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Arts on prescription for community dwelling older people with a range of health and wellness needs

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Abstract

Published evidence for the role of participatory art in supporting health and wellbeing is growing. The Arts on Prescription model is one vehicle by which participatory art can be delivered. Much of the focus of Arts on Prescription has been on the provision of creative activities for people with mental health needs. This Arts on Prescription program however, targeted community dwelling older people with a wide range of health and wellness needs.

Older people were referred to the program by their health care practitioner. Professional artists led courses in visual arts, photography, dance and movement, drama, singing or music. Classes were held weekly for a period of eight to ten weeks, with six to eight participants per class, and culminated with a showing of work, or a performance. Program evaluation involved pre- and post-course questionnaires, and focus groups and individual interviews. Evaluation data on 127 participants aged 65 years and older were available for analysis.

We found that Arts on Prescription had a positive impact on participants. Quantitative findings revealed a statistically significant improvement in the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), as well as a statistically significant increase in the level of self-reported creativity and frequency of creative activities. Qualitative findings indicated that the program provided challenging artistic activities which created a sense of purpose and direction, enabled personal growth and achievement, and empowered participants, in a setting which fostered the development of meaningful relationships with others.

This evaluation adds to the evidence base in support of Arts on Prescription by expanding the application of the model to older people with a diverse range of health and wellness needs.

Key words:

Ageing; Health; Mental health; Community dwelling; Community services for elderly, Art;

What is known about the topic:

- Evidence for the role of participatory art to support health and wellbeing is growing.
- *Arts on Prescription* (first delivered in the UK) is one model for delivering participatory art.
- There is limited peer-reviewed research on the benefits of *Arts on Prescription* for older people with diverse health and wellness needs.

What this paper adds:

- *Arts on Prescription* has a positive impact on the mental wellbeing of older people with diverse health and wellness needs.
- Purpose and direction, personal growth and achievement, empowerment and meaningful relationships with others were reported by participants.
- The *Arts on Prescription* model can assist in an holistic approach to meeting the health and wellness needs of older people.

Arts on prescription for community dwelling older people with a range of health and wellness needs

1. Introduction

There is a growing body of evidence supporting the role of the arts in the enhancement of health and wellbeing (Clift 2012), (Clift and Camic 2016), (Cann 2017), (Boyce, Bungay et al. 2018). Arts on Prescription (AoP), first delivered in the United Kingdom in 1995 (Rigby 2004), is one vehicle by which participatory art has been delivered to people with health and wellness needs. In such programs, health and social care practitioners refer people to a range of creative activities undertaken in a group setting within the community, facilitated by professional artists and as an adjunct to conventional therapies, with the aim of aiding recovery and promoting health and wellbeing (Bungay and Clift 2010). The 'prescription' is one way in which the activity is validated. Much of the focus of AoP has been on the provision of creative activities for people with mental health needs, and the evidence suggests positive benefits which include improvements in self-esteem, confidence and mood, as well as greater social contact (Bungay and Clift 2010) (Jensen, Stickley et al. 2017). Further, evidence finds that it is valued by referring health professionals (Stickley and Hui 2012), and may be cost-effective (McDaid and Park 2013). More recently, significant improvements in well-being following an arts-on-referral intervention have been reported for primary care patients (mean age of 53.2 years) with self-reported multi-morbidities (e.g. metabolic, neoplastic, cardiovascular) (Crone, Sumner et al. 2018). Scandinavian research suggests that AoP may also assist participants' ability to cope with long-standing pain (Rydstad, Löfgren et al. no date) cited in (Jensen, Stickley et al. 2017).

AoP reflects the international shift away from the biomedical model of health to a more holistic approach which sees health as complete physical, mental and social wellbeing (Rigby 2004). In keeping with this holistic perspective, AoP programs are often delivered by the community,

voluntary or social enterprise sector (Jensen, Stickley et al. 2017), utilising artists (rather than therapists) to work with small, community-based groups of participants (Bungay and Clift 2010). Therefore, active participation in the creative activity operates not only at the individual level, but also at the group level through social engagement and inclusion (Bungay and Clift 2010). Further, de-medicalised settings make AoP programs potentially less stigmatising for participants (Jensen, Stickley et al. 2017). Since creative activity is inherently flexible, it can be adapted to meet the skills and limitations of participants, and thus there are likely to be few restrictions on the type of participant who may attend. However, there continues to be limited published peer-reviewed evidence of the benefits of AoP outside its role for participants with mental distress; much of the research is qualitative with small sample sizes; and studies involving older populations are scarce.

This paper reports the findings from an AoP program in Sydney, Australia, which targeted community-dwelling older people with a wide range of health and wellness needs. The program was developed, implemented and evaluated through a unique collaborative partnership comprising a large aged care provider (expertise in service delivery), and a University Faculty of Medicine (expertise in evaluation) and Faculty of Art and Design (expertise in arts education and practice). The program was funded for an 18-month period by the Australian Government as a new and innovative service delivery project to address healthy and active ageing, an identified aged care priority area. This paper addresses some of the limitations of previous research and includes: a large sample size, evaluation using a before and after design with both quantitative and qualitative methodologies, and a broad target group comprising older people with a diverse range of needs.

2. Methods

2.1 *Program Design*

The AoP Program was publicised within the two local communities through visits by program staff to health practitioners, local councils, libraries, community groups, and local hospitals. Media coverage

through local papers was also achieved. Referrals to the program were accepted from a wide range of health practitioners.

Eligible participants were aged 65 years or older, living at home within the catchment areas, able to participate in a small group program, and independent or requiring only minimal assistance with self-care.

Courses were available in the visual arts, photography, dance and movement, drama, singing and music. Classes were held weekly for a period of eight to ten weeks, with six to eight participants per class. A community care worker or volunteer was available during each class to assist participants and artists; and to help with the preparation of morning or afternoon tea. Each course concluded with a showing of work, or a performance. Participants could take up to three consecutive courses; a fourth consecutive course was only possible under special circumstances. The ability to take consecutive courses was limited by the program duration, and participants who were referred towards the end of the program, were usually limited to a single course only. At the conclusion of the AoP program a professionally curated exhibition with performances was held in the local community, and on the University campus.

2.2 *Artist recruitment and training*

Professional artists were recruited through advertisements. Eleven were selected at interview and subsequently attended two days of training which highlighted the role of art in health, the health and wellness needs of older people, and ways of working with older people. While some art forms, such as movement and dance, naturally required physical activity, all artists were instructed to encourage physical activity where possible, such as encouraging participants to get their own morning or afternoon tea from the tea room, to stand at an easel, or to walk outside to find objects. The training also allocated time for artists to work together to plan their first class activities.

2.3 *Questionnaires and data collection*

The referring health practitioner provided basic demographic details, and relevant health information from a tick box list, with additional written details if needed. Referrers also identified their health and wellness aims for each referral, selected from listed tick box responses (for example, increased physical activity levels, improved mental health, cognitive stimulation, etc.). The referred person provided an emergency contact, their preferred availability, any special requirements (e.g. mobility needs), and written consent for their health and personal details to be shared with the AoP team to enable appropriate course placement.

On enrolment, participants received a participant information statement explaining the planned evaluation of the AoP program; those willing to participate in the evaluation provided written informed consent.

2.3.1 Pre-course questionnaire

At the commencement of each course, participants completed a pre-course questionnaire which contained open ended questions, statements to respond to using Likert scales, and validated measures of mental wellbeing and frailty.

Open ended questions sought the ways in which participants hoped to benefit from the AoP program. Likert scales measured participants' perceived levels of level of creativity (ranging from 0 (I don't feel that I am at all creative) to 10 (I am an extremely creative person)) and their frequency of engaging in creative activities (ranging from 0 (I stay away from creative activities) to 10 (I am always doing creative activities)).

Mental wellbeing was measured using the Warwick-Edinburgh Mental Health and Well-Being Scale (WEMWBS), developed and validated by Tennant, Hiller et al. (2007). This self-administered scale

containing 14 positively worded items (answered on a 1 to 5 Likert scale) relating to different aspects of positive mental health. Scores range from 14 to 70, with a higher level indicating a higher level of wellbeing. The WEMWBS has been shown to be sensitive to change at both the individual and group level (National Health Scotland 2015).

To determine decline in physiological reserve and function, frailty was measured based on the definition by Fried and colleagues (Fried, Tangen et al. 2001). Five recognised criteria which include unintentional weight loss, exhaustion, low physical activity level, slow walking speed and weakness were used (Fairhall, Aggar et al. 2008). Participants meeting three, four or five criteria, as defined in Table 1, were deemed as frail; participants meeting one or two criteria were considered as possibly pre-frail (Fried, Tangen et al. 2001). Unintentional weight loss, exhaustion and low physical activity levels were based on self- reported responses by participants on the pre-course questionnaire. Program staff took two measures of the time to walk four metres at usual pace (allowing a lead up of two metres) and two measures of grip strength (in kilograms) in the right and left hands, using a dynamometer; these measures were added to the pre-course questionnaire. The first pre-course questionnaire completed by a participant was considered to provide the baseline data.

Table 1: Frailty measures used. Adapted from Fairhall, Aggar et al. (2008).

[Insert Table here]

2.3.2 Post-course questionnaire

At the conclusion of each course, participants completed a questionnaire similar to the pre-course questionnaire. Open ended responses asked participants to report the ways in which they had benefitted from the AoP program, and which aspects of the course they enjoyed the most and the least. Measures of creativity (level and frequency), the WEMWBS, and measures of the frailty criteria

were repeated (with the exception of unintended weight loss since this question related to a 12 month period); post-program data for these variables were drawn from the last post-course questionnaire completed by a participant.

2.3.3 Focus groups and interviews

Eight focus groups of participants (19 males, 29 females), and four individual interviews (two males and two females) were undertaken over the program period. Each was guided by the same pre-determined list of questions. Interviews were recorded and transcribed for analysis.

2.4 Data analysis

2.4.1. Quantitative data

Quantitative data analysis was undertaken using SPSS Version 24. Baseline and post-program comparisons were made using the paired t-test for paired numerical data and the McNemar test for paired categorical data; an independent samples t-test was used to compare mean differences in WEMWBS scores for participants who attended more (three or four) compared to less (one or two) courses. Assumptions of approximate normality were confirmed by graphical assessment (Q-Q plots) prior to the use of parametric tests.

The management of missing data on the WEMWBS has not been tested and reported in the literature, but the estimation of more than three missing items is considered unlikely to be robust (National Health Scotland 2015). Where a score on one of the 14 items was missing on the WEMWBS, the missing value was imputed by giving it the average score derived from the 13 completed items. Where two or more items were missing from the WEMWBS, the total score was considered missing and excluded from analysis, or, in the case of a pre-course WEMWBS, replaced with the subsequent pre-course WEMWBS, if available. Using the second or third pre-course

questionnaire as the baseline score might be expected to minimise any difference between pre- and post-program scores, thus we considered our approaches to missing data to be conservative.

2.4.2 Qualitative data

After reading and re-reading the transcripts, focus group and interview data were coded inductively by the first author (RP), using NVIVO 11 (NVivo qualitative data analysis software, 2010). Initial codes were grouped into a number of themes, and extracts within the data which most typically illustrated each theme were selected and reviewed, with themes being refined as necessary (Braun and Clarke 2006). Textual responses to the open ended questions on the pre- and post-course questionnaires were also read and coded thematically, and where data overlapped, responses were found to support existing themes. Thematic analysis was confirmed by a second author (DH) who reviewed the survey responses and transcripts.

2.5 Ethics

The AoP evaluation was approved by the UNSW Human Research Ethics Committee.

3. Findings

Between August 2015 – April 2017, 190 referrals were received, however, 31 of those referred did not commence (changed their mind, could not find a conveniently timed class, moved away). Also excluded from analysis are: 19 participants referred for special pilot courses (courses for non-English speakers, or residents living with dementia in an aged care home); 12 participants aged under 65 years of age who were accepted onto the program at the special request of their health care practitioner; and one participant who could not provide informed consent. Thus data on 127 participants, aged 65 years and over are available for analysis.

3.1 Referral source and courses attended

The majority of participant referrals (n=126, missing data=1) came from medical practitioners (59.5%), followed by pharmacists (16.8%), allied health practitioners (15.1%), pastoral carers (7.1%) and nurses (1.6%).

Most participants attended between one and three courses (see Table 2). Enrolment in a fourth course occurred because a participant had become unwell and was unable to complete a previous course (n=7), or because a participant had expressed an interest in doing an additional course, and a place was available (n=6).

Table 2: Number of art courses attended

[Insert Table 2 here]

3.2 Demographics, health information and health aims for the program

Most participants were female (n=94, 74.0%); the average age on enrolment was 78.1 years (S.D. 7.99 years), with a range from 65.0 years to 96.2 years.

Table 3 shows relevant health information provided by referring health care practitioners. Declining physical function, social isolation and declining sense of overall wellbeing were the most commonly identified issues. Almost two-thirds (62.4%) of participants had two or more issues identified. Additional health information about participants considered relevant by referrers included the following conditions: lung disease (e.g. COPD, asthma, bronchiectasis), cardiac disease, diabetes, venous insufficiency, osteoporosis, stroke, Parkinson's disease, joint replacements, back pain and mobility issues. Special requirements impacting program participation identified by participants themselves focussed on mobility concerns (poor balance, fear of falling, limitations in walking

distance, needing assistance to stand, and being unable to stand for long periods of time), poor vision and hearing loss.

The most common health and wellness aims for the participants identified by their referring health care practitioners included increased social connections, the creation of new interests, and improved mental health. Referrers identified multiple aims for most (91.2%) participants. See Table 3.

Table 3. Participant health information and health and wellness aims as indicated by referring health care practitioner, n= 127.

[Insert Table 3 here]

3.2 *Physical measures of frailty*

At baseline, unintentional weight loss was reported by 19 (17.3%, n=110) participants; self-reported exhaustion by 29 (25.2%, n=115) participants, and low physical activity by 14 (12.2%, n=115) participants. Slow walking speed was identified in 22 (21.4%, n=103) participants and weakness in 56 (49.6%, n=113) participants.

Nine (7.5%) participants scored three or more on the recognised criteria indicating frailty (n=120); 30 (25.0%) participants scored two and 48 (40.0%) scored one on the criteria, suggesting possible pre-frailty. The number of participants with frailty and pre-frailty may be an underestimate, as data on all five criteria were available on only 91 (71.5%) participants.

There were no statistically significant differences between baseline and post-program assessments in the proportion of participants scoring on the individual frailty criteria of self-reported exhaustion

(determined from two items), low physical activity levels (determined from three items), slow walking speed or weakness.

3.4 Creativity measures

On a Likert scale ranging from 0 to 10, the average baseline level of creativity was 5.1 (S.D = 2.5) and of frequency of creative activities was 4.4 (S.D. 2.7) (n=116). Post-program the mean levels had increased to 6.9 (S.D. 2.1) and 6.2 (S.D 2.4) respectively (n=110). Paired samples t-tests found a mean difference of 1.56 (95%CI 1.14-1.98) for level of creativity (t=7.35, df=99, p <0.001), and 1.60 (95%CI 1.06-2.14) for frequency of creativity (t=5.91, df=99, p<0.001).

3.5 WEMWBS

For four participants, an imputed score on a single missing item in the baseline WEMWBS was required; and because multiple WEMWBS items were missing, pre-course WEMWBS scores from the second (for four participants) and third (for three participants) courses were used as baseline scores. This resulted in baseline WEMWBS scores for 123 participants. Scores ranged from 24 to 68, with the mean baseline WEMWBS score being 49.8 (S.D. 9.4).

An imputed score on a single item in the post program WEMWBS was required for six participants, giving post-program WEMWBS scores for 107 participants. Scores ranged from 33 to 70, with the mean post-program WEMWBS score being 56.6 (S.D. 7.7).

There was a statistically significant increase in WEMWBS scores between baseline and post-program. The mean increase was 6.86 (95% CI 5.33 – 8.38) points on a paired samples t-test (t=8.91, df=104, p<0.001). Over two-thirds (69.5%) of participants had an increase of three or more points between the baseline and post-program.

There was a statistically significant increase in scores for participants who attended one or two courses only (mean increase of 7.25, 95% CI 5.39-9.11, t=7.78, df=63, p<0.001); with 71.7% having an increase of three points or more. For those who attended three or four courses, the mean increase was 6.24 (95% CI 3.53-9.00), also a statistically significant increase (t=4.65, df=40, p<0.001); with 65.9% of participants having an increase of three points or more. The mean increase in WEMWBS scores did not differ by number of courses attended (that is, one or two courses only versus three or four courses; t= 0.636, df=103, p=0.526).

3.6 Qualitative data analysis

3.6.1 *Ways in which participants hope to benefit from AoP (pre-course)*

Textual responses provided on pre-course questionnaires (Q-Id no.) about the ways in which the participants hoped to benefit from the program suggested several different themes. The first theme centres on participants hoping to '*learn something new'* (Q-w1), to develop a '*new skill*' (Q-e7) and to do '*something different'* (Q-z3). Some participants were more specific such as wanting '*to be able to play guitar'* (Q-e9) or '*to use water colour paint'* (Q-a6); others hoped '*to stir my creativity'* (Q-z5), to be '*challenge[d] to try out new things'* (Q-a2) or to have '*help in finding out what little talent we have'* (Q-u4).

Connecting with others and wanting to socialise was the second theme. This was often expressed as a desire to '*meet*' (Q-t4) or '*talk*' (Q-t6) to people or '*making friends'* (Q-v4); others expressed a wish to become '*a member of a group*" (Q-k9) and to '*enjoy being in group activities'* (Q-m0).

The third theme identified was a hope to benefit by addressing some of the limitations, losses or conditions associated with ageing. Some related to physical functioning, for example, t*o 'help with chronic pain' (Q-w9), to 'get more movement in my hands' (Q-a0), 'to keep me walking despite*

peripheral neuropathy' (Q-u8) or to gain '*physical stamina and fitness' (Q* -j0). Others related to mental wellbeing for example, participants were seeking '*motivation'* (Q-k4), '*confidence' (Q-k*7), '*relaxation'* (Q-k8), to '*forget about worries ' (*Q-t1), and to have '*a reason to get dressed and go out'(Q-z4).* Maintaining brain health was also identified with participants wanting *'to stay positive and slow memory loss' (Q*-o8) and *'to keep my brain active' (Q-z8).*

3.6.2 *Benefits identified by participants of AoP (post-course)*

Thematic analysis of focus group (FG) and interview (I) data, and textual questionnaire (Q) responses on the benefits of AoP can be described under four main themes.

a. A sense of purpose and direction

The first theme relates to participants finding a new interest to pursue, feeling motivated and being optimistic about the next stage in their lives.

Some participants described a sense of loss associated with ageing,

> *as you get older it's very easy to sit there and feel sorry for yourself and say there's nothing out there for me, what can I do?* (FG-1)

In contrast, they described AoP as offering '*something constructive'* (FG-7), providing '*an interest*' (FG-4) and of '*going somewhere with a particular purpose in mind*' (FG-4).

For others, the program provided a new focus for the loss of direction which they experienced specifically related to retirement,

> *I think once we get a bit older and we retire, sometimes we wake up and say well what am I going to do today apart from the washing and the ironing or whatever; what am I going to*

do today? …But now we know okay Wednesday I'm going to [] class….I think it gives you something to look forward to…you just get a bit of motivation in life. (FG-4)

Participants also spoke of their artistic endeavours as '*being a starting point' (FG5)* and *'the start of really something opening up for [me]'* (FG-7).

A number of participants pursued their new interest at home in conversations with family, by buying their own paints and brushes, or '*finding songs that I want to put into my own repertoire'* (FG-4).

b. Personal growth and achievement

This theme related to self-discovery gained by taking on a new challenge and finding success**.** This was reflected in statements about '*a real sense of satisfaction'* (FG-1), and of '*surprise'* (FG-8) in regard to their achievements. Participants invariably approached the program with the impression that they were '*no good at art'* (FG7)*,* did not have *'a musical bone in our body'* (FG-7) or were not *'capable of doing that'* (FG-4).

Participants spoke about being '*inspired*' (Q-n9), of realizing they had '*some sort of gift there'* (FG-7), of being '*more creative than I thought'* (Q-n4) or of uncovering a '*latent talent'* (FG-3). Participants shared how they had needed help to begin this journey of personal growth and achievement, with one participant describing this as '*something else to actually pull that trigger. And for me this is what it [AoP] has been'* (FG-7).

The artistic activities challenged participants, and it was this sense of rising to meet the challenge that enhanced their sense of achievement,

Basically my brain is getting dead and there is not much I can do about it because I can't remember anything. So I am limited in what I can do. But [ ] I've made four things now [in clay], and two of them came in very well. (FG-2)

I think it gave me a sort of sense of achievement because like [name] I mean I haven't painted [ ] but when you're actually trying something and some aspect of it works [ ] there's a real sense of satisfaction there. (FG-1)

Praise which celebrated achievement provided participants with validation that they had succeeded.

I've enjoyed every part of it and I suppose you know like all of us, we enjoy a bit of praise when we do something that you know, you think oh I didn't think I'd ever be able to do that… but I did it. (FG-4)

c. Empowerment

Increased self-confidence and self-determination were evident among participants. They spoke about the program building '*self-esteem*' (Q-j2), and developing their confidence to tackle what they did not have the confidence to take on previously.

I've always wanted to do artwork, but I never had the confidence. (FG-7)

I thought, you are useless, you are really bad, and I had no confidence but now I feel, 'Oh.' So it's been like an awakening. (FG-7)

Several spoke of being inspired by others in their class, and thus empowered,

I thought to myself, if they can do it, I can do it. (I-2)

Given their recent successes, some participants voiced plans to challenge themselves with new and different artistic endeavours.

I am now going to the next course and I am going to learn to play ukulele because I spoke up and said I would really like to learn the ukulele, done, right so that's what's happening next time, I hope. (FG-5)

A number of participants implied a new sense of assurance, empowered to meet broader challenges in their lives, and even to seek challenges.

[I] have gained confidence and belief in myself and new challenges. (Q-b8)

I have learnt to see beyond my expectations of myself. (Q-a2)

This course is….a stepping stone for all of us to go on to something bigger and greater in our own lives. (FG-7)

d. Relationships with others

The fourth theme relates to meaningful companionship - interactions where people shared their experiences, listened to each other, encouraged one another and displayed empathy. The program provided *'company because I'm very lonely at home'* (Q-b6) as well as interactions which were described as '*enriching'* (Q-t9)*, 'invigorating'* (FG-7) *and 'terribly important' (FG-3).* Participants described their group interactions as comprising *'in-depth talks' as well as 'laughs'* and *'chatter, chatter work, work, chatter, chatter'* (FG-7).

Participants indicated that art created a shared interest which facilitated connection between people and the development of friendships; and one group (unprompted) reported meeting outside the program for coffee.

I think when people who are of a similar age or a similar outlook on things, it creates that little safety zone and we're okay to share some deep personal things along with the enjoyment of doing something as a collective. (FG-7)

Sentiments that the group was about more than just the art were expressed by a number of participants:

Whether we did a good job or not a good job, that was not important [ ] it was just having an opportunity to spend time with one another, enjoying one another. (FG-5)

3.6.3 The role of the artists

Focus group interviews suggested that the artists played an important role in creating and supporting participant autonomy, through working in partnership with participants, and supporting the artistic process with constructive encouragement, and 'formal' recognition.

Participants described artists as coming alongside them to provide guidance rather than strict instruction or direction.

They let us find our own way. They kind of guide us but they tell us you know, you try and see what you can do. (FG-1)

She was a marvellous tutor and she didn't sort of take on just the brilliant people you know, she actually helped people to really do it without taking over, brilliant. (FG-5)

She seems to work in a way wherever people feel a bit restricted. She seems to open things up and make it work. (FG-3)

Artists drew out participant ideas and supported their development into creative works which participants owned, as opposed to artists stipulating an idea or leading the work.

> *We actually hadn't been taught anything but it's worked out well – [the artist] sits there and says "Okay, recommend some songs, tell me songs that you like" … and [he's] taken them away and the next week he's come back with the words and all that, the chords, and we've had to almost do it ourselves, he's thrown it back on us, and it's great.* (FG-4)

Participants described artists as *'very supportive'* (FG-4) and *'very encouraging and complimentary' (FG-2)* which provided participants with the confidence to proceed with their artistic challenges.

> *Well she encourages no matter what you do. The encouragement that you're doing well. Oh yes...she'll come beside you and say, well how about, have you thought of this? And it was just the gentle way she interacted with me.* (FG-2)

Artists provided validation and celebration of participants' artistic achievements through exhibition or performance at the conclusion of a course.

> *when we got to the end, we were given the chance to perform, okay, to show-off what we had actually been doing.* (FG-5)

4. DISCUSSION

This paper presents the findings from a large AoP program targeting older people with diverse health and wellness needs. Referrals to the program were sought from a range of community based health professionals. As AoP is not an established program in Australia (to our knowledge this is the first program under this banner), considerable effort by the project manager and team was required in the initial stages, to raise awareness within the community and to educate local health

practitioners on its potential uses and benefits. While the role of arts and health through creative, participatory or receptive interventions has recently been acknowledged by the Australian Government through its National Arts and Health Framework indicating a supportive policy climate (Australian Government 2014), it was our experience that health practitioner knowledge of participatory art as a non-medical intervention alongside existing treatments for patients, is limited.

Making art has always been an intrinsic part of what it means to be human (Langer 1966) (MacGregor 2011), but a constant creative practice is not a given; its development can be either stifled or cultivated by a whole range of cultural and societal factors (Pinker 2003) (Hickman 2010). Baseline questionnaire responses indicated that in general, our older participants did not see themselves as 'creative'; this finding was supported in focus groups and individual interviews. Increases in the level of self-reported creativity and self-reported frequency of creative activities suggests that AoP was both nurturing participants' sense of creativity and authorising its practice. Further, facilitation by professional artists enabled the production of creative works which were worthy of celebration and acknowledgement through exhibition or performance, affirming 'creativity' to the participants themselves, their family and their community. Some work, professionally framed, remains on display in facilities frequented by participants.

Baseline data indicates that the program was delivered to participants within the target group. Issues relating to mental wellbeing were common indications for referral. Limitations in reported physical capacity (such as declining physical function, chronic pain, frailty or pre-frailty, and limited mobility) suggest that opportunities for active engagement within the broader community may have been restricted for many participants; this would appear to be supported with the identification by referrers of 'increased social connections' as the most frequently reported health and wellness aim for participants.

We found evidence in support of the positive impact of participatory arts on the mental wellbeing of participants, as measured by the WEMWBS. Over two-thirds of participants in the AoP program showed an increase of three or more points on the WEMWBS. The mean improvement of almost seven (6.86) points from baseline to post-program was statistically significant, with other research suggesting it may also represent clinical improvement. Data gathered from a University Staff Counselling Service found a statistically significant correlation between level of improvement on the WEMWBS and level of clinical improvement observed by counselors (Ragonesi, Parsons et al. 2013). Other work reported suggests that a change of three or more points is likely to be recognisable as an important change to an individual (National Health Scotland 2015).

Our thematic analysis of qualitative data from focus groups, individual interviews and textual questionnaire responses on the benefits of participatory art, resonates with theoretical dimensions of eudaimonic wellbeing from other research. Eudaimonia refers to living life to its fullest potential, gained through engagement in meaningful endeavours (Ryan and Deci 2001), (Steger, Kashdan et al. 2008). Ryff (1989) described six theory-guided constructs that are associated with psychological wellbeing. These include self-acceptance (defined for example, by a positive attitude toward self), positive relations with others (defined for example by, warm, satisfying, trusting relationships with others), autonomy (defined for example by, self-determination and independence), environmental mastery (defined for example, by a sense of mastery and competence in managing the environment), purpose in life (defined for example, by having goals in life, a sense of directedness, belief that life has purpose) and personal growth (defined for example, by a feeling of continued development, of realising one's potential, and changes that reflect more self-knowledge and effectiveness). Activities which are meaningful, worthwhile and enable one's potential to be fulfilled, foster the achievement of these constructs and the development of enduring wellbeing (Steger, Kashdan et al. 2008). This is in contrast to activities which focus only on achieving simple pleasure or happiness (hedonia), which are more fleeting (Steger, Kashdan et al. 2008).

Some of Ryff's dimensions of psychological wellbeing, specifically, purpose in life and personal growth, show declines in older age, from middle age (Ryff 1989). Ryff and Singer (2008) propose that sharp downward trends in purpose in life and personal growth particularly, may reflect the current challenges faced by society in offering older people roles which are meaningful and in providing opportunities for sustained growth. Given that three of the four themes identified in this current research (which we labelled personal growth and achievement, a sense of purpose and direction, and empowerment) overlap aspects of these constructs shown by Ryff (1989) to decline in older age, suggests that programs such as AoP are helpful in addressing this societal void experienced by older people.

For some participants, the AoP program also addressed loneliness, by encouraging the development of relationships with others. Australian research indicates that around one third of older people report feeling lonely at least sometimes which is comparable to samples in other countries (Steed, Boldy et al. 2007). Steed, Boldy et al. (2007) found that having friends and a confidant were important in protecting against loneliness. The common point of interest created by the art-making process was reported by participants to facilitate relationship building which enabled participants to share personal matters within their group. This finding is supported by other research which suggests that friendships emerge more readily from shared activities than in settings which are more overtly focused on friendship formation (Cattan 2005).

We suggest that the manner in which the professional artists worked with participants also facilitated the gains in mental wellbeing attained. Participants reported that they were challenged by their artistic endeavours, and met these challenges in partnership with the artists who provided constructive encouragement. Importantly, artists avoided activities which were prescriptive and

directive, focussing on empowering participants and maximising opportunities for personal growth and achievement.

The WEMWBS provides a single quantitative measure combining both hedonic and eudaimonic perspectives on mental wellbeing (National Health Scotland 2015). The qualitative findings from focus groups and individual interviews were valuable as a means of triangulating the program outcomes as determined by the WEMWBS; and in providing a deeper understanding of how and why AoP may enhance positive mental health in older people.

The proportion of participants with frailty at baseline was somewhat similar to reported estimates of frailty for community dwelling older Americans (65 years and older), which range from 7-12% (Xue 2011). Frailty puts older adults at greater risk of poor health outcomes, and pre-frailty puts older adults at risk of progression to frailty (Xue 2011). Therefore, calls have been made to prioritise research into interventions to prevent or reduce frailty (Xue 2011). We were unable to demonstrate statistically significant reductions in the number of participants scoring on individual frailty criteria. Given that specific and intensive interventions are generally required to address frailty (Fairhall, Aggar et al. 2008) these findings are not unexpected. We had insufficient data to examine the impact of individual art forms, such as movement and dance, on frailty; and all courses were offered only on a weekly basis. However, other research on arts and health has found effects on physical health more generally. For example, Clift, Morrison et al. (2013) found that singing reduced chronic respiratory symptoms and Heiberger, Maurer et al. (2011) found that dancing improved functional mobility.

Limitations

The AoP program was only offered to older people from two geographic areas in metropolitan Sydney. These areas represent people from diverse cultural backgrounds, and areas of higher and

lower socioeconomic status. However, caution should be applied in generalising our findings to a broader population. As focus group transcripts were de-identified, it is possible that focus group findings may include some participants aged less than 65 years of age. Given the small number of younger participants in the AoP program this is unlikely to have had a marked impact on our qualitative results. Since our AoP program was a funded service, rather than a research project, we deliberately limited the number of measures at baseline and outcome so as not to burden participants. Anecdotal accounts of improvements in physical health were shared with artists, but these were not objectively measured. We suggest future researchers consider the inclusion of measures to capture changes in chronic respiratory symptoms and functional ability.

CONCLUSION

This evaluation adds to the limited evidence base in support of AoP for older people, and presents, to our knowledge, the first evaluation of AoP in Australia. Our results suggest a positive impact on mental wellbeing for participants with a diverse range of health and wellness needs. This may be due to the program's ability to foster eudaimonic wellbeing through the provision of challenging artistic activities which create a sense of purpose and direction, enable personal growth and achievement, and empower participants, in a setting which fosters the development of meaningful relationships with others. The Australian Government is currently pursuing a wellness and reablement agenda in the delivery of funded support services in the community to eligible older people (Department of Health 2018). The group based nature of AoP presents an efficient model of service delivery in comparison to services delivered on an individual basis; and the outcomes from AoP align closely with the intended outcomes of the Commonwealth Home Support Programme (Department of Health 2018). These elements may support the wider adoption of AoP programs for older people, in Australia.

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Table 1: Frailty measures used. Adapted from Fairhall, Aggar et al. (2008).

a. Unintentional weight loss defined as a loss of more than 4.5 kg unintentionally in the past 12 months.
b. Self- reported exhaustion – this criterion was met if, for the last seven days, the response to both the following questions was 'occasionally or a moderate amount of time (3-4 days)' or 'most or all of the time (5-7 days)': 'How often did you feel that everything you did was an effort in the last week' and 'How often did you feel that you could not get going in the last week?"
c. Low physical activity – this criterion was met if, in the past three months, participants did not perform weight-bearing physical activity (e.g. housework, outside chores, gardening), spent most of their time sitting, and only went for a short walk once per month or less.
d. Slow walking speed was defined as a walking time of six seconds or more over four metres (average of two measures).
e. Weakness – defined as grip strength of 30kg or less for male participants; 18kg or less for female participants. The best of attempt achieved from either the left or right hand was used as the maximum handgrip strength measure.

Table 2: Number of art courses attended

Number of courses attended	Count	Percentage
One	52	40.9
Two	33	26.0
Three	29	22.8
Four	13	10.2
Total	127	100

Table 3. Participant health information and health and wellness aims as indicated by referring health care practitioner, n= 127.

Relevant health information (one or more may apply from defined list)	**Count**	**Percent**
Declining physical function	52	40.9
Socially isolated/declining social interaction	41	32.3
Declining sense of overall wellbeing	38	29.9
Chronic pain and illness affecting wellness	30	23.6
Frail or pre-frail	30	23.6
Anxiety	28	22.0
Depression	28	22.0
Mild cognitive impairment, early or moderate dementia	24	18.9
Carer burden	10	7.9
Recent bereavement or loss	9	7.1
Health and wellness aim (one or more may apply from defined list)		
Increased social connections	79	62.2
Create new interests	73	57.5
Improved mental health	69	54.3
Cognitive stimulation	65	51.2
Increased physical activity levels	63	49.6
Help find contentment/spiritual wellbeing	34	26.8
Help manage loss/bereavement	10	7.9
Enrich relationship with caregiver	9	7.1