Culture, Sport and Wellbeing Evidence Programme

Systematic Review #3 Protocol

Visual Arts, Mental Health and Wellbeing

SR#3 Team (in alphabetical order): Dr Kerry Ball, Professor Norma Daykin, Professor Paul Dolan, Ms. Lily Grigsby-Duffy, Dr Alistair John, Professor Guy Julier, Professor Tess Kay, Mr. Jack Lane, Dr Louise Mansfield, Professor Catherine Meads, Dr Christine Tapson, Mr. Stefano Testoni, Professor Alan Tomlinson, Professor Christina Victor

Background

The aim of this systematic review is to evaluate the subjective wellbeing outcomes of visual arts interventions for adults ("working-age", 15-64 years), who have been diagnosed with a mental health condition.

Mental health conditions represent almost 50% of all illnesses in people younger than 65 years (Uttley et al., 2015). Whilst mental health problems account for a high degree of sickness, the NHS budget to treat people with mental illness is relatively modest, and the costs (from unemployment, sick leave, crime, etc.) and impact of mental illness on an individual and community level are significant. The Organisation for Economic Co-operation and Development (OECD) estimated that - in 2015 – mental health problems cost the UK economy approximately £80 billion (Naylor et al., 2016). Therefore, the NHS has come under increasing pressure to initiate cost-effective alternatives to better manage the needs of people suffering from mental health conditions (Uttley et al., 2015). It is progressively recognised that visual arts projects can reduce the burden on the NHS (White, 2004), by encouraging community relationships and providing skills that increase personal expression and control (Malley et al., 2002). As Professor Michael Marmot points out, the degree to which people are able to participate in their community and exercise control over their own lives, provides a 'critical contribution to psychosocial well-being and health' (Foot, 2012: 3).

The notion that arts-based initiatives can be beneficial for wellbeing and mental health is increasingly acknowledged, with a growing evidence base reinforcing anecdotal claims (Clift, 2012). Visual arts interventions have been shown to reduce anxiety and improve mood (Bell and Robins, 2007), enhance self-reported health (Johansson et al., 2001), promote personal growth through skill acquisition and improve self-esteem and quality of life (Hacking et al.,

2006), and prevent re-admission to psychiatric hospitals (White, 2004). In clinical healthcare, people are commonly regarded as patients (Smith, 2002), whereas in arts-based initiatives, people can become artists with genuine control over what they are doing or creating (Argyle and Bolton, 2005). Argyle and Bolton (2005) found that practical involvement in visual arts provided a range of health and wellbeing benefits for vulnerable and mentally ill participants. They also highlight the relatively low cost of administering something simple, such as a drawing group, which can have a highly valuable outcome for people and communities (Argyle and Bolton, 2005).

Previous evidence reviews in this field have focussed on; the wellbeing and mental health benefits of arts attendance and participation (Jindal-Snape et al., 2014); the clinical effectiveness and cost-effectiveness of art therapy for those with non-psychotic mental health conditions (Uttley et al., 2015); the wellbeing outcomes of participatory arts for older adults (Castora-Binkley et al., 2010); the therapeutic benefits of creative activities on mental wellbeing (Leckey, 2011); and the impact of art, design and environment in a mental healthcare setting (Daykin et al., 2008). The evidence in the aforementioned reviews generally points to positive wellbeing outcomes for participants involved in visual/creative art interventions and projects. However, it is widely acknowledged that a substantial degree of evidence supporting these claims lacks reliability and validity, and is indistinct in the clarity of key terms, such as mental health and wellbeing (Leckey, 2011). Whilst visual arts interventions are increasingly understood as a public health resource, which can support health and wellbeing, there needs to be a higher level of robust and critical evidence of their effectiveness, outcomes and real costs (Public Health England, 2016). Systematic reviews play a crucial role in gathering and extracting meaningful and influential evidence, but are equally valuable in locating gaps in research, exposing methodological inadequacies (and triumphs) and identifying future, more rigorous, research objectives.

To our knowledge, this is the first systematic review to specifically focus on the subjective wellbeing outcomes associated with visual arts participation for working age adults (15-64 years) who have been diagnosed with a mental health condition.

Title

A systematic review of the wellbeing outcomes of visual arts for adults (“working-age”, 15-64 years) with mental health conditions, and of the processes by which wellbeing outcomes are achieved.

Research Questions

1. What are the subjective wellbeing outcomes of engaging with (taking part in, performing, viewing) visual arts for adults ("working-age', 15-64 years) with diagnosed mental health conditions?

2.What are the processes by which the subjective wellbeing outcomes are achieved?

Criteria for considering reviews for inclusion

Population / types of participants

Adults ("working-age", 15-64 years) with a diagnosed mental health condition, but excluding dementia. The population will include any group or individual taking part in, performing or viewing visual arts, but not as paid professional artists. We will include studies from countries economically similar to the UK.

Types of interventions

Focus on participatory visual art interventions including making, viewing and performing. This will exclude art therapy for clinical outcomes but will include arts-based wellbeing interventions offered by a range of professionals and volunteers. We will also exclude evidence relating to paid professional artists and clinical procedures such as surgery, medical tests and diagnostics.

Comparison

No visual art intervention or usual routine/care, i.e. an inactive comparator or historical/time-based comparator, and including studies with an alternative intervention as the comparator/comparison group (for instance, sport or drama intervention).

Types of outcome measure

Included studies must have measured wellbeing. Studies will need to have measured subjective wellbeing using any recognised method or measure.

For the health economic component key outcomes are the outputs from cost, cost-utility, cost-effectiveness, cost-benefit and cost-consequence analyses.

Types of studies / study design

Empirical research: quantitative, qualitative or mixed methods, outcomes or process evaluations, and published from 2007-2017, will be included. Grey literature and practice surveys published from 2014 will be included. Discussion articles, commentaries or opinion pieces not presenting empirical or theoretical research will be excluded.

Search methods for identification of reviews

Electronic searches

Electronic databases will be searched using a combination of controlled vocabulary (MeSH) and free text terms. Search terms will be incorporated to target empirical evidence on visual arts, mental health and wellbeing. We will incorporate specific filters to identify health economic evaluations. The OVID MEDLINE search strategy can be found below. All database searches will be based on this strategy but will be appropriately revised to suit each database. The following databases will be searched from 2007-2017:

- PsychInfo
- OVID MEDLINE
- Eric
- Arts and Humanities Citation Index (Web of Science)
- Social Science Citation Index (Web of Science)
- Science Citation Index (Web of Science)
- Scopus
- PILOTS
- CINAHL
- International Index to Performing Arts (IIPA)

For the review of health economic evaluations we will separately search the following databases:

- OVID MEDLINE
- Scopus
- CINAHL
- NHS EED (NHS Economic Evaluation Database)
- HTA Technology Assessment) database

Searching other sources

The reference lists of all relevant systematic reviews from the last 5 years will be hand-searched to attempt to identify additional relevant empirical evidence. A search of 'grey literature' will be conducted via an online call for evidence. Grey literature will be included if it is a final evaluation or report incorporating empirical data, has the evaluation of a visual arts intervention as the central objective, was published between 2014-2017, and includes details of authors (individuals, groups or organisations).

Identification of studies for inclusion

Search results will be independently checked by two overview authors and eligible studies will be included. Initially the titles and abstracts of identified studies will be reviewed. If it is clear from the title and abstract that the study does not meet the inclusion criteria it will be excluded. Where it is not clear from the title and abstract whether a study is relevant the full article will be checked to confirm its eligibility. The selection criteria will be independently applied to the full papers of identified reviews by two overview authors. Where two independent reviewers do not agree in their primary judgements they will discuss the conflict and attempt to reach a consensus. If they cannot agree then a third member of the review team will consider the title and a majority decision will be made. Studies in any language will be included.

Data collection and analysis

Data extraction and management

Data will be extracted independently by two overview authors using a standardised form. Any discrepancies will be resolved by consensus. Where agreement cannot be reached, a third overview author will consider the paper and a majority decision will be reached.

For quantitative evidence of intervention effectiveness, the data extraction form will include the following details:

- Evaluation design and objectives (the interventions studied and control conditions used, including detail where available on the intervention content, dose and adherence, and ethics)
- Sample (size, eligibility criteria, representativeness, reporting on drop-out, attrition and details of participants including demographics and protected characteristics)

- The outcome measures (independence, validity, reliability, appropriateness to wellbeing impact questions)
- Analysis (assessment of the methodological quality/risk of bias)
- Results and conclusions relating to relevant objectives
- The presence of possible conflicts of interest for authors/funding bodies

For qualitative evidence of intervention effectiveness the data extraction form will include the following details:

- Research design and objectives (interpretive, examining subjective experiences of participants, ethics)
- Data collection (type/form, appropriateness, recording, theoretical justification)
- Participants (numbers and details including demographic, recruitment strategy, theoretical justification)
- Analysis (rigor, assessment of methodological quality, identification of bias/involvement of researcher, attribution of data to respondents, theoretical justification, relevance to wellbeing impact question)

For health economic studies we will extract the following additional information:

- Included study designs, analytic methods, perspective, time horizon, discount rate
- Type of sensitivity analysis undertaken
- Type and sources of data use for resource use and costs, reporting figures for costs;
- Methods of preference elicitation (e.g. contingent valuation, revealed preferences, trade-off methods), reporting estimates of preference values
- Main results including specified types of ICERs (e.g. health service or societal perspective)
- Main health economic conclusions of the review

We will contact the authors of articles in the event that the required information cannot be extracted from the studies and is essential for interpretation of their results.

Assessment of methodological quality of included studies

We will use the quality checklists and standard approaches for assessing quality of included studies for quantitative and qualitative studies detailed in the What Works Centre for Wellbeing methods guide; and for economic evaluations use The Drummond Checklist (1996) to assess the methodological quality of the studies.

Included studies are likely to have assessed the methodological quality/risk of bias in a variety of ways. We will use the judgements made by the authors of studies regarding the

quality of evidence/risk of bias and report it within the context of our assessment of the quality of a study itself.

Data synthesis

We will tabulate summaries of the characteristics of the included studies.

The precise findings presented will primarily be determined by the content of the included studies. We will present effect sizes using appropriate metrics including estimates of precision. Data will be grouped according to visual art intervention type and wellbeing outcomes. We will report on processes by which interventions work and do not work, for whom and in what contexts in enhancing wellbeing. Important limitations within the evidence base will be presented and discussed. We will consider the possible influence of publication/small study biases on study findings. Where included studies have not rated the quality of the body of evidence we will apply the GRADE approach for key findings.

For health economic evidence we will summarise the study designs, analytic methods, perspective, time horizon, discount rate, type of sensitivity analysis undertaken, type and sources of data use for resource use and costs, reporting figures for costs, methods and results of preference elicitation, main results including specified types of ICERs (e.g. health service or societal perspective with and without health care savings) and main health economic conclusions of the review.

Demonstration Search Strategy (OVID MEDLINE)

1. MeSH descriptor: [well being]
2. well-being
3. wellbeing
4. “visual art*”.mp
5. drawing.mp
6. painting.mp
7. sculpture.mp
8. craft*.mp
9. handicraft.mp
10. ceramics.mp
11. pottery.mp
12. printmaking.mp
13. knitting.mp
14. woodwork.mp
15. textiles.mp
16. tapestry.mp
17. dressmaking.mp
18. “clothes making”.mp

19. upholstery.mp
20. crochet*.mp
21. illustration.mp
22. photography.mp
23. video.mp
24. filmmaking.mp
25. “moving image”.mp
26. animation.mp
27. “computer games”.mp
28. “digital art”.mp
29. “internet art”.mp
30. “performance art”.mp
31. “community art”.mp
32. “body painting”.mp
33. “body art”.mp
34. “face painting”.mp
35. graffiti.mp
36. “street art”.mp
37. “public art”.mp
38. “urban design”.mp
39. “landscape architecture”.mp
40. “participatory art”.mp
41. gardening.mp
42. “land art”.mp
43. “interior design”.mp
44. “interior decoration”.mp
45. “graphic design”.mp
46. (1 or 2 or 3) and (4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18, or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45)
47. “mental health”.mp
48. “mental illness”.mp
49. anxiety.mp
50. phobias.mp
51. “mood disorders”.mp
52. depression.mp
53. bipolar.mp
54. “postnatal depression”.mp
55. “seasonal affective disorder”.mp
56. mania.mp
57. hypomania.mp
58. “obsessive compulsive disorder”.mp

59. “psychotic disorders”.mp
60. schizophrenia.mp
61. hallucinations.mp
62. delusions.mp
63. paranoia.mp
64. “split personality”.mp
65. “personality disorder”.mp
66. “dissociative identity disorder”.mp
67. stress.mp
68. psychosis.mp
69. “panic disorder”.mp
70. “panic attacks”.mp
71. addiction.mp
72. “substance abuse”.mp
73. “eating disorder”.mp
74. anorexia.mp
75. bulimia.mp
76. “binge eating”.mp
77. “body dysmorphic disorder”.mp
78. “post traumatic stress disorder”.mp
79. “tic disorders”.mp
80. “quality of life”.mp
81. self-esteem.mp
82. loneliness.mp
83. “life adj satisfaction”.mp
84. happiness.mp
85. worthwhileness.mp
86. anxiety.mp
87. (46) and (47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79) and (80 or 81 or 82 or 83 or 84 or 85 or 86)
88. limit to humans, peer reviewed articles, age range 15-64.

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