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A constructive-critical response to *Creative Health: The Arts for Health and Wellbeing* (July 2017) by the All–Party Parliamentary Group on Arts, Health and Wellbeing

Kate Phillips

ABSTRACT

The recent report from the United Kingdom (UK) All-Party Parliamentary Group on Arts, Health and Wellbeing is receiving widespread publicity across the media. Newspaper articles and social media posts espouse the benefits and importance of employing creative arts within the health domain, citing the report as proof of this. The report is inclusive of the entire range of arts practices, while its recommendations relate in the most part to UK policy and systems. The focus of this article is specific to visual arts practices and art therapy (art-for-health), but may have relevance across arts modalities and approaches (arts and health). This article questions the approach to the evidence taken in the report, and highlights the need for rigour, balance and impartiality in conducting research and presenting evidence. A case is made for the use of formal systematic reviews as appropriate ways to develop the evidence base. Another suggestion is a request for more explicit consideration of the ideological commitments underpinning beliefs about purpose and value within art therapy and the wider arts and health arena.

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Introduction

The United Kingdom (UK) All-Party Parliamentary Group on Arts, Health and Wellbeing (APPGAHW) published *Creative Health: the Arts for Health and Wellbeing* in July 2017, claiming to provide 'the most comprehensive overview of the field to date' (APPGAHW, 2017, p. 5). The report is interdisciplinary by nature and encompasses the full range of art modalities: music, singing, drama, literature, dance, performance, digital and visual art. It covers all health domains from preventative approaches to acute care and non-health domains such as festivals and other cultural events. The impact of the arts is considered from the patient perspective, and that of carers, health care trainees and professionals, other workers and the public. The report is inclusive philosophically and methodologically, comprising the arts therapies, participatory arts, personal arts practices, art in hospitals, environmental design and medical humanities.

This article grew out of an attempt to glean the information specifically relevant to visual arts therapists and practitioners. It is based on a collation of all the evidence cited in the document in relation to visual art, detailed in the Appendix. The article is a response to the report and the aim is to highlight the need for rigour, balance and impartiality in conducting research and presenting evidence. A case is made for the use of formal systematic reviews as an appropriate way to advance the evidence base. The feasibility of an overview is considered and philosophical explication is also called for; clear statements concerning the ideological commitments underpinning beliefs about purpose and value within arts and health are needed.

Discussion

The issue of evidence (both the question of whether there is any, and of what constitutes evidence) has played a central role within the interdisciplinary arena of arts and health for many years. In 1999, there was little evidence to support the use of art as part of health or social policy (Dept. for Culture Media and Sport. Policy Action Team 10, 1999). This led the Arts Council to commission a review 'to strengthen the existing anecdotal and qualitative information demonstrating the impact that the arts can have on health' (Staricoff, 2004, p. 4). Staricoff's (2004) report, *Arts in Health: a Review of the Medical Literature* is frequently cited in policy documents and other literature as presenting a convincing account of the beneficial impacts of the arts across health domains. The Staricoff (2004) report is not a systematic review per se, and does not include a comprehensive description of the search strategy or selection criteria of the studies cited. While the author describes the data evaluation as rigorous, the processes of quality assessment and date extraction are not explicit. The Staricoff (2004) report is heavily weighted towards music. It does not include community settings, nor artist-led initiatives in healthcare settings.

CONTACT Kate Phillips k.phillips@derby.ac.uk
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The Staricoff (2004) review is broad and includes the effects the arts can have on staff morale and skills as well as a role in terms of the quality and management of health services. These areas are outside the focus of this article, which relates to clinical outcomes for service users and their quality of life.

Fast forward to 2017 and the APPGAHW document similarly presents a case for the arts in healthcare, suggesting they are effective, relevant and affordable (APPGAHW, 2017). Both documents are significant publications, extensive and detailed, drawing together relevant evidence to promote the use of arts in healthcare. There has been a marked increase in the volume of service delivery and research activity within the field, as well as a broadening of the notion of health, reflected in the use of 'medical' in the 2004 report title (relating to the use of the arts predominantly in hospital settings), evolving to 'wellbeing' in 2017 (which has more broad connotations and applications). The report introduces the realm of arts and health and considers the challenges of definition and measurement inherent in exploring such complex concepts. There are sections on types of evidence, policy and the social and environmental determinants of health. The main body of the APPGAHW considers the use of the arts across the lifespan, from gestation through childhood and adulthood to the end of life.

The APPGAHW (2017 foreword suggests that using the arts 'to promote health and wellbeing, can help to realise the Prime Minister's vision of a shared society' (APPGAHW, 2017, p. 5). The transformative potential of the arts to change established practices and perspectives is identified. The arts are proposed as a means to counter and complement the medical model. While the relationship between art, health and politics is not fully explored, the ethos of using the arts to address the social determinants of health is espoused, suggesting something more fundamentally political than a more humanised version of the current system. Despite this hint of radical transformation, the presentation of the studies through the body of the report paints a picture of the arts as a panacea rather than provocateur. Moreover, the report is lacking a critique of the philosophical context of 'the evidence of efficacy' (APPGAHW, 2017, p. 5), or perhaps this belies a muddling of issues more broadly across the field. Endorsing the value of the arts as a public health intervention (while also embracing the arts' emancipatory potential) creates a tension that remains unexplored in this report. To what extent can arts initiatives effect measurable health outcomes and simultaneously challenge normative social inequalities and reframe conceptualisation of health?

The issue of instrumentalism, whether art is valuable in its own right and/or for what it can achieve, is addressed within the report with the assertion that 'it is the validity of art itself that can lead to better health and wellbeing' (APPGAHW, 2017, p. 5). This statement is somewhat unclear as the authors seem to foreground the intrinsic value of art ('validity of art itself'), but then describe this value in terms of social function ('lead to better health'). Perhaps they concur with Matarasso who states that 'usefulness can be beautiful and beauty useful'…[suggesting the arts are]…'neither use nor ornament but both' (1997, p. 81). It seems necessary to acknowledge that the arts, whilst they may have many uses and values, are discussed within the APPGAHW report within a health and social care context, thus ultimately in the service of something other than themselves. As Matarasso (1997, p. 80) says '[…] how much creative autonomy can you have with someone else's money?'

The tension between intrinsic and instrumental value remains central to the arts and health agenda. It seems at times that engagement with the arts is encouraged without sufficient formulation around identified need, theories of change, anticipated outcome or alternative approaches. Perhaps part of the difficulty stems from the scope of arts and health being so broad. The arts do not exist independently; they are not a noun (like a medicine to be applied in specific doses); nor are they an adjective (like exercise or eating, to be practiced within the bounds of moderation); but rather they represent an approach or attitude, and not a homogenous one. As forms of enquiry, expression and communication, they provide ways of engaging with and responding to the world. There is a risk that attention becomes directed at the finger pointing to the moon, instead of the moon; it is not the arts themselves, or 'any old art' that can effect change, as the APPGAHW (2017, p. 5 report states, their value comes from when they are appropriately, sensitively and thoughtfully implemented, when they are 'intelligently engaged'. The realm of arts and health could benefit from greater discernment regarding which aspects of the arts might be useful in particular contexts, and an occasional reminder that the improvements in quality of life can be achieved via various routes. Perhaps it is better to conceive of arts and health as part of an approach that values creativity and consideration (within healthcare). Adequate resourcing assumed, it seems that innovation coupled with respect for diversity and dignity are at the heart of successful interventions.

The report considers why 'if there is so much evidence of the efficacy of the arts in health and social care, it is so little appreciated and acted upon' (APPGAHW, 2017, p. 5). The report suggests that 'barriers are attitudinal rather than legislative or inherent in formal policy' (APPGAHW, 2017, p. 5). Despite considerable development in the arts and health field, a lack of traction in terms of evidence, appears to remain a central challenge. This could stem from a

lack of clarity about their purpose, that is to say, whether interventions are employed because of their health-improving potential, social impact or artistic integrity. Perhaps such confusion is an inevitable result of the essential sociopolitical nature of art within society. Perhaps a significant barrier is the scarcity of independent evidence.

Neither the Staricoff (2004) nor the APPGAHW (2017) document are systematic reviews, although both purport to provide comprehensive overviews of the field, and both attempt to situate current systematic reviews within that context. The Arts Council report cites six systematic reviews and the report language infers high regard for this approach (Staricoff, 2004). The APPGAHW (2017) report references about 20 systematic reviews from across the arts, but is critical in highlighting the potentially limiting nature of purely positivist paradigms and/or quantitative reviews that focus exclusively on whether something works.

Systematic reviews present an explicitly critical stance and method to the synthesis of evidence, gaining precedence across research disciplines for several years, having achieved such credence as to be described as 'one of the turning points in history' (Gough, Oliver, & Thomas, 2017). If research is about finding new knowledge, then systematic reviews can have two functions. As Gough et al. (2017) explain, they allow researchers to gather together what is already known about an area. This is a function in its own right as the synthesis can inform practice and policy (Gough et al., 2017). Synthesis of data involves 'conceptual innovation', some new form of understanding, rather than a sum of the information analysed. Furthermore, the review process also enables researchers to identify suitable areas for additional primary research. Indeed, Gough at al. (2017) highlight potential ethical implications in conducting primary research without adequate prior understanding of the relevant research. This can stop research being carried out that has known potential to cause harm, and can also stop unnecessary research where there is already a clear evidence base (Gough et al., 2017).

A systematic review differs from a literature review. In seeking to answer a research question with clearly defined parameters, a systematic review is inherently more focussed. There is an explicit intention to reduce bias, demonstrated by a priori design, including search strategy, inclusion criteria, data extraction, quality appraisal and data synthesis. The aim is usually to produce a comprehensive (exhaustive) and robust (valid and reliable) account of the evidence. Transparency and replicability are emphasised. The specific remit of the research is often delineated using Population, Intervention, Control, Outcome and Setting (PICOS).

There are currently about 30 English-language systematic reviews relating to arts and health, each one contributing a piece of the larger picture. I am in favour of the APPGAHW suggestion for consolidating the findings, and the repository initiatives by the University of Florida and the Royal Society for Public Health Special Interest Group already underway.

The Cochrane Collaboration (2017) have been producing overviews of systematic reviews for several years now. These bring together the findings of related systematic reviews. They have also made significant shifts in relation to the inclusion of qualitative data (Noyes et al., 2013). Nevertheless, Cochrane is not necessarily appropriate for arts and health; the biomedical focus means review groups are largely diagnosis-specific and the traditional notion of a hierarchy of evidence, with randomised control trials (RCTs) at the top, still prevails.

The APPGAHW (2017) report discusses the idea of an overarching review to consolidate the evidence base. Cochrane aside, trying to synthesise findings across the entire arts and health field would require considerable collaboration and coordination, and may be premature. The arts are variously employed across a multitude of populations and settings. Potential outcomes are diverse and appropriate controls debatable. This heterogeneity of PICOS is echoed in methodological affiliations. Even from a single philosophical standpoint such as a realist perspective, arts activities could operate through a profusion of potential context–mechanism–outcome (CMO) configurations with the resulting heterogeneity confounding aggregation. Moreover, overviews require systematic reviews. Meaningful systematic reviews require comparable high-quality primary research in sufficient quantities. Whether a realist evaluation is chosen, realistic expectations are necessary.

The topic of systematic reviews is inextricably bound up with methodology. The realist approach seems to be offered within the APPGAHW (2017) report as an alternative to systematic reviews; however, a realist perspective and a systematic review process are not incompatible. In fact, they are suggested as appropriate for complex interventions by leading proponents such as Pawson, Greenhalgh, Harvey, and Walshe (2005). A realist perspective is an approach to research and evaluation that extends the question of what works, to ask 'what works for whom, in what circumstances, in what respects and how' (Pawson et al., 2005). The basis of a realist perspective is the belief in causal mechanisms and an explicit attempt to discover and interrogate them.

Whether the realist approach adopted by the APPGAHW (2017) report is compatible with a relativist ontology is a potentially rich area for exploration. How is the prioritisation of subjective meaning compatible with the positivist assumptions of evidence-based medicine? Does the departure from a biomedical model to an approach that considers social

determinants of health, and expands notions of health to well-being, demand a critical realist perspective? Could such an approach, distinguishing objective reality from subjective knowledge, encompass meanings and motivations as well as trends and correlations?

The APPGAHW (2017, p. 40) report 'shows, multifarious physical and psychological benefits have been observed to arise from arts engagement in ways that evade simple description and a theoretical framework appropriate to all activity in the field has been elusive'. At the same time, the report suggests a realist framework. There is a distinction between theoretical framework and theory. A discipline may draw upon, test and build various theories or ideas which will rest on other theories and ideas (assumptions) about the nature of reality and our ability to know or understand it.

A realist approach need not sit in opposition to RCTs but may provide a suitable approach for synthesising evidence about complex (non-pharmacological) interventions. An RCT often represents many years of preliminary research, with a single mechanism of change established well before the trial. Realist evaluations are often used to elucidate mechanisms where research is less developed and/or there may be many mechanisms in operation. Within health and social care interventions, which do not lend themselves to experimental conditions, the intervention is considered within its wider interactive system. Despite the proposal of a realist approach within the report, there is little explicit reference to mechanisms. Whether the arts are utilised through therapy or participation, privately or publicly; if they are effective, is it not through a range of potential mechanisms? Surely arts and health practitioners draw on a range of skills to inform a process of assessment, planning, implementation and evaluation. This iterative progression involves exploration of strengths and limitations, and creative thinking to come up with possibilities (myriad intersecting mechanisms) that can then be tried on, accepted, rejected, suspended or modified (observed, tested, verified). The APPGAHW (2017, p. 40) report cites an example of the use of the arts allowing people to assert control (Daykin, Byrne, Soteriou, & O'Connor, 2010) and references Jacobs' (as cited in APPGAHW, 2017) work as a means of building trust through 'casual social contact at a local level'.

A sense of agency and social contact could represent two possible mechanisms through which the arts might exert an effect (for some people in some circumstances). Pawson (2017) raises the possibility of creating a mechanism library that maps the potential of different treatments. Perhaps this is a way forward for arts and health?

Neither the Staricoff (2004) report nor the APPGAHW (2017) report provide the kind of critique we need to advance the field. While the variable quality of studies is stated in both, neither document mentions adverse effects, nor do the documents give sufficient weight to the limitations of the included studies. If the arts have power, we must recognise this potential as an agent of social change or social control. We need to look critically at what is considered art and culture and the assumptions that underlie these conceptions. The role of advocacy must be exercised with caution to avoid the accusation of producing propaganda. Some have already commented that the field is awash with rhetoric and exaggerated claims (Belfiore, 2006; Mirza, 2006) or that much of the data is old and recycled (Stickley, 2007).

The APPGAHW (2017) report has missed an opportunity in this respect. Citing an example to support the use of the arts in perinatal care (Staricoff, Duncan, & Wright, 2004) the report (APPGAHW, 2017, p. 85) states the 'duration of labour has been found to be more than two hours shorter and requests for pain relief lower when an artist-designed screen has been installed in the delivery room'. However, the original research article is clear that reduced requests for pain relief were not found to be statistically significant, and limitations of this study include an absence of randomisation and lack of suitable control. In this study the control group could see infant resuscitation equipment, while the experimental group could not; this could be considered a confounding factor as sight of such equipment may increase anxiety. In addition, 'those cases that suffered medical complications were omitted from this research' to 'avoid any bias due to clinical intervention' (Staricoff et al., 2004, p. 24). This introduces a different potential bias, addressed through intention-to-treat analysis, a statistical concept where the data for all participants randomised, is included in the analysis (ignoring 'noncompliance, protocol deviations, withdrawal, and anything that happens after randomization') (Gupta, 2011). The prognosis balance created through randomisation is thus maintained and a more realistic estimate of the effect achieved (Gupta, 2011).

Given the volume of literature available, there are remarkably few references to art therapy (the author found under 20). References to research are fewer with no indication of how they are selected for inclusion within the report. Regarding chronic ill health in children, the report (APPGAHW, 2017, p. 92) suggests that art therapy 'diminishes fear and pain and helps to build coping strategies'. However, the reference given is a website that does not contain any links or references to research articles.

Significantly, the APPGAHW (2017, p. 6) report does not ask for increased funding or changes in legislation, suggesting that 'properly informed, realistic, unbiased assessments' will be sufficient to identify and operationalise (or harness) the healing potential of the arts. The report suggests that there is extensive evidence

and yet acknowledges much of it remains scattered, elusive or otherwise inaccessible. The report (APPGAHW, 2007, p. 7) calls for 'change in culture', citing 'decentralised leadership and collaboration … technical innovation with social innovation … greater staff, patient and community involvement in the design and delivery of services'. While a nod is made to the lack of rigour in arts evaluations, I maintain that the most important change of culture, which everything else can build upon, needs to be a commitment to rigour.

Conclusion

A certain quantity and quality of evidence is required to confidently present the strengths and limitations of various arts and health approaches. Systematic reviews can be used to accumulate data and as springboards to develop appropriate primary research studies. This primary research can contribute to further systematic reviews (or systematic review updates) in an ongoing process of refinement. An adherence to rigour in qualitative, quantitative and mixed-method primary and secondary research and evaluation will provide a much needed critical edge.

In addition, a commitment to exploring philosophical orientation (including ontological opposition) is a necessary pursuit rather than a distraction. Realist reviews have limitations; they might examine the effectiveness of an intervention, but they do so without questioning the value of the intervention or the assumptions it is based on (Edgley, Stickley, Timmons, & Meal, 2016). Critical realism often has an explicit anti-oppressive agenda. Adopting this kind of approach means critiquing not just the research findings, but the sociopolitical infrastructure that supports the production of such research. Arguably, as noted earlier, it is this socio-political environment which predicates the need for interventions in the first place.

Practitioners are adaptive; many art therapists pride themselves on their ability to sit with not-knowing, regarding this as the realm of possibility and insight. This 'not-knowing' relates to 'what works, for whom and in which circumstances' as well as what is mean by 'works'. These things can be discovered and understood through art processes. Perhaps suffering and pain are inevitable parts of the human condition and the role of art is to help us explore their meaning, and in so doing create meaningful lives, rather than taking a pill, or picking up a paintbrush with the aim of 'feeling better'. As the APPGAHW (2017) report suggests when quoting Samuel Johnson, the role of the arts is wide, diverse and nuanced. Health and well-being have connotations of lives well lived, and how to live well will always be a contentious matter. The amelioration of health-related conditions is only part of what there is to do and debate. Art therapists and art practitioners have an opportunity, or perhaps a responsibility, to consider their position in this regard. Are they agents of social control or agents of social change? Whether they align themselves with one position, or entertain both, there may be implications in relation to the expectations of commissioners and/or clients.

We certainly need more research! The report has created excitement and solidarity between disparate elements of arts and health. The review demonstrates the breadth of potential for arts and health and highlights some salient research. The recommendations are comprehensive and strategic, encouraging collaboration and communication across and within organisations and sectors, as well as amplifying the marginalised voice of the patient. Many of the recommendations are around sharing, promoting or embedding the value of art at an organisational level. This could be built upon to include highlighting the role of impartial evidence in establishing value and guiding action, be it strategy, policy, delivery or advocacy. Dissemination of research findings could be aided by systematic reviews (this was what they were developed for). The symbiotic production of rigorous primary and secondary research can progress the evidence base, taking it to a place where a truly comprehensive overview is possible. Critical enquiry within primary and secondary research (such as critical discourse analysis and critical realist reviews) can enrich the discipline. These kinds of approaches may be necessary to mobilise the population in critically addressing 'the burning injustices that undermine the solidarity of our society' (May, 2017) because 'the revolution will not be televised' (Scott-Heron, 1974).

Response from the All-Party Parliamentary Group on Arts, Health and Wellbeing

The All-Party Parliamentary Group on Arts, Health and Wellbeing is grateful to the author of this article and to the Arts and Health Special Interest Group of the Royal Society for Public Health for this critique of our *Creative Health* report and for granting us this opportunity to respond.

Creative Health came out of a two-year parliamentary Inquiry which aimed to 'inform a vision for political leadership in the field of arts, health and wellbeing in order to support practitioners and stimulate progress'. The Inquiry comprised 16 round-table discussions and various meetings with ministers, officials and key people in arm's-length bodies. *Creative Health* aimed to capture this process and to combine it with substantial desk-based research. The process was overseen by an Advisory Group, made up of academics, experts and practitioners in the field of arts and health (p. 159),

which met three times to guide the development of the report. Towards the end of the process, four Inquiry meetings were convened through which parliamentarians and others interrogated the evolving chapters of the report.

Early in the Inquiry process, a systematic review of the whole field of arts and health was ruled out. The basis of such reviews tends to be quantitative, whereas *Creative Health* argues for more qualitative and observational studies and advocates the gathering of testimonies and case studies. On 13 September 2016, an Inquiry meeting on evidence considered systematic reviews being conducted in discrete areas – including the excellent work being carried out by the What Works Centre for Wellbeing – and again ruled out a systematic review of the entire field as both impractical and undesirable. This meeting advocated a realist method on the basis that everybody's response to a subjective experience like arts engagement is different.

Creative Health acknowledges that 'Arts therapies have amassed evidence of the impacts of precise interventions' (p. 34), some of which are presented in the report. At the same time, we note that 'this is less the case for the participatory arts' and attempt to redress the balance while reporting the limitations of research into community-based arts and health activity.

In *Creative Health*, we take the arts to include not only 'music, singing, drama, literature, dance, performance, digital and visual art' but also crafts, the culinary arts and gardening – as 'shorthand for everyday human creativity' (p. 19) – and we acknowledge the impact upon health and wellbeing of the built and natural environment. Rather than referring to 'the arts' as an abstract noun, we speak about engaging with the arts as a verb. We acknowledge that 'the arts are not anodyne; they allow us to access a range of emotions, including anguish, crisis and pain, which can serve as a preferable alternative to being sedated' (p. 20). We recognise many first-order benefits of arts engagement, and we frame any health and wellbeing benefits as positive side effects of such encounters. In a section on Environmental Adversity (pp. 28–29), we provide hints about the mechanisms through which this might operate, but we take pains to avoid blanket explanations and utilitarian approaches.

It is important to stress that *Creative Health* is a parliamentary rather than an academic report. Its purpose is to achieve change in policy and practice, and it is against that test that its usefulness is most appropriately judged. *Creative Health* takes as its starting point current priorities in health policy and aims to illustrate how these might be addressed through arts engagement. Much recent health policy recognises the significance of the social determinants of health and the necessity of ironing out the gross health inequalities that blight our society. We discuss ways in which arts engagement can interact with education, employment and housing to improve health. We point to the long-term potential of this approach, and we identify a need for more research in this area.

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Notes on contributor

Kate Phillips is a PhD candidate at the University of Derby, Derby, UK, supervised by Professor Susan Hogan and Professor David Sheffield. She gained a bachelor's degree in visual art from Lancaster University and a master's degree in art psychotherapy from Goldsmiths College, University of London. Her work within health and social care spans acute psychiatry, primary health care and humanitarian settlement in the UK and Australia.

Kate's current PhD research is on the role of art-based interventions to support the well-being of refugees and asylum seekers. She is interested in understanding whether the non-verbal and symbolic potential for expression can provide a unique form of intervention where factors such as language, culture and trauma may influence efficacy and acceptability.

Through conducting a mixed-methods systematic review, inclusive of art therapy and other art-for-health initiatives, she has become increasingly interested in promoting scientific rigour within this interdisciplinary area. Kate is the Early Career Researcher representative on the committee for the Royal Society for Public Health Special Interest Group in Arts and Health.

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Appendix

Mental health

- patient outcomes are 'affected by noise, lighting, colour, windows, views and art' (Daykin & Byrne, 2006 as cited in APPGAHW, 2017, p. 68)
- 'the arts supported healing environments by "enhancing valued features and diminishing negative aspects. Most importantly, the arts created opportunities for service users and staff to assert control and affirm non-stigmatised identities"'. (Daykin et al., 2010 as cited in APPGAHW, 2017, p. 68).

Postnatal depression

- improvements in general health, reduction in levels of depression, reduced GP visits and increased social participation (Tyldesley & Rigby, 1997, as cited in APPGAHW, 2017, p. 74)

New mothers and new-borns

- 'Visual art and music relieve the pain and anxiety of childbirth, lead to weight gain in premature babies and encourage parent–child bonding' (APPGAHW, 2017, p. 85).

Parent of premature babies

- 'alleviates the stress of parents waiting at bedsides, simultaneously providing a welcome distraction from, and a focus of artistic attention onto, their premature babies' (White, Anderson, Stansfield, & Gulliver, 2010, as cited in APPGAHW, 2017, p. 492)
- 'The duration of labour has been found to be more than two hours shorter and requests for pain relief lower when an artist-designed screen has been installed in the delivery room' (Staricoff et al., 2004, as cited in APPGAHW, 2017, p 84)

Children/young people

- 'eases the transition to adulthood and providing continuity with peers … social and emotional benefits derived from group creative activity by both participants and parents' (Black, n.d., as cited in APPGAHW, 2017, p. 87)
- 'a positive association between the development of socio-emotional skills and (early childhood engagement with) all the branches of the arts under investigation' (Menzer, 2015, as cited in APPGAHW, 2017, p. 89)
- 'arts/ creative projects have the potential to address young people's sense of self-worth and life skills as a mechanism for promoting behaviour change and healthy lifestyles' (Bungay & Vella-Burrows, 2013, as cited in APPGAHW, 2017). Conclusion of Bungay and Vella-Burrows (2013) report: 'Although the research evidence is generally weak there is some evidence that using creative activities as part of a health-promoting strategy may be a useful method of increasing knowledge and positive behaviours in children and young people.'

Hospitalised young people

- 'External evaluation suggested that the young people taking part gained physical, cognitive, social and emotional benefits. Young patients said how much they looked forward to the workshops, and parents expressed joy at seeing their children deriving so much pleasure from creative activities. Staff shared the enthusiasm of parents, while the artists gained satisfaction from the opportunity to make a positive difference to people's experience of hospital.' (Adam, 2016, as cited in APPGAHW, 2017, p. 99)

Working age

- 'aiding recovery from anxiety and depression', 'Seventy-one percent of participants reported a decrease in anxiety, and 73 percent reported a decrease in depression. Sixty-nine percent of participants reported an increase in social inclusion, while 76 percent of participants reported an increase in wellbeing. Participants rated their experience very favourably; 77 percent reported a development in their art skills; 64 percent reported an increase in confidence; 71 percent reported an increase in motivation and 69 percent reported feeling more positive about themselves after taking part.' (Potter, 2013, as cited in APPGAHW, 2017, p. 103)

War veterans

- 'visual arts activities contribute to emotional recovery' (APPGAHW, 2017, p. 106)
- 'Art therapy unlocks pathways to recovery from post-traumatic stress while participatory arts aid the transition from military to civilian life' (APPGAHW, 2017, p. 113)
- 'Between 2012 and 2014, 87 percent of veterans who completed the programme saw a reduction in their PTSD symptoms and co-morbid anxiety and depression, anger and alcohol use, and this was maintained at their six-month follow-up' (Combat Stress, 2017, as cited in APPGAHW, 2017, p. 111)

Older people

- 'a reduction in loneliness over the initial period, with some participants also reporting improvements in their health' (Windle, George, Porter, McKay, & Culliney, 2016, as cited in APPGAHW, 2017, p. 127)
- 'as compared to a group engaged in art appreciation – participants who actively produced art over 10 weeks showed greater functional connectivity in the brain, which was related to stress reduction and psychological resilience' (Bolwerk, Mack-Andrick, Lang, Dörfler, & Maihöfner, 2014, as cited in APPGAHW, 2017, p. 131)
- 'creative strides being made by participants and new relationships being forged' (APPGAHW, 2017, p. 127)
- 'new links between participants and healthcare staff and among neighbours in rural areas' (Memories Through Music, an intergenerational community project designed to alleviate isolation in older people, n.d., as cited in APPGAHW, 2017, p. 127)

Care home residents

- 'Interim evaluation suggested improvements in residents' wellbeing and the quality of care being provided by staff' (cARTrefu – arts in care settings | Arts Health and Wellbeing, n.d., as cited in APPGAHW, 2017, p. 129)

Dementia

- 'that the episodic memory of people with dementia could be enhanced through aesthetic responses to visual art' (Eekelaar, Camic, & Springham, 2012; Young, Tischler, Hulbert, & Camic, 2015, as cited in APPGAHW, 2017, p. 135)
- 'arts-based activities had a positive impact on cognitive processes, in particular on attention, stimulation of memories, enhanced communication and engagement with creative activities' (Young, Camic, & Tischler, 2016, as cited in APPGAHW, 2017, p. 131)
- 'benefits ranging from mental stimulation to increased confidence and a positive outlook' (Harper & Hamblin, 2010, as cited in APPGAHW, 2017, p. 128)
- 'provides familiarity with people's life stories and capabilities, opening the way for people with dementia to benefit through the arts.' (http://www.westminsterarts.org.uk/)

In relation to dying

- 'Through the arts, we can transcend suffering and enable our own healing' (Lidzey, 2008, as cited in APPGAHW, 2017, p. 142)