

Understanding well-being outcomes in primary care arts on referral interventions: a mixed method study

Abstract

Background: Arts on Prescription programmes are designed to support mental health and well-being of patients with a variety of clinical needs within the community. Despite a number of studies reporting benefits, there are some patients that do not see improvements in well-being. Yet, there is limited research investigating the reasons for this.

Methods: Using a sequential mixed-methods design the present study sought to understand why some participants (N=312) experienced an increase in well-being and others did not (N=95) after attending an Arts on Prescription intervention based in the South West of England between 2009 and 2016.

Results: Quantitative comparisons between the two groups identified little differences, aside from age and baseline well-being (WEMWBS scores), with those that improved being slightly younger, and having lower well-being at the outset compared with those that did not improve. A process model depicting the perceived facilitative and inhibitive factors of attending the programme was developed from the qualitative findings. This model suggests that the social aspect of the course may be implicated in the participants differential outcomes; with those that showed a decrease in well-being reporting difficulties in interacting with others during the intervention. Further, the participants who reported an increase in well-being felt vulnerable to “relapse” when finishing the course due to uncertainties regarding future support and at their ability to maintain their well-being without the provision of the programme.

Conclusions: This research suggests a need to promote communication amongst groups in such interventions with the hope that this will provide a more facilitative environment for all participants to benefit. Also, such programmes should consider follow-on options to ensure the participants feel supported and confident in managing their well-being once the course comes to an end. Findings will be pertinent to those commissioning primary care art interventions, ensuring that referral policies and pathways are designed for optimal effectiveness and for potentially tailoring social prescribing programmes to suit the participants specific needs.

Keywords

Mental health, social prescribing, arts for health, well-being, mixed methods, primary care

Introduction

In England mental illness carries an economic and social cost of £105.2 billion a year (1, 2). This is predicted to rise over the coming years, creating a projected £30 billion funding gap by 2020 (3-6). Radical reviews of health service delivery remain high on the policy agenda (3, 6), where a more proactive and preventative approach, with a focus on well-being, is regarded as necessary in order to relieve pressures on services and to reduce expenditure (7, 8). Social prescribing is one such approach,

where primary care patients are referred to a range of non-clinical support services based in the community (9). Prescribed activities include participation in arts, physical activity, gardening, volunteering, befriending and self-help programmes (9, 10). By addressing the broader causes of mental health, participation in such programmes has been shown to improve patient psychological and social well-being, decrease their use of medication and health services (11) and prevent further health deterioration; thereby avoiding the need for costly medical or specialist support (12).

Arts on prescription (AoP) interventions have been reported as efficacious across a range of health care settings and population groups (see 7, 13, 14) including mental health (15), primary care (16, 17), and specific clinical groups such as cancer (18) and stroke (19). Not only have they been shown to enhance the attendees' well-being, they have also been proposed to reduce medication usage and decrease primary care utilisation (7, 10, 20). As such, they are becoming an increasingly popular and accepted treatment option in social prescribing (7, 10, 13, 21). Recently, an analysis examining factors associated with outcomes in AoP highlighted a significant portion of participants that either experienced no change, or a decrease in well-being (22). This analysis highlighted, for the first time, that AoP interventions may not be beneficial for all. However, the analysis was not able to provide much insight as to why some do not increase in their well-being, with only baseline well-being being associated with well-being change at follow-up (22). It is, therefore, important to attempt to understand this issue further using other available data, namely the qualitative feedback provided by the participants.

In an attempt to address this particular issue, the present study utilises a subset of data from the largest dataset of AoP referrals currently available to explore the discrepancies in well-being outcome for some (17). In order to address this concern, the present study uses a mixed methods design from those that provided sufficient qualitative feedback (N=407).

The first stage of these analyses included a quantitative comparison of specific patient characteristics that might explain differences between those whose well-being improved and those whose did not in this smaller sub-sample of participants. The second stage was to undertake a qualitative exploration of data collected in this cohort, in order to further understanding of how and why the intervention benefits specific patient groups.

Method

Participants and Procedure

The participants in this research were drawn from a larger study (17), where adults were referred to a primary care AoP intervention by their GP or other health professional. Patients (age range 14-95 years) in the South West of England were referred for this programme between 2009 and 2016 for any combination of seven referral reasons including: to reduce stress/anxiety/depression; to improve self-esteem/confidence; to improve social networks; to help alleviate symptoms of chronic pain or illness; to distract from behaviour related health issues; to improve overall wellbeing; and to provide support following a loss or major life change.

Individuals attended an eight- or ten-week course, run by a local artist, who is skilled in the art type being used; this included drawing, mosaic, painting, or creative writing. AoP programmes do not include any formal therapeutic process per se as part of the intervention, however it is argued that the art itself constitutes a type of therapeutic process (17, 23). The group size was between three and 10 patients, depending on the available space and art type. Each individual participant referred to their local art intervention, is “anonymous” from the other, in terms of their specific reason for referral. The intervention took place at GP surgeries or in a local community space, such as a village/church hall.

The data for the present study were obtained from the anonymised referral form, from self-complete questionnaires and from participant evaluation forms provided by the artists at the point of the intervention. Attendance data (i.e. whether the patient was present at the session or not) and engagement data (a subjective assessment of the patient’s engagement by the artist) was also collected at each session. Data were anonymised by a unique identification number on each form completed by the patients or referring practitioners, these were collated into participant packs to ensure accurate data linkage at inputting. For more details of the procedure please see Crone et al. (17).

The participants in the present study were included as they provided post-intervention feedback for the qualitative aspect of the analyses.

Measures

Well-being was assessed using the Warwick-Edinburgh Mental Well-being scale (WEMWBS: 24), administered to the participants on the first and last day of their attendance at the intervention. Demographic information of the patients were drawn from an anonymised referral form, including: age, sex, referral reason, referring health professional, and details of the patients’ postcodes, which were used to obtain Index of Multiple Deprivation quintile from the latest available data (25). The qualitative data were drawn from the patient satisfaction survey that was provided to the participants on the last day of attendance and included responses to the following two free-text questions “what have you enjoyed most?”, and “what have you enjoyed least?” about the intervention. Although reliance on a satisfaction survey potentially limits the depth of qualitative data, it is varied in its breadth, and, importantly, draws from the largest data set of its kind within the field to date. Similar methods have been used elsewhere (23) (26).

Design

This research adopted a sequential mixed methods design (27) to examine the effects of an AoP intervention on patients’ mental health and well-being. The specific mixed methods design was derived from observations during the primary analyses (17, 22) that a substantive number of participants completing the intervention reported either no change, or a decrease in well-being. At this point in the analysis, the qualitative data from the participants’ satisfaction survey were separated into the two groups; Group A (decrease or no change in WEMWBS), and Group B (increase in WEMWBS), and were given to the first author for the purpose of

qualitative analysis. In order to prevent bias in the analysis, the first author was blind to both the research question, and the grouping of the data. The qualitative analysis was carried out by the first author using two free-text responses taken from the patient satisfaction survey: “what have you enjoyed most?”, and “what have you enjoyed least?” about the intervention.

Data analysis

Data included quantitative and qualitative elements, which were linked through the use of the unique patient identification number. Data were anonymised using this number and through the use of gender-specific pseudonyms. Quantitative analysis identified the two different groups within the data (no change/decrease in WEMWBS or increase in WEMWBS), while the qualitative analysis offered insight into the reasons why patients may belong to that particular group.

Quantitative

Quantitative data analysis was undertaken using IBM SPSS version 23. Change scores for the WEMWBS were derived by subtracting participants “pre” measures from their “post” measure. As the intervention is implemented specifically to increase well-being, those participants that had no overall change (N=26) were grouped with those that experienced a decrease in well-being. This created two groups that to an extent operationalise success (increase) or non-success (all other) of the intervention’s original objectives. The present analyses were carried out on the subgroup that provided qualitative data only, so that meaningful comparisons could be made between the quantitative and qualitative data should any bivariate differences be observed. Comparisons between the two groups (decrease/no change or increase) were carried out using Pearson X-square or one-way ANOVA.

Qualitative

Of those that either increased or decreased, data provided in the qualitative feedback were put forward for analysis. Of those that increased (N=419), 311 (74.2%) provided an “enjoyed most” response, and 162 (38.7%) provided an “enjoyed least” response. For the decreased group (N=130), 96 (73.9%) provided an “enjoyed most” response, and 51 (39.2%) provided an “enjoyed least” response. Any “not applicable” or “nothing” or other similar entries were considered as item non response for the purposes of the qualitative analysis. The data presented for qualitative analysis were uploaded to NVivo 11 and analysed using inductive thematic analysis (28). Following the six phases displayed in Figure 1 thematic analysis was undertaken for the participants in the decrease/no change group and for the participants in the increase group, independently. Subsequently a comparison between the two groups was conducted.

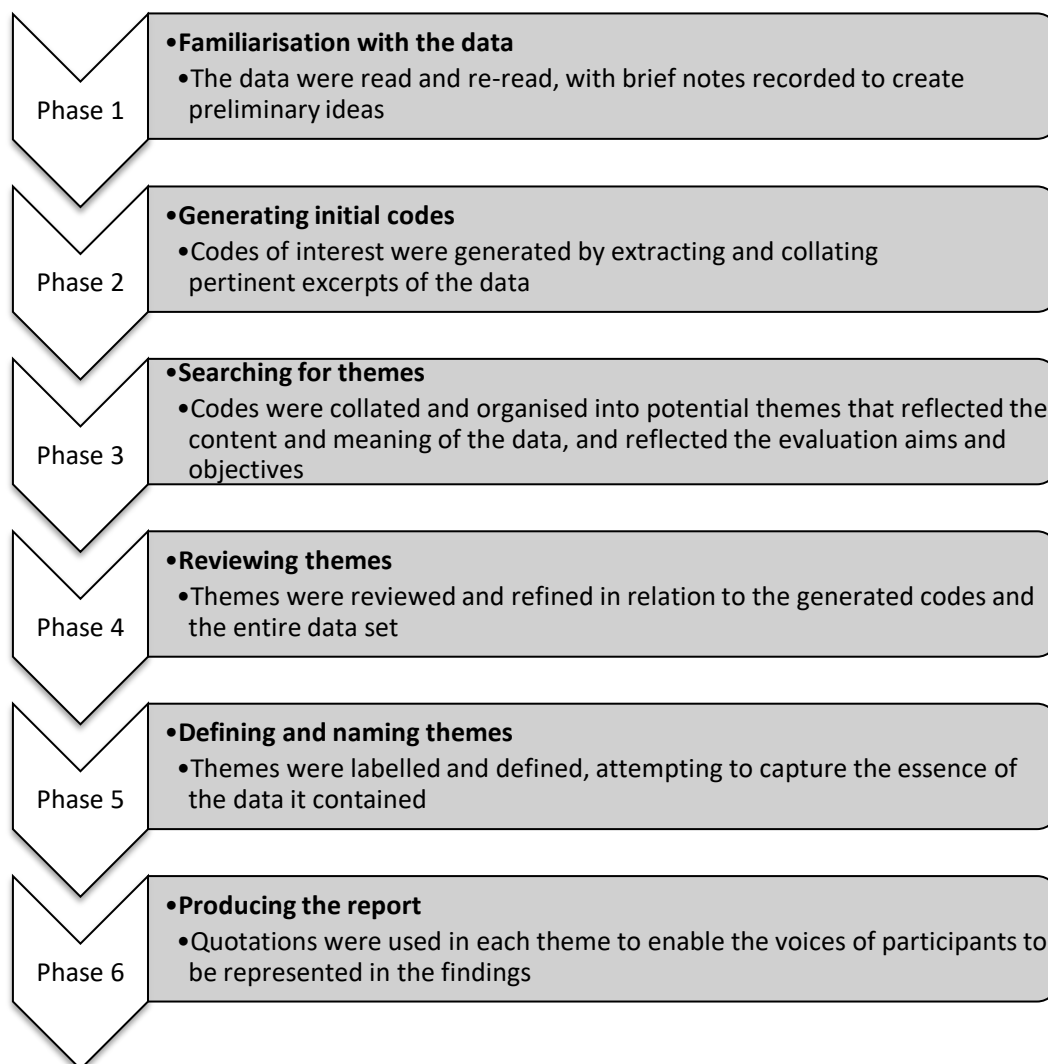


Figure 1. The Six Phases of Thematic Analysis followed in this Study

Ethical approval

This research was approved by the National Health Service Local Research Ethics Committee and the County Commissioning Group, R&D Reference: 08/GPCT01/SE.

Results

Quantitative

A descriptive overview of the whole group of participants, as well as the two individual subgroups is presented in Table 1. As can be seen from Table 1, the whole sample were majority female (N=318, 78.5%), were not currently occupied (i.e. were not working, nor in education; N=277, 76.3%), and were more commonly from the lowest quintile of deprivation (N=106, 28.0%). The overwhelming majority were classed as attenders (98.5%) and were also rated

by the artists as being engaged in the intervention (98.3%). The mean age of the participants was 50.8 ± 15.54 years. Comparisons between the two groups showed no significant differences on any of the variables that had been assessed aside from age, and the well-being measures. These findings are in line with those from the larger sample reported elsewhere (22). The group that decreased or showed no change in well-being tended to be slightly older ($F_{(1, 383)}=19.87, p=.001$), and had higher pre-intervention well-being ($F_{(1, 406)}=12.53, p<.001$) than those who had an overall increase in their well-being. These very limited differences were the prompt to explore the qualitative feedback provided by the participants in the satisfaction questionnaire. It was hoped that by exploring participants' reported experiences of the intervention, insight could be obtained to account for these differences.

Table 1. A Descriptive Overview of the Participants in this Study

	Whole Group N=407	Group A (decrease) N=95	Group B (increase) N=312	Test of difference
Mean age (SD)	50.8 (15.54)	55.6 (13.88)	49.4 (15.75)	F_(1, 383)=19.87, p=.001
Sex - female (%)	318 (78.5)	69 (73.4)	249 (80.1)	X ² (1)=1.90, p=.197
Occupation – not occupied (%)	277 (76.3)	69 (80.2)	208 (75.1)	X ² (1)=0.96, p=.385
IMD Quintile				
Highest deprivation (%)	46 (12.1)	10 (10.9)	36 (12.5)	
High (%)	67 (17.7)	16 (17.4)	51 (17.8)	
Medium (%)	83 (21.9)	20 (21.7)	63 (22.0)	X ² (4)=0.57, p=.966
Low (%)	77 (20.3)	21 (22.8)	56 (19.5)	
Lowest (%)	106 (28.0)	25 (27.2)	81 (28.2)	
Reduce stress/anxiety/depression	324 (80.4)	71 (76.3)	253 (81.6)	X ² (1)=1.26, p=.297
Improve self-esteem/confidence	252 (62.5)	60 (64.5)	192 (61.9)	X ² (1)=0.20, p=.715
Improve social networks	216 (53.6)	51 (54.8)	165 (53.2)	X ² (1)=0.08, p=.813
Referral reason – yes (%)				
Help alleviate symptoms of chronic pain or illness	143 (35.5)	36 (38.7)	107 (34.5)	X ² (1)=0.55, p=.461
Distraction from behaviour related health issues	71 (17.6)	16 (17.2)	55 (17.7)	X ² (1)=0.01, p>.999
Improve overall wellbeing	294 (73.0)	64 (68.8)	230 (74.2)	X ² (1)=1.05, p=.351
Support following loss or major life change	84 (20.8)	21 (22.6)	63 (20.3)	X ² (1)=0.22, p=.663
Referring professional - GP (%)	142 (40.0)	34 (41.5)	108 (39.6)	X ² (1)=0.10, p=.798
2009	29 (7.2)	7 (7.5)	22 (7.1)	
2010	37 (9.2)	10 (10.8)	27 (8.7)	
2011	37 (9.2)	9 (9.7)	28 (9.1)	
Year of attendance				
2012	45 (11.2)	4 (4.3)	41 (13.3)	
2013	33 (8.2)	6 (6.5)	27 (8.7)	X ² (7)=7.16, p=.412
2014	70 (17.4)	19 (20.4)	51 (16.5)	
2015	100 (24.9)	24 (25.8)	76 (24.6)	
2016	51 (12.7)	14 (15.1)	37 (12.0)	
Attendance – completers (%)	399 (98.5)	92 (97.9)	307 (98.7)	X ² (1)=0.35, p=.626
Engagement – engaged (%)	393 (98.3)	92 (98.9)	301 (98.0)	X ² (1)=0.32, p>.999
Mean pre wellbeing score (SD)	38.3 (9.55)	41.3 (10.51)	37.4 (9.05)	F_(1, 406)=12.53, p<.001
Mean post wellbeing score (SD)	45.0 (9.79)	38.8 (10.90)	46.9 (8.60)	F_(1, 406)=56.76, p<.001

Qualitative

The qualitative findings are presented as a process model (see Figure 2), which highlights the main themes that emerged from the qualitative feedback. Findings from the participants in the two groups (decrease/no change, herein referred to as “decrease”, and “increase”) are presented simultaneously to demonstrate similarities and differences between the two groups.

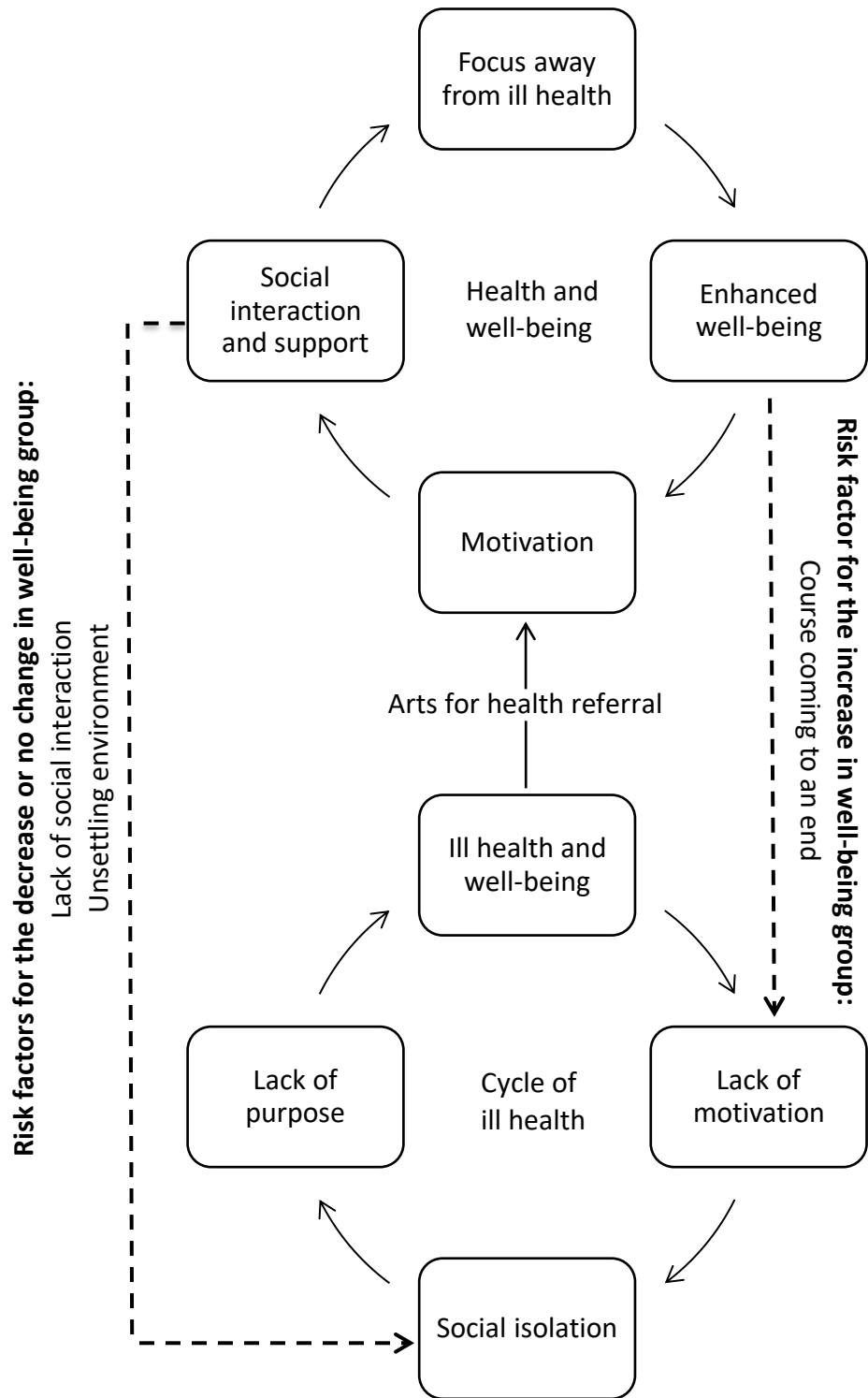


Figure 2. A Process Model of the Perceived Outcomes and Risk Factors of the Arts for Health Intervention for the Participants in this Study

Motivation

Prior to the course, participants reported feeling trapped in a cycle of ill health (socially, physically and mentally). One individual saw himself as being “too unwell to attend [the intervention]” (David, decrease group) while another participant acknowledged the “deterioration [of her] physical and mental health” (Edith, increase group) prior to participating in the course. These individuals reported becoming isolated, feeling “lonely” (David, decrease group) and not enjoying “going back to an empty home” (Jane, increase group), which only perpetuated their ill health further. Thus, one of the enjoyable aspects of the intervention, was that it offered participants a renewed sense of motivation that not only “got [them] out of the house” (Lorna, decrease group; Jane, increase group), but also provided them with a sense of “purpose” in life (Maude, decrease group). Furthermore, being offered a referral “stimulated” (Harriet, decrease group) their enthusiasm and became “something to look forward to” (Kim, decrease group; Trevor, increase group).

Although encouraged by the prospect of the intervention, participants demonstrated initial trepidation. Physical limitations, social anxieties, and a perceived lack of capability were amongst the least favourable aspects of the course, signifying potential risk factors to participation:

Physical limitation:

“[I least enjoyed] trying to get to [the intervention] on time as I’m very slow [because of] pain” Doreen, increase group

“I have tremors due to medication and find it difficult handling the art materials” Lorraine, decrease group

Social anxieties:

“[I least enjoyed] having to meet new people” Martin, decrease group

Perceived lack of capability:

“I’m a slow thinker, so...the session is quite stressful” David, decrease group

Given that the majority of individuals attended (98.5%) and engaged (98.3%) in the course it appears that the act of referral encourages people to challenge the symptoms of their ill health.

Social interaction and support

On attending the course participants were immediately positioned in a social environment. All of the participants perceived “company” (Daphne and Ann, decrease group) as one of the most enjoyable factors of the course. This provided a range of benefits including opportunities for “meeting other people” (Emma, decrease group), and for positive

human contact “friendly people to do art with and chat to” (Julia, increase group).

However, favourable outcomes varied for the two groups depending on the nature of the interaction between individuals. For the decrease group the intervention was enjoyable because it offered them a means to engage with a wider social community in a reciprocal way. They enjoyed humour and being able to “get on and have a laugh” (Louise, decrease group), being with others “camaraderie” (Rose, decrease group), feeling valued “companionship and being taken an interest in” (Doris, decrease group) and positive interactions “chatting with other members of the group” (Ethne, decrease group).

But the social interaction, acknowledged above was not evident for all participants. One individual stated that people were “not as chatty and social as I hoped” (Hannah, decrease group). As a result some participants felt as if they did not belong in the group:

“Other participants can make you feel uncomfortable” Megan, decrease group

“Other participants were very unhelpful and at times I sat almost the whole class not being involved” Claire, decrease group

In contrast, participants in the increased well-being group stated that the course offered them an environment in which they were able to feel “comfortable” (Daisy). These individuals enjoyed “meeting with other people who ha[d] similar problems” (Edith and Celia) and “similar life experiences” (Patricia). Perceiving a shared understanding these participants were able to empathise with, “support” (Edith and Celia), and to “help and encourage each other” (June).

Focus away from ill health

The AoP intervention provided individuals with a distraction, and for some a “project to work on” (Leanne, increase group). For participants in the increased well-being group this was enjoyable because it offered them “the chance to focus” (Joy) and “concentrate” (Dorothy) on something other than their worries. This, in turn, seemed to ease symptoms of their ill health:

“Doing something and concentrating...[took] my mind off [of] my anxiety” Dorothy

“The chance to focus and be creative, reduc[ed] stress” Joy

“Trying something different helped my confidence” Gillian

The intervention presented the individuals in the increase group with a space and time in which they were able to focus on, and care for, themselves. This seemed to facilitate the individual's ability to "relax" (Holly, Earl, Pam, and Marj), "escape [their] problems" (Holly), "switch off" (Joan), and "forget for a while" (Eve).

Conversely, those individuals in the decrease group appeared as being unable to relax, with one participant referring to the environment as "unsettling" (Megan). Although this group enjoyed "the art itself" (i.e. doing art for art's sake; Emma, Jeff, and Lorraine) no themes emerged to suggest any cathartic benefits from the intervention.

Enhanced well-being

Individuals in the increased well-being group perceived that being in a supportive social environment and having a focus away from ill health facilitated distraction. This, in turn, enhanced their well-being, and a sense of feeling better in themselves. One individual stated that "[the course] was a good mood changer...it helped [me] to relax and cope" (Earl). Others "loved [the course]" because it "improved [their] confidence socially" (Beth, Agnes, and Gillian) and "gave [them] positive thoughts" (Joan). Ultimately, the participants in this group recognised that "[the course] proved a real turning point for [them]" (Eric and Zoe). For this group, the intervention appeared to enhance their well-being, and in doing so, facilitated their capability and confidence in managing their health and well-being.

Nevertheless, participants in the increased well-being group did not enjoy "the end" (Celia, and Lionel) of the course or "knowing that it had to finish" (Liz). They were concerned that not having access to the intervention would diminish their state of well-being and felt "worried" (Sarah) at the prospect of maintaining their health and well-being without the support of the programme.

Discussion

This research aimed to understand specific patient groups that have differing outcomes in well-being from an AoP intervention. Through qualitative investigation we sought to uncover the dynamics of participation, and how these might relate to patient outcome. From the quantitative analysis little differed between the groups, aside from age and baseline well-being. The qualitative findings explored these differences further, and in doing so, identified a Process Model (see Figure 2.) depicting the perceived outcomes and factors affecting those outcomes, for participants in the two groups.

Outcomes and risk factors process model

Being referred to the course provided participants with the motivation to attend, and enabled some to break free from the 'cycle of ill health' that they felt trapped within. Participating in the intervention provided individuals with a sense of structure and reinvigorated their interest in the world. These findings support previous research that found such programmes to initiate interest, drive and

ambition (29), facilitate hope for the future (30), and engender a renewed sense of purpose (31). Although it cannot be ascertained whether the boost in motivation experienced by the participants in this research is exclusive to AoP schemes, the fact that people were stimulated to reengage with life reinforces the benefits that such programmes can contribute to health and well-being, and supports the potential role of social prescribing in person centred holistic health management (32).

Having been motivated to attend the course, a further outcome for the participants was the opportunity for social interaction and support. In line with previous findings (12, 14, 31, 33), individuals in the increase well-being group enjoyed the opportunity to connect socially and engage with the wider social community. Interestingly, it is this same aspect of social connection that was cited as being unfavourable by the decrease group. The lack of interaction experienced by this group reinforced a sense of social isolation, leaving them anxious and unable to relax in the environment in which the arts intervention operated.

This finding has significant implications for practice and policy. In respect to practice, not only has this research identified a sample of participants who do not appear to benefit from the social aspects of the course but it has also recognised that certain patients may be at risk of becoming further isolated and vulnerable as a result of attending the course. This appears to corroborate Spandler et al. (33) who note that “...despite the importance of arts participation for many individuals...we cannot necessarily assume this is a universal facet of recovery [or] ‘good for’ [all] people with mental health needs” (pp.797-798). If we are to ensure that pathways to health promotion are as efficacious as possible, there is a need to identify, and further understand, the perspectives of individuals that say they do not benefit from such interventions, in addition to people that do. In respect to policy, with the increase interest and use of social prescribing, and arts and creativity as key aspect of these initiatives (32), these findings support calls for robust evaluation methods to be applied to develop evidence on effectiveness and efficacy for different population groups and characteristics (34, 35).

Examining the metric of well-being used herein the post-intervention well-being levels of the decrease group are still higher than the pre-intervention levels seen in those that experience an increase. This might suggest that not only are those with lower initial well-being actually in a position to gain more, but they may also be at a point where they can gain more. However, it is likely that there are other unexplored factors involved within this grouping that may be driving these different outcomes. Personality, for example, is a significant driver of social behaviour in both unfamiliar circumstances generally as well as in clinical group settings (36, 37), and it is highly likely that there are elements involved in this sphere that may relate to the divergent outcomes observed. Given the apparent pivotal issue of group activity, it may be pertinent to investigate the efficacy of individual art-based interventions as an alternative to a group-based intervention. This may also help to understand more about the creative process of such interventions, versus the holistic experience of the intervention, which has been previously suggested as influential to patients’ positive experiences in primary care physical activity referral schemes (38).

Although social aspects of the course were potentially limiting for some, the majority of those in the well-being increase group enjoyed being around others. They experienced an enriched sense of belonging which, in turn, enhanced their capability to relax and an opportunity for distraction, progressing them along the Process Model (Figure 2.). For these individuals, attending the intervention provided an alternative focus to their thoughts and enabled them to concentrate on and care for themselves; this, in turn could be responsible for their enhanced well-being. This supports the theory that it was not the art per se that facilitated beneficial outcomes for individuals, but that favourable outcomes were an indirect result of engaging in the holistic experience that the artistic process provided. This finding supports previous conclusions, for example Daykin et al. (14) who, on conducting a systematic review of the impact of art, design and environment in mental healthcare, found that the health benefits of such programmes were primarily indirect for example, art was seen as offering a distraction from problems. Moreover, the present study adds to current understanding by providing a report of the perspectives of those that have not experienced an increase in well-being and a model to explain the dynamics of participation, and how these may relate to perceived and actual outcomes. The Process Model (Figure 2.) developed from this research identifies the important factors of motivation, social interaction, support and a shift in focus, which may influence the relationship for participants taking part in AoP interventions.

Well-being has been identified as an important and beneficial outcome for commissioned health services in both primary and secondary health care in the United Kingdom and beyond (7). In this study, increased well-being was observed in those who were able to relax in the environment and were capable of shifting their focus away from their ill health. Attending the programme made these individuals feel better in themselves and, as a result, more autonomous over managing their health. However, these participants also perceived the inevitability of the course ending as a cause for concern. The activity had become part of their routine, providing them with a sense of purpose. They felt anxious at the prospect of losing the support structure that they relied upon and lacked the confidence to maintain their health and well-being on their own. This confirms previous research (14) and Russell's (39) acknowledgement that arts programmes are 'perishable commodities' (p.22), whereby, once they stop, the stimulating impact on health disappears.

Conclusion

The present study sought to explore and understand the dynamics in which some individuals benefit from engaging in an AoP programme, and some do not. In exploring the participants' perspectives of the intervention, a Process Model (Figure 2.) was developed from the findings, depicting the perceived outcomes and factors affecting outcomes for both participatory groups, and their interrelationships. This model represents a new contribution to the literature, identifying factors that participants perceived as both facilitative and inhibitive to their well-being. The model can support clinicians, artists and academics to understand more about the dichotomous and varied experiences of people on these programmes and the journey they have to take for positive

outcomes to be achieved. While being referred to an AoP intervention can constitute a catalyst for change in individuals, the identification of these factors may help to identify those for whom this type of intervention may or may not be beneficial. These factors and their interrelationship with the elements of the intervention has highlighted possible target areas that can be challenged in social prescribing practice to help facilitate the process towards supporting a positive well-being change for people referred onto such programmes. This constitutes useful evidence for the future targeting of the social prescribing offer that is increasingly available in primary care and the community. Thus, the findings of this research will be pertinent to those commissioning primary care art interventions, ensuring that referral policies and pathways are designed for optimal effectiveness and for potentially tailoring social prescribing programmes to suit their needs, be they group or individual. Of importance is the need for research in the field of social prescribing to actively explore instances where such interventions have not been successful so that they can be adapted to potentially increase efficacy. Further research is also needed to explore the interrelationships identified in the Process Model to understand further whether the identified facilitative and inhibitive factors are representative in similar arts for health interventions.

Limitations

Although this research has contributed further understanding to the literature there are a number of limitations that must be noted. Firstly, there was a lack of randomised control group in the delivery of information, as such it is difficult to determine whether a cause effect relationship exists between the AoP intervention and the patient's well-being. Secondly, due to the heterogeneity of the intervention type it cannot be ascertained whether the outcomes experienced by the participants are exclusive to AoP programmes. Thirdly, since the intervention took place in the South West of England generalizability of the results is limited. Finally, the fact the sample was non-representative and also a sub-sample of a larger overall sample means that this study may have suffered from selection bias. Nevertheless, this research has provided a vital first step towards understanding the factors of an AoP intervention that may account for individual differences in well-being outcomes and in doing so, this research has identified factors that may be targeted to facilitate the process towards a positive well-being change for all people referred onto such courses.

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