research undertaken by Anglia Ruskin University (ARU) and the Older People's Research Group, Essex (OPRGE), an independent research group led by and for older people, aimed to generate evidence for the impact as well as the mechanisms through which participatory arts can build social relationships and address issues of loneliness and social isolation in care homes. Ethical approval was received from ECC's Research Governance Group on 30 December 2016 and ARU's Faculty Research Ethics Panel. Members of the OPRGE contributed to each stage of the research. This article presents the qualitative findings from the interviews, focus groups, structured and unstructured observations and free-text survey comments across the two stages of the research. The full report is available elsewhere.[26]

Stage 1

Stage 1 of the research comprised case studies conducted in three care homes in Essex. Three arts organisations delivered a programme of activities in one of the three homes. Age exchange used reminiscence arts, theatre and story-telling to explore memories, stories and experiences. Activities varied, but often involved introducing an object/artefact to spark conversation and story-telling. They worked with eight female residents along with the activities coordinator for 2 h each week over 10 weeks, with the final two sessions lasting longer to facilitate filming the residents telling their stories. This care home had 106 beds across three floors that functioned as separate units. Residents who took part were from different units and were particularly frail, with specific physical/cognitive impairments which meant that initial plans to create a piece of theatre had to be adapted. Green Candle Dance Company facilitated seated dance activities for 12–20 female residents who took part in 2-h sessions each week for 12 weeks. Each session took a different theme that would determine the props and guide dance moves, such as the seaside. A pianist or guitarist would follow the flow of the sessions and provide live music accompaniment. A total of 54 residents lived in this home, 29 in the residential unit and 25 in the dementia unit. Those who took part were from both units and had a range of capacities and conditions, and were supported by two activities coordinators, a staff member who worked in the laundry and a family member who attended every week. Sinfonia Viva with Orchestras Live delivered orchestral experiences including activities such as residents singing, conducting and writing their own song. Around 20 residents were involved at different points over three half-day sessions that culminated in a final performance in a local venue. A professional orchestral composer and cellist led the sessions, with support

from a trumpeter, a violinist and an education officer. The care home had a total of 47 residents, many of whom had dementia to varying degrees. Two activities coordinators supported the programme, and many staff members, volunteers and family members helped with and attended the final performance.

Data collection methods included quantitative wellbeing and social relationship measures[26] observations, semi-structured interviews and focus groups with residents, relatives, care home staff and arts facilitators. Observations were undertaken by the first and third authors, as well as a member of the OPRGE at four full sessions in each of the homes ($n = 12$). A bespoke structured observation tool, the Social Interaction in Residential Settings (SIRS) observation schedule (see Supplemental material), was developed to capture the nature of the social interactions that occurred and what activities/actions/events preceded the interactions. Meanwhile unstructured observations captured wider contextual details. Observations were of all the residents, staff members and artists taking part in the sessions. Semi-structured interviews and focus groups were conducted by the first and third authors at the end of each programme with residents, care home managers, activities coordinators, care home staff, relatives and arts facilitators. They explored the impacts of the activities on social interaction and relationships, as well as perceived enablers and barriers. An example of one of the questions we asked the residents is: 'Was there anything about the arts programme that helped you to engage with other residents/staff in the care home?' and for activities coordinators: 'Have you noticed any changes in the relationships between residents and/or residents and staff?' Follow-up interviews with residents, activities coordinators and care home staff took place 3 months later to gauge the development and sustainability of impacts. Unfortunately, one of the care homes closed before the follow-up interviews took place. Across the case studies, we conducted interviews/focus groups with 20 residents, 12 care home staff and two relatives.

Stage 2

Stage 2 included an online survey to provide a broader perspective of the use of arts activities in residential care homes across Essex. Stage 1 data informed the survey development, with a total of 24 questions. These included a number of free-text questions to identify enablers and barriers to providing arts activities, perceived immediate and long-term impacts, and any particular qualities of arts and arts facilitators considered to promote those impacts. A total of 27 care homes took part in the survey, with 13 managers, 11 activities coordinators (or equivalent), one senior carer, one team leader and one admin manager completing the survey on behalf of their respective homes. Three care homes who completed the survey were invited to take part in follow-up interviews to explore the issues raised in more depth. Semi-structured interviews were conducted by the first and third authors with seven residents and 12 staff members (care home managers, activities coordinators and carers). Survey topics included what arts activities take place and who delivers them; what is the motivation behind delivering or participating in arts activities; and the effect they have on residents, staff; and connections with the local community, with a particular focus on social relationships. An example interview question asked of the residents is: 'Do you think there's anything special about arts activities that makes a difference to your relationships with other people?' and for care home managers: 'Can you tell me about whether you think the arts activities could be used to help to connect residents with the local community?' Finally, a focus group conducted by the second author took place with five representatives from the stage 1 arts organisations, exploring their shared learning, perceptions of the distinctive features of the art-forms that helped to build relationships, and perceived enablers and barriers to the impacts of the arts on social relationships.

The multiple data collection methods informed the overall understanding of how the arts impacted on social relationships in care homes, allowing for a more holistic view of the impacts and the mechanisms through which participatory arts can build social relationships.

Data analysis

The data from the interviews, focus groups, observations and free-text survey comments were subjected to thematic analysis following Braun and Clarke.[27] Group data analysis sessions (with ARU researchers and members of the OPRGE) enabled us to reach consensus on themes, and ensured rigour and transparency. Initial analysis was conducted after completion of the stage 1 data collection, with the research team individually reading through interview/focus group transcripts and observation notes and making notes about potential codes, followed by a group meeting to agree codes and collate themes. The first and third authors then re-read transcripts/observation notes to refine the themes and ensure key points in the data had been captured. All authors reviewed themes and agreed theme labels. Initial analysis then informed our survey, interview and focus group questions in stage 2. The same data analysis approach was followed for stage 2 data. The authors then reviewed the analysis from stages 1 and 2 and identified themes which cut across both stages (and across each method of data collection). Due to the similarities in findings across stages and data collection methods, it was deemed most appropriate to present themes from across both stages of the research. The findings below bring together data from across the different qualitative data collection methods to look at the impact of arts on the social relationships of older people in care homes.

RESULTS

The data showed that involvement in participatory arts helped to address issues of loneliness and social isolation by promoting the social relationships between older people and between older people and staff in care homes. Four overarching themes were identified: engagement in shared experiences,

communication and interaction, social connectedness and changing dynamics of relationships. A number of mediating factors that could be enablers or barriers to the impact of participatory arts on social relationships were also identified, including factors relating to the care context, such as the care home capacity and culture, the creative process itself, and the approach of the arts facilitator, which are described elsewhere.[26]

Engagement in shared experiences

Social relationships were facilitated through bringing people together for a shared experience, including residents who did not usually participate in group activities:

> *[I]t brings together residents that would not normally choose to do other activities and builds friendships within the home.* (Survey respondent)

> *It was nice to join with people, that perhaps you didn't see all that often.* (Stage 1 resident)

> *You meet more people, like, intimately, than you would normally ...* (Stage 1 resident)

> *One particular resident stood out as being someone that we've not really had great success in engaging with a group. He's a very solitary person, and has always, happily, done things on his own, and doesn't join in overly in a group. From the moment it started, he responded with both the music and the singing, and the actions actually. He was someone that definitely, we saw a huge difference in his way of being.* (Stage 1 care home manager)

Residents and staff were able to engage with each other and to a greater extent than they normally would when doing something creative and having fun together:

> *So, it's nice that they can talk to each other and learn more about each other. Because then it builds stronger friendships.* (Stage 2 staff member)

> *Again shared interests, laughing together, having fun together makes a bond stronger, getting to know families and develops easier communication*. (Survey respondent)

Finally, the activities enabled residents and staff to share quality time together, which is not always possible in care homes. These enjoyable shared experiences and quality time also promoted staff satisfaction and morale:

> *Yes staff do enjoy the activities. It helps when we have entertainers in as it can free up some time. It can mean the team enjoy an activity with the residents, it makes it a fun place to work.* (Survey respondent)

> *I certainly know a lot more people now, know a lot more about them, as well, and have interacted with a lot more than I would have done ...* (Stage 1 staff member)

> *Spending time with them doing stuff they enjoy makes us happier, to see them actually having a good time, rather than sitting and being quite withdrawn themselves.* (Stage 2 staff member)

Communication and interaction

Observations of the activities showed that residents expressed themselves verbally but also using non-verbal forms of communication, including facial expressions, smiling and making eye contact, and through modelling or mirroring dance moves and dancing with partners:

> *The skills that they picked up over that time were very varied, from the actual motor skills of expression and physical movement, and then, also, very creative skills.* (Stage 1 arts facilitator)

Touch was also observed as a form of non-verbal communication, particularly between care home staff and residents, for example, staff holding hands with residents, helping them to move to the music and hugging or stroking the arm of a resident when they were sharing emotional memories or were unsure of the activity.

In addition, new topics of conversation were initiated during the activities, sometimes about the arts themselves while other times the arts facilitator would encourage everyone to share ideas, memories and stories from their lives:

> *I saw how it affected people's relationships when they were talking about the music or the way they'd been encouraged to be involved in the discussions about lyrics and songs or what the actual programmes would involve. For me it was really interesting to see that actually it brought in some conversation to people's days because they do chat to each other but quite a lot of the time, because of their dementia, it can often be just nonsense really. This was a structured conversation ... they were just expressing their views.* (Stage 1 activities coordinator)

This helped all participants get to know each other and build their confidence in interacting with each other. Stage 1 follow-up interviews found that interactions and conversations continued outside of the arts activities, and residents had more confidence to get involved:

> *They've learnt each other's ways now. They feel comfortable with each other, so that means that when they go past each other they'll say, 'Hello'. They'll communicate and say, 'How was your day?' Rather than just walking by and going, 'Oh hello' politely ...* (Stage 1 activities coordinator)

> *... with one of my ladies, she's got more confidence to talk to people. And there's more people getting involved in things now.* (Stage 1 staff member)

> *Normally, if I sort of moved around the home, you go past people and you just smile. But, now we stop and say hello. We have a little chat. Yes, it has improved things.* (Stage 1 resident)

Social connectedness between older people

For residents, participatory arts produced a sense of collective enjoyment. This was demonstrated in the observations and the interviews, with participants not only

having a good time together but also feeling happy that other residents were enjoying themselves:

> *Enjoying each other's company, doing something together.* (Stage 1 resident)

> *I think it was the general atmosphere. Watching other people really enjoying themselves ... I really love it. I really do ... It was so nice ... seeing the people from the [dementia unit] getting so much out of it.* (Stage 1 resident)

Building on these connections, observations and interviews also showed how the residents supported each other during the activities, for example, by modelling dance moves or encouraging each other to join in:

> *If somebody wasn't sure what they were doing, and they were next to someone who did they really helped each other, which was lovely ... Then there was someone like [Gladys], who was, kind of, more encouraging people by being quite enthusiastic. So, she would get up and then other people would be like, 'Oh, we could do that too', and so she would encourage people in that more dynamic way.* (Stage 1 arts facilitator)

This suggests how participatory arts can promote reciprocity in relationships within care homes whereby residents are able to make a contribution by helping others. Responses to the survey also indicated how participatory arts provided opportunities for residents to support and praise each other, including those who may not be directly involved in the activity:

> *They appear to enjoy compliments within the peer group.* (Survey respondent)

> *Our residents' choir also has a great following from our non-participating residents.* (Survey respondent)

The closeness and camaraderie that developed through the participatory arts built social connections, for example, some residents in stage 1 described their new group identity as being a member of a *'club'*:

> *Yes, it's made it more a communal feeling.* (Stage 1 activities coordinator)

> *We didn't know each other before but we all felt close [during the activity].* (Stage 1 resident)

> *We were like a little family.* (Stage 1 resident)

> *I think they really interacted really, really well with each other, which created a very fantastic group dynamic. The best kinds of group sessions are always when the group take off ... and that camaraderie ... They listen to each other's stories.* (Stage 1 arts facilitator)

Residents developed new friendships or strengthened existing ones, and this led to a sense of community:

> *[Margaret] was a bit down because she was new here, but she's got friends now. She's made friends. She's got a best friend in [Mary] now because of [the activities].* (Stage 1 staff member)

> *I think coming together on those sessions, and then finally with the end result ... I think that definitely benefitted with certain friendships, because friendships have grown here. Different people, friendship groups, were being stronger because of it.* (Stage 1 care manager)

Changing dynamics between older people and care home staff

By participating in something new and different together, residents and care home staff were on a more equal footing, which changed the dynamics of their relationships. Observations and interviews suggested that residents could relate to the artistic material presented to them – such as familiar songs or old objects – and shared memories and knowledge of these things in the group, while care home staff were often unfamiliar with such history:

> *Oh yes. Oh anything where I knew the words, yes.* (Stage 1 resident)

> *They've [care staff] probably listened to Radio 1 their whole lives and then all of a sudden along comes classical music and it just brings a different power and emotion to it.* (Stage 1 activities coordinator)

> *... never heard anything like that before.* (Stage 1 staff member)

Residents were empowered to take on different roles within the group, for example, being the lead storyteller, dance instructor or music conductor, which changed the usual dynamic where care home staff lead day-to-day activities. It also helped staff and artists to see residents in a new light:

> *So, it was quite nice to see some of the more creative ones having an opportunity to be quite free and to be the leader. Because, actually, some of the people with more advanced dementia were actually more creative. So, to give them that time to lead and to feel ... a sense of ownership, I guess, was really nice.* (Stage 1 arts facilitator)

> *It's taught me a lot. It showed me a lot about my residents ...* (Stage 1 staff member)

> *She looks so disabled you think 'Is she just going to sit in the corner all the time like that, but listen and maybe enjoy it?' It was amazing that she turned out one of the lead storytellers, the most lively in terms of her engagement.* (Stage 1 arts facilitator)

In addition, residents became more confident in talking with care home staff. The activities enabled more informal and personal interactions. This was not limited to the staff that participated in the arts sessions, but also other staff who would ask residents about what they had been doing:

> *She's an open book now, she doesn't stop ... she's got the confidence to*

talk about things, now, and ask and say, 'Well, actually I don't like cornflakes. I want porridge, and I need someone to help me eat it because I can't'. (Stage 1 activities coordinator)

Well yes, the friendly talk, you know, about our lives as well as theirs. Yes. No. that was very good. I enjoyed it anyway. (Stage 1 resident)

I think for a start it can give us something to talk about to [the staff], because obviously the staff can't be here, but I think generally speaking, well let's say the bonding. It helps, definitely. (Stage 1 resident)

Finally, through involvement in participatory arts and watching the arts facilitators, care home staff learnt new skills and techniques for engaging with residents:

I learnt new interaction techniques, techniques to get a group of people able to communicate with each other more as well ... (Stage 1 staff member)

You just bring up bits and pieces about what they have mentioned about the past, and that is when they start feeling comfortable again, and then they will have a laugh and joke with you. It has brought a few of them out of themselves. (Stage 1 staff member)

DISCUSSION

The findings demonstrate the impact of participatory arts on the social relationships between older people and between older people and staff in care homes, with the potential to address issues of loneliness and social isolation. Engagement in shared experiences leading to increased communication and interaction has the potential to address social isolation in particular. Previous research reported that residents found it difficult to make friends and foster intimate relationships with other residents because they had no apparent common interests, and the ability to connect was even more difficult when residents had different levels of cognition.[13] Our findings, however, showed that the shared experience of participatory arts, promoted interactions within sessions and provided new topics of conversation for ongoing interactions. In addition, residents with cognitive impairments were able to express themselves through the arts, which may make it easier for them to engage with others. In terms of relationships between residents and staff, participatory arts allowed opportunities to share meaningful experiences and spend time together beyond care routines. Indeed, spending 'non-care' time together is crucial for residents to develop close friendships with staff.[25]

Social connectedness is a fundamental human need, and can be a protective factor against loneliness.[24] Our findings show that participatory arts promoted social connectedness through facilitating collective enjoyment, supporting and encouraging others, developing a sense of camaraderie and community and strengthening friendships. These impacts demonstrated reciprocity whereby residents were able to make a meaningful contribution to the group or relationship; an important factor in older people's relationships and wellbeing.[28] Residents are otherwise unlikely to be engaged in reciprocal relationships,[29] and can experience loneliness and a loss of meaning and identity as they transition to becoming largely cared for.[30]

Reciprocity was also observed in the changing dynamics between residents and care home staff. Residents shared knowledge and memories of objects and histories that staff had little awareness of and took on lead roles during arts activities, allowing staff to see them in a new light and value their contribution. Indeed, it has been suggested that reciprocity in caring relationships empowers not only the resident but also the carer, and benefits the whole care home community.[31] Furthermore, through the participatory arts, residents gained confidence, staff learnt new skills to engage residents, and both felt more comfortable to interact informally and on a personal level with each other. This is significant, as it has been suggested that relationships with staff are hugely important in addressing the loneliness and social isolation of residents and may become a substitute for their lost relationships with friends and family outside of the care home.[13]

Our findings clearly indicate the potential of participatory arts to respond to issues of loneliness and social isolation particularly in care homes. Despite this, the UK Government Loneliness Strategy[8] only mentions the arts as part of broader social prescribing schemes, which are unlikely to be inclusive of care homes. Similarly, in the Age UK and Campaign to End Loneliness report on approaches to reduce loneliness and isolation in later life,[32] creative approaches using the arts are only briefly referred to as part of group approaches that focus predominantly on coffee mornings and non-arts-based activities. The report identifies a knowledge gap in our understanding of loneliness and social isolation in care homes. Indeed, people living in care homes are often excluded from the discourse on loneliness and social isolation, evident in a recent analysis of characteristics and circumstances associated with loneliness in England,[33] which was based on data from people living in the community.

Though this research contributes evidence on the potential of participatory arts in tackling loneliness and social isolation in care homes, there were a number of challenges and limitations to the design. Challenges were centred largely around care home capacity and routines, and in conducting the research in the care context; for example, our methods did not include an established measure of loneliness or social isolation in part due to the challenges of employing established baseline and end-point measures with care home residents. Also, it would have been useful to have captured the views of residents and staff who had not participated in the activity and may have expressed negative views about the project. The arts organisations in the focus group also described instances in other care homes where staff had been unsupportive of the sessions although this was not observed in the case studies.

CONCLUSION

Participatory arts engage older people, enable them to express themselves creatively, connect with others including care home staff and provide the opportunity for them to make meaningful contributions to their social relationships in care homes. To implement this in practice we recommend training opportunities for care home staff, and particularly activities coordinators, in delivering participatory arts for their residents. This could be delivered as part of arts programmes from external arts organisations, who should aim to leave a lasting legacy through their work to promote sustainability. Furthermore, policy makers and those working in the care sector should consider including participatory arts as an integral and necessary component of quality care for older people living in care homes.

Further research into this area could look specifically at older people's feelings of social connectedness and reciprocal relationships within care homes, and how participatory arts can specifically target, encourage and promote these to address loneliness and social isolation.

ACKNOWLEDGEMENTS

The authors thank all of the care homes, residents, staff and family members, as well as the arts organisations and facilitators who participated in this research. The authors are also grateful to their partners and funders for supporting the research.

CONFLICT OF INTEREST

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

ETHICAL APPROVAL

Ethical approval was received from Essex County Council's Research Governance Group on 30 December 2016 and Anglia Ruskin University's Faculty Research Ethics Panel. Informed consent was gained from all research participants.

FUNDING

The author(s) disclosed receipt of the following financial support for the research, authorship and/or publication of this article: This work was supported by the Arts Council England Research Grants Programme 2016–2018.

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SUPPLEMENTAL MATERIAL

Supplemental material for this article is available online.

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