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Participatory Arts and Wellbeing: Evidence, Mechanisms and Limits

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Abstract

The claim that participation in the arts improves health has moved from advocacy into policy, and it now supports referral schemes, commissioning decisions and funding streams in several health systems. This paper examines what the evidence actually establishes. It distinguishes receptive engagement, such as visiting a gallery or attending a concert, from participatory engagement in making, since the two have different evidence profiles and different plausible mechanisms. Cohort studies find consistent associations between arts engagement and outcomes including depression, loneliness and mortality, and the associations survive adjustment for the obvious confounders, though residual confounding by health and by socioeconomic position cannot be excluded from observational designs. Trial evidence is thinner, is concentrated in music and singing, and reports small to moderate effects on wellbeing measures with considerable heterogeneity. The paper then examines mechanism, drawing on frameworks that decompose arts activities into their component ingredients and trace their effects through psychological, social, behavioural and physiological pathways. The final sections address social prescribing, where the policy commitment has outrun the evidence, and the practical questions of dose, equity of access and the risk that instrumental justification displaces the intrinsic case for public support of the arts. The conclusion argues for a modest, specific and honest reading of a genuinely promising literature.

Keywords: Arts and Health, Wellbeing, Social Prescribing, Cultural Engagement, Loneliness, Evaluation

INTRODUCTION

Institutions that fund the arts have long argued that the arts do people good. What has changed in the past fifteen years is that the argument has acquired a quantitative literature and, following that, a place in health policy. Referral from primary care into community arts activity is now an established route in several health systems, and public health strategies increasingly name cultural participation among their instruments.

The evidence supporting this movement is real and it is uneven. A comprehensive scoping review commissioned by a regional health body examined more than three thousand studies and concluded that the arts have a role in the prevention of ill health, in the promotion of health and in the management and treatment of illness across the life course.[1] That conclusion is defensible on the volume of evidence assembled. It is also broad enough to accommodate a great range of underlying study quality, and the interesting question for anyone designing or commissioning a programme is narrower: which activities, for which people, produce which effects, and how large are they?

This paper works through that question. It separates receptive from participatory engagement, reviews the observational and trial evidence for each, examines the mechanisms proposed, and considers where the policy commitment has moved ahead of what the research supports.

TWO KINDS OF ENGAGEMENT

The literature covers two distinguishable behaviours that are often reported together.Receptive engagement means attending or consuming: visiting museums and galleries, going to the theatre, opera or concerts, reading. It is typically episodic, requires no skill acquisition, and is strongly patterned by education and income.Participatory engagement means making: singing in a choir, playing an instrument, dancing, painting, writing, taking part in drama. It involves repeated attendance, skill development and, usually, a group.

The distinction matters because the plausible mechanisms differ. Receptive engagement plausibly operates through aesthetic experience, cognitive stimulation and the social occasion of attending. Participatory engagement adds skill mastery, sustained group membership, role and identity, and in the case of singing and dancing a substantial physiological component. Studies that pool the two are measuring a composite whose parts may behave quite differently.

OBSERVATIONAL EVIDENCE

Mortality and physical health

The most striking findings come from long running cohort studies. Analysis of a national ageing cohort followed for fourteen years found that frequency of receptive arts engagement was associated with lower all cause mortality in a graded fashion, with the association persisting after adjustment for demographic, socioeconomic, health related, behavioural and social factors.[2] The dose response pattern is important, since a graded relationship is harder to explain by simple confounding than a threshold one.

The obvious objection is reverse causation. People who are already ill attend fewer concerts, and illness precedes death. The authors addressed this by adjusting for baseline health and by excluding early deaths, and the association survived, though no observational design can eliminate the possibility entirely. Unmeasured confounding by factors such as cognitive reserve, social network quality or personality remains plausible.

Mental health and loneliness

Cohort evidence also links cultural engagement to mental health outcomes. Studies of older adults report associations between receptive arts engagement and lower loneliness both cross sectionally and over time, with the longitudinal associations weaker than the cross sectional ones, as would be expected if part of the cross sectional relationship reflects selection.[3] Comparable analyses report reduced incidence of depression among those who engage regularly.

The pattern across these studies is consistent: moderate effect sizes, dose response gradients, and attenuation but not elimination after adjustment. That pattern is what one would expect from a real but modest causal effect operating alongside substantial selection.

TRIAL EVIDENCE

Randomised evidence is scarcer and is concentrated in particular art forms.The best developed area is music and singing. A systematic review of wellbeing outcomes for music and singing in adults found evidence of benefit for wellbeing measures, with the strongest results for group singing in relation to social wellbeing and belonging, alongside considerable heterogeneity in populations, interventions and outcome measures.[4] Reviews of creative activity in children and young people report similar patterns, with improvements in self esteem and self confidence and weaker evidence on clinical outcomes.[5]

Three methodological problems recur across this literature and should temper any confident summary.Blinding is impossible. A participant knows whether they are singing in a choir, and the expectation of benefit is part of what is being tested. Waiting list controls make this worse, since the control condition is not neutral.Outcome measures are inconsistent. Studies use a wide variety of wellbeing instruments, often selected after the fact, and selective reporting of the measures that moved is difficult to rule out where protocols were not registered in advance.Attrition is differential. Participants who do not enjoy an activity leave it, so the group measured at follow up is not the group randomised, and per protocol analysis of arts interventions is close to guaranteed to show benefit.None

of this means the effects are illusory. It means that the effect sizes reported in the literature are likely to be upper bounds, and that a programme designed on the basis of published effect sizes should expect to observe less.

MECHANISMS

Understanding why arts activity might affect health matters practically, because it determines which features of a programme are essential and which are incidental.One influential framework identifies the components of leisure activity and traces their effects through psychological, biological, social and behavioural pathways, cataloguing several hundred candidate mechanisms operating at individual, community and societal levels.[6] The value of the exercise is not the count but the structure. It makes clear that most arts activities operate through several routes at once, and that two programmes that look similar may share very few active components.

A complementary framework focuses specifically on arts in health activities and decomposes them into active ingredients relating to the project, the people involved, the contexts and the mechanisms of change.[7] The practical use of this approach is in replication. A choir that improves wellbeing in one setting may fail in another, and the framework provides a vocabulary for identifying which of the differences might account for it, rather than attributing failure to implementation in general. Table 1 sets out the principal pathways with an assessment of the evidence supporting each.

Table 1. Proposed pathways from arts participation to health outcomes, with the strength of supporting evidence

Pathway	Proposed process	Evidence status
Social connection	Regular group attendance builds and maintains relationships	Consistent across observational and trial evidence
Physical activity	Dance, drama and singing involve movement and controlled breathing	Strong for dance, moderate for singing
Psychological resource	Mastery, self efficacy and a sense of purpose from skill development	Moderate, mostly self reported measures
Emotion regulation	Aesthetic experience provides distraction, expression and reappraisal	Moderate, mainly short-term laboratory and diary studies
Stress physiology	Reduced cortisol and altered autonomic response during participation	Suggestive, small samples and inconsistent protocols
Cognitive reserve	Novel and complex activity sustains cognitive function with age	Plausible, difficult to separate from education and selection
Health behaviour	Participation displaces harmful behaviour and improves routine	Weak, few studies measure it directly

The distribution of evidence across this table is itself informative. The pathways with the strongest support, social connection and physical activity, are not specific to the arts. A walking group would engage both. This does not undermine the case for arts programmes, since the arts may recruit and retain people that a walking group would not, but it does bear on how the case should be made and on what the comparison condition in an evaluation ought to be.

SOCIAL PRESCRIBING

Social prescribing links patients from primary care to community activity, frequently including arts provision, usually through a link worker who makes the connection and provides initial support. Adoption has been rapid and evaluation has lagged. A systematic review of the evidence found that most published evaluations were small, lacked comparison groups, reported outcomes selectively and had short follow up, and concluded that the enthusiasm for social prescribing was not matched by evidence of effectiveness.[8] A parallel systematised review of schemes reached similar conclusions about study quality while documenting the range and diversity of what is offered.[9] More recent commentary on arts in public health policy notes both the growth of formal policy commitment and the persistence of the evaluation gap.[10]

Three specific difficulties account for much of this.Definition is the first. Social prescribing names a referral mechanism rather than an intervention, and the activities referred to differ so widely that pooling them produces an average without a referent.Counterfactual is the second. Many people referred would have found the activity themselves in time, so the effect of the scheme is smaller than the effect of the activity.Attribution is the third. Where a link worker provides practical help with housing, benefits or debt alongside the referral, improvement may be due to that help rather than to the activity, and few evaluations separate the two.

The reasonable position is that social prescribing is a plausible and inexpensive mechanism whose effectiveness is not yet established, and that continued expansion should be accompanied by evaluation designs capable of detecting failure. The current pattern, in which schemes are expanded on the basis of evaluations incapable of showing anything else, serves neither the evidence nor the participants.

ARTS ON PRESCRIPTION AND CARE SETTINGS

The general scepticism about social prescribing evaluation should not be extended without qualification to every programme within it, since some strands are better evidenced than others. Arts on prescription, in which patients are referred to a structured programme of creative activity over a defined number of weeks, has now been reviewed with meta-analysis. Drawing on seven studies that used a common wellbeing instrument, the analysis found a mean improvement of 5.82 points on that scale, with a confidence interval from 4.90 to 6.75, against a threshold of three points conventionally treated as the smallest change of practical importance.[11] Participants began with low baseline scores, which is consistent with referral operating as intended and also means that regression to the mean contributes to the observed improvement. Heterogeneity across studies was moderate, and longer programmes were associated with larger gains, which is the first reasonably direct evidence on dose in this literature.

The result is encouraging and it should be read with the design in mind. None of the pooled studies had a randomised control condition, so the estimate describes change over the course of a programme rather than change attributable to it. A single arm pre and post design in a self selected group with low baseline scores will overstate effect under almost any circumstances. What the analysis establishes is that participants improve substantially and consistently across settings, which is worth knowing, and not that the programme caused the improvement.

Care settings present a different picture again. Community based arts interventions for people living with dementia have been reviewed for cognitive outcomes, and the review found improvements in some cognitive and behavioural measures alongside considerable methodological weakness, with small samples, varied outcome instruments and short follow up.[12] The more consistent findings in this population concern engagement, mood and the quality of interaction with carers rather than cognition itself, and these may be the outcomes that matter most to participants and families even where they attract less research attention. Museums and galleries have developed programmes for this population, and the sector has argued that cultural institutions should be understood as partners in public health rather than as venues occasionally hired by it.[13]

EQUITY, DOSE AND DISPLACEMENT

Three practical issues deserve more attention than they receive. Access to the arts is patterned by income, education and geography, and the populations with the worst health are systematically those with the least cultural provision. A programme that operates by referral from primary care will reach some of these people, but a scheme that depends on existing local provision will deliver most where provision already exists. Arts and health policy that does not fund provision in underserved areas will widen the gap it intends to close.

Dose is largely unexamined. The literature reports frequency categories rather than tested doses, and almost no study compares intensities to establish how much participation is needed for how long. Cohort findings on frequency suggest that even infrequent engagement is associated with benefit, which is encouraging but is exactly the pattern that selection would also produce.[2,13] Displacement is a risk to the arts sector itself. Where public funding is justified instrumentally, by health outcomes, the arts become answerable to a standard of evidence that few cultural activities were designed to meet, and provision that fails to demonstrate health benefit becomes vulnerable. The instrumental case and the

intrinsic case for public support are not in competition intellectually, but they compete for the same budget lines, and a sector that has argued only instrumentally has weakened its position for the day the effect sizes are re-examined.

CONCLUSION

The evidence that arts participation is associated with better health is substantial and consistent, and the associations are graded, plausible and robust to adjustment for the obvious confounders.[1,2] The evidence that arts participation causes better health is weaker, is concentrated in music and singing, and rests on trials with structural limitations that inflate apparent effects.[4] Both statements are true and neither should be reported without the other.

For practice, three conclusions follow. Programmes should be designed around the mechanisms with the best support, which means sustained group participation rather than one off events.[6,7] Evaluation should be built in from the start and should be capable of returning a negative result, which social prescribing evaluation to date generally has not been.[8] And provision should be funded where it is thinnest rather than where it is easiest to commission, since otherwise a programme intended to reduce inequality will track it instead.

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