deeble institute evidence brief

title Is there compelling evidence for using the arts in health care?

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policy issue

A national arts and health policy framework being developed in 2012 proposes whole of government engagement to strengthen arts and health initiatives for community wellbeing (1). This framework should assist health providers at all levels to assess existing programs, consider new directions and identify community partners for using the arts to improve treatment and build health.

Arts and health practices create arts and cultural experiences that aim to improve health and wellbeing. The number of networks, projects and organisations contributing these practices to many different healthcare and community settings is increasing (2). The whole range of art forms, including craft, writing, music, theatre and drama, dance, visual arts, film and new media, and multimodal combinations of these, is being used (3).

This paper briefly outlines evidence of the effectiveness of arts and health strategies across the whole spectrum of population needs, from interventions targeting the complex needs of a few to those appropriate to all. The focus in this brief is upon arts-based practice in clinical contexts, but evidence concerning arts and health in the community is also included.

what does the evidence say?

The overall finding of the review is that utilising the arts in health settings can lead to greater effectiveness and efficiency in healthcare delivery. Evidence also suggests the potential for overall cost savings through better management of symptoms and reduced use of health services. Reductions in need for analgesia (4, 5), medication requirements (6) and in GP visits (7) have been documented.

Evidence is contained in many published reports and a few systematic reviews, and spans a continuum from the effectiveness of the arts in treating illness to the contribution of the arts in promoting and maintaining health.

Studies of different patient groups in various contexts show that involvement in the arts can reduce medication needs, increase tolerance of symptoms/treatment, reduce stress and anxiety, increase self-efficacy, improve personal and social skills, and improve communication with health professionals (8, 9). Outcomes are achieved through many different programs and strategies, and participation can take the forms of experiencing, making and performing art. The responses may reflect the fact that most participants in the studies we reviewed were self-selected: not surprisingly there is evidence of benefit for many participants, and little evidence of harm. Springham (10) however reports a compensable injury attributable to inadequate training and supervision of an art therapist. This, while an isolated finding, has important implications for healthcare management.

Acute and continuing care: interventions focused on individuals

Arts interventions take both passive and active forms, with a focus upon treatment.

1. Good design that facilitates contact with the natural world has a positive effect on the mood of patients, staff and visitors (11). This may be reflected in improved response to treatment and reduced hospital stay (12), improved job satisfaction for staff (13) and improved retention of staff (14).
2. Both observing and making visual art can reduce anxiety and stress, and help alleviate pain (15).
3. Music has been shown to be effective in reducing anxiety, alleviating stress and depression, reducing drug consumption, shortening length of stay in hospital (16) and improving clinical outcomes for a range of conditions (17). Studies include music being broadcast, delivered through headphones, or performed live.
4. Art making in participatory arts programs or with arts therapists has been shown to improve psychological and physical outcomes. Work with a therapist allows individual tailoring of strategies and the development of personal and social skills (18).
5. Staff development can be furthered through using arts-based strategies. There is evidence for improvement in clinical observation (19), communication skills, empathy across genders and cultures, better staff patient relationships, and job satisfaction (20).

The arts workforce producing these outcomes is diverse and largely professional. In

the acute care sector, arts therapists who may work with any art form are specialists employed by institutions or agencies, usually working with referred patients over

several sessions. Arts-based programs in acute and continuing care are conducted in most instances by these specialists or by project workers qualified in the arts, education, health, or a combination of these disciplines, in some cases supported by trained volunteers. Environmental and design strategies involve architects and design consultants.

Particular communities: interventions focused on specific groups

Studies focus upon arts and health interventions for populations in aged care, palliative care, mental health, disability, indigenous communities, and people with Acquired Brain Injury, Motor Neurone Disease or Dementia. The positive findings for good design and aesthetics in the environment also apply in particular ways to design for aged care, dementia care, and end of life care facilities (21). The most extensive evidence has been found in groups addressing mental health issues, where significant improvements in empowerment, mental health and social inclusion have been found (22-24).

Interventions and programs, in addition to those featured in acute care, focus on participatory arts, and often include singing, drama, storytelling, biography and reminiscence. Narrative has also been used to increase health literacy and provide patient support (25). Evaluations of arts programs across a wide variety of contexts have reported reductions in symptoms, reduced use of medication, fewer GP visits, increased social inclusion and self-efficacy, and enhanced living and social skills (26-29). Higher attendance and completion rates for arts-based programs in comparison with other primary care program referrals have also been reported (30).

These community programs are potential referral resources for patients discharged from acute settings; they develop arts literacy that can then be utilised in clinical contexts; and community arts programs develop resilience that enhances community capacity for chronic illness self-management and informal care.
The arts workforce producing these outcomes typically involves partnerships between the arts and health sectors, increasing the capacity of each (31, 32). Community artists develop capacity in health promotion whilst health education and promotion workers develop a wider repertoire of communication skills (33).

Population wide: interventions focused on society

Large-scale epidemiological studies in Scandinavia and the USA have found attendance at cultural events, exhibitions and performances correlates with increased wellbeing and decreased morbidity and mortality (34). Arts-based practices have been shown to enhance capacity to resolve social issues (35) and to assist in recovery from natural disasters (36). Further research is needed to establish the contribution of the arts to social determinants of health such as employment and social inclusion.

The cultural life of communities is a contributor to health, and an important referral source for health practitioners.

what is the quality of the evidence available?

The specific tailoring of arts projects and interventions to local contexts and clients makes comparisons of programs and strategies difficult, although outcomes are similar across a variety of participants from a range of settings and programs in several countries. Evidence is cumulative, justifying arts-based practices rather than leading to a synthesis identifying best practices (37).

Many reviews and reports comment that there is little evidence from randomised controlled trials (RCT), but Clift (38) reports a search of the Cochrane Library that found 27 Cochrane reviews and 49 other reviews of arts therapeutic interventions. These identified over 1000 randomised controlled trials, mostly conducted in acute care settings, although there were some controlled community studies. Thus there does appear to be high quality evidence for the effectiveness of arts-based interventions, although often it is embedded as a sub-theme of other studies. This evidence suggests arts-based practices are effective as a complement, rather than alternative, to other practices.

RCT studies usually intentionally bracket out the social, emotional and spiritual variables that are of primary interest to practitioners and consumers (39). This makes them less able to answer questions about process and best practice, particularly for participatory arts projects where there can be many steps between initiating a project and evaluating its outcomes. This complexity is one of the strengths of arts interventions: the fact that they attend more to participants' interests than particular professional techniques is important for client satisfaction.

There are notable gaps in the evidence. For example, cost-effectiveness can be inferred but is usually not calculated. Only a limited number of populations have been studied. Integrated models of care have yet to be implemented and evaluated, particularly models that link clinical with community contexts. Considerable further work is required to identify best practice, both in terms of strategies and workforce allocation.

what does this mean for policymakers?

Policy needs to link and coordinate the activities of arts therapists, primary care practitioners, community artists and volunteers. Interventions in a comprehensive arts and health program should include:

For the few: individual therapy provided by professional arts therapists; arts strategies for relaxation, pain relief, diversion, and self-management. This may involve improving team coordination around these therapeutic goals, and broadening arts therapist position descriptions to incorporate practice elements suggested by evidence.

For some: targeted participatory arts-based programs based around particular needs such as rehabilitation, reintegration, or return to work. This may

involve forming a range of partnerships within and between acute care, continuing care, primary care, community care and arts organisations.

For many: good design, arts in the environment; opportunities to attend performances and participate in cultural events. Access issues should be addressed by institutions and local communities, taking into account social inequity. This may involve improving liaison within healthcare institutions between infrastructure departments and clinical units, and between healthcare organisations and the network of cultural organisations in their neighbourhood.

We conclude that the evidence is sufficient to justify healthcare managers incorporating arts-based strategies in strategic plans. We further suggest that:

- An integrated care model is required to set up referral and consultation pathways between healthcare institutions, agencies and the community. An implication is a shift from project workers to continuing appointments in arts and health staffing.
- Large institutions or specialised institutions with arts therapists on staff, should consider including education, coordination, and consultation responsibilities in revised workloads for these specialists. This broadening of the role should allow institutions to attend to the diversity of programs as outlined above.
- Institutions and agencies without arts therapists on staff should consider engaging a sessional arts consultant/educator from another healthcare institution or from the community.
- Ongoing training of arts therapists to incorporate new responsibilities, and training of other staff members and volunteers, is needed to implement an integrated model of care. Some staff and volunteers will develop particular skills; others need to become familiar with arts strategies if they are to provide a supportive context for a variety of arts interventions. Skilled supervision is essential for non-specialist staff and volunteers working in the field.
- Priority should be given to forming partnerships between health care agencies and arts organisations. These partnerships should facilitate sharing knowledge, staff exchanges, and creation of joint arts and health events and programs.

key readings

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