Introduction & Scope: The impact of Arts, Leisure and Culture on health and wellbeing'

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Key lines of enquiry

Explore the opportunities for addressing health concerns of Stockton Borough residents by:

- Examining the range of arts and health activities
- Examining the resources spent on arts initiatives and the return on investment
- Identifying how to record and utilise service user wellbeing through services / survey indicators to influence how we develop and commission services

Considerations

Tensions

- Physical vs mental health
- Prevention vs treatment
- Universal vs targeted interventions

Drivers

- Inequality
- Increased focus on ‘wellbeing’ and societal factors, as well as medical model of health
- Improving sickness absence rates and workplace health (internal & external)
- Asset-based approach: resources in communities

Health & Wellbeing in Stockton

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The Stockton picture

There are a range of data sources around health and wellbeing and communities, including:

- Stockton-on-Tees Joint Health and Wellbeing Strategy 2012-2018
- Director of Public Health Annual Report for the Borough of Stockton-on-Tees 2012-2013
- “Shaping Our Future” A Sustainable Community Strategy for Stockton-on- Tees 2012 – 2021
- Joint Strategic Needs Assessment 2010

Deprivation is associated with poorer health and wellbeing outcomes

Stockton Health Profile 2013

A wide range of health and wellbeing indicators could be impacted by engagement in arts, leisure and culture

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Children's and young people's health	7 Smoking in pregnancy ‡	426	17.8	13.3	30.0		2.9
	8 Starting breast feeding ‡	1368	57.5	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡ *	422	22.1	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18) *	32	74.3	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	145	38.7	34.0	58.5		11.7
Adults' health and lifestyle	12 Adults smoking	n/a	17.8	20.0	29.4		8.2
	13 Increasing and higher risk drinking *	n/a	22.6	22.3	25.1		15.7
	14 Healthy eating adults *	n/a	21.9	28.7	19.3		47.8
	15 Physically active adults *	n/a	54.0	56.0	43.8		68.5
	16 Obese adults ‡ *	n/a	27.7	24.2	30.7		13.9

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Stockton Health Profile 2013

Participation and impacts can be across the life course

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Disease and poor health	17 Incidence of malignant melanoma	28	14.6	14.5	28.8		3.2
	18 Hospital stays for self-harm *	643	348.3	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡ *	5571	2523	1895	3276		910
	20 Drug misuse	1971	15.5	8.6	26.3		0.8
	21 People diagnosed with diabetes *	8376	5.4	5.8	8.4		3.4
	22 New cases of tuberculosis	9	4.9	15.4	137.0		0.0
	23 Acute sexually transmitted infections	1503	784	804	3210		162
	24 Hip fracture in 65s and over *	201	520	457	621		327
Life expectancy and causes of death	25 Excess winter deaths ‡	89	17.2	19.1	35.3		-0.4
	26 Life expectancy – male *	n/a	78.0	78.9	73.8		83.0
	27 Life expectancy – female *	n/a	81.9	82.9	79.3		86.4
	28 Infant deaths	9	3.7	4.3	8.0		1.1
	29 Smoking related deaths	306	226	201	356		122
	30 Early deaths: heart disease and stroke *	141	67.2	60.9	113.3		29.2
	31 Early deaths: cancer *	266	126.2	108.1	153.2		77.7
	32 Road injuries and deaths	61	32.1	41.9	125.1		13.1

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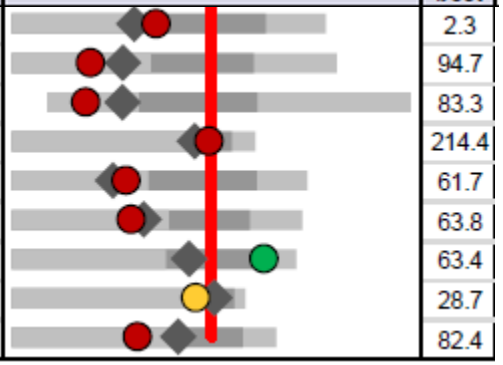
Child Health Profile 2014

Examples from children's data

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst		Eng. best
Prevention of ill health	**24** Smoking status at time of delivery	415	17.7	12.7	30.8		2.3
	25 Breastfeeding initiation	1,267	53.9	73.9	40.8		94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	587	24.6	47.2	17.5		83.3
	27 A&E attendances (0-4 years)	6,485	525.5	510.8	1,861.3		214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	492	140.9	103.8	191.3		61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	475	189.2	130.7	277.3		63.8
	30 Hospital admissions for asthma (under 19 years)	55	123.0	221.4	591.9		63.4
	31 Hospital admissions for mental health conditions *	48	114.0	87.6	434.8		28.7
	32 Hospital admissions as a result of self-harm (10-24 years) *	236	643.7	346.3	1,152.4		82.4

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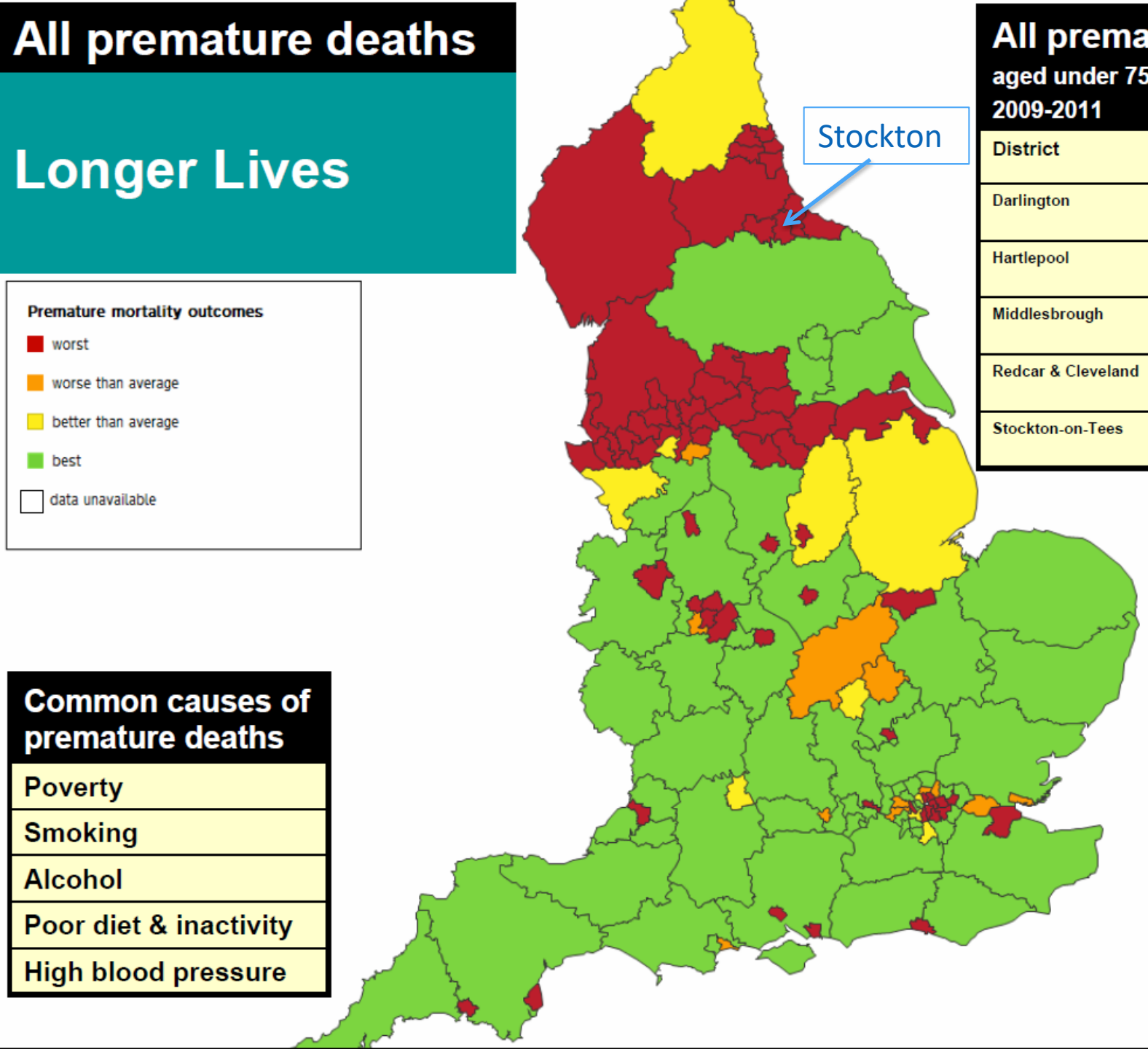
All premature deaths

Longer Lives



All premature deaths, aged under 75 years, 2009-2011

District	Death rate (per 100,000)	Category In England
Darlington	298 *94th of 150*	Worst
Hartlepool	336 *131st of 150*	Worst
Middlesbrough	371 *145th of 150*	Worst
Redcar & Cleveland	297 *93rd of 150*	Worst
Stockton-on-Tees	301 *102nd of 150*	Worst

Common causes of premature deaths

- Poverty
- Smoking
- Alcohol
- Poor diet & inactivity
- High blood pressure

Wellbeing

The Office for National Statistics is leading national work on measuring wellbeing.

Stockton Borough Residents' Survey (2012) showed:

- Most important factors for quality of life: community safety (39%), parks and open spaces (20%)
- Most important improvements needed for quality of life: more facilities for teenagers (17%) and children ‹13yrs (15%), reducing crime and anti-social behaviour (14%)
- 70% of respondents said their health was 'very good' or 'good'
- 28% said day-to-day activities were limited (a little or a lot) because of a health problem / disability lasting at least 12 months
- 32% were feeling optimistic about the future all of the time / often; 24% none of the time / rarely
- 51% had been dealing well with problems all of the time / often; 7% none of the time / rarely

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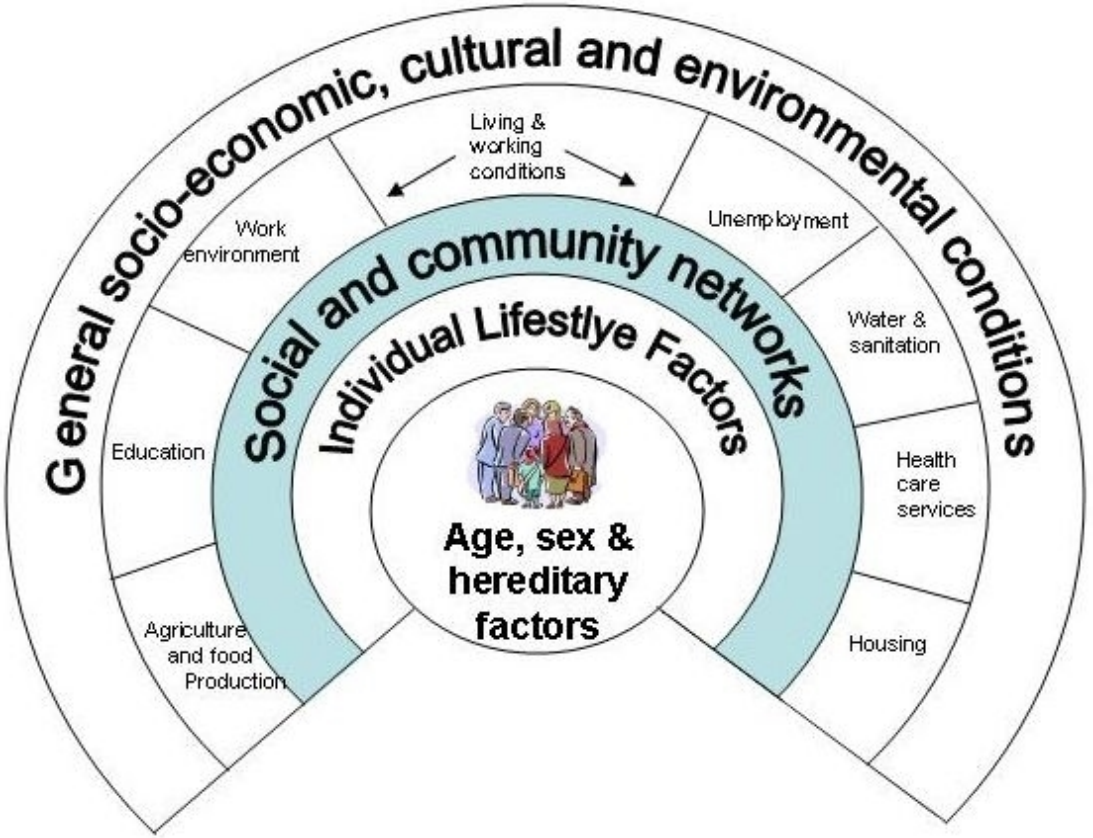
Source: DPH Annual Report (2012-13)

Determinants of health & wellbeing

Determinants are broad-ranging:
there is potential for impact through a range of arts, leisure & cultural activities



Source: Dahlgren & Whitehead 1991

Targeted support

- People in areas of greater deprivation have poorer mental and physical health outcomes, in general

- Particular vulnerable groups have poorer mental and physical health outcomes, including:
  - people with mental health conditions
  - particular ethnic groups
  - travellers, asylum seekers and migrants
  - people suffering from loneliness and isolation can experience poorer mental health

The Evidence

Evidence (1)

Evidence shows:

- Physical activity helps prevent overweight / obesity and helps reduce weight in people who are overweight / obese[1]
- Participating in physical activity has a positive effect on mental health[1]
- Regular exercise & participating in meaningful activities e.g. arts, sports or volunteering help promote good mental health and wellbeing[2]
- Physical activity interventions are just as effective with deprived communities and older people[2]
- Exercise is associated with improved cardiovascular disease risk factors even if no weight is lost[3]. The cost of CVD and diabetes to the health and care system is significant

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[1] NICE guidance: Obesity (2006); [2]No Health without Mental Health (2011); [3]Shaw *et al.* 2006: Exercise for overweight or obesity

Evidence (2)

Evidence shows:

- People with poor mental health tend to have worse physical health outcomes e.g. depression increases the risk of mortality by 50%; and doubles the risk of coronary heart disease in adults[2]
- Volunteering can build self-esteem and contribute to forming social networks and community cohesion (for the volunteer and recipient)[2]
- Participating in leisure, arts and other community activities can promote improved wellbeing and community connectedness[2]
- Social isolation can lead to poorer physical and mental health[4]
- Creative activities can be effective in treating mental health conditions e.g. NICE recommends art therapies are considered for everyone with a diagnosis of schizophrenia and related diagnoses

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[2] No Health without Mental Health (2011); [4]Social Care Institute for Excellence (Oct. 2014)

National / international evidence (1)

Do we measure the important things or make the measurable things important?

- Physical benefits are more measurable and understood
- Creative activity can be tested but not consistently duplicated or scaled up
- No ‘control group’ or absolute standard, no randomized trails
- Numerous, subjective variables
- Prevention can be hard to measure even without other variables
- Measuring effectiveness is hard, comparable cost-effectiveness harder still

National / international evidence (2)

Trying to nail blancmange to the wall:

- 2010 – 2013 DCMS sponsored Culture Sport Evidence Programme

  Narrow definitions of value rather than impact/benefit

  Social Wellbeing benchmarked against other policy outcomes

- Arts Council funded work, with NCVO and NEF (current)

  attempting to collate evidence, policy fit, and commissioner interest

  focus on Older People, Mental Health, and Place Based Commissioning

  - Older People – good standards of practice evaluation, growing body academic evidence
  - Mental Health – good results via established tools but questions over measurement techniques
  - Place Based – lack of academic evidence

In summary

In general:

- Physical activity has a positive impact on promoting good physical and mental health and this is well-documented
- Physical activity helps to improve poor physical and mental health (well-documented)
- Creative activities can help to treat mental health conditions

It is more difficult to quantify:

- The impact of participation in cultural / arts activities in preventing mental and physical ill health
- The cost effectiveness of the impact of cultural / arts activities in preventing mental and physical ill health and in promoting good physical and mental health

Focus of the Review

Art, Leisure or Culture?

Culture or culture

- Arts, music, dance, literature, film, photography, heritage, history
- Beliefs, behaviours, shared traits, symbols, interpretation and meaning

Sports or leisure

- Formalised and regulated competitive physical activity
- Formal and informal physical activity in any setting for any purpose

Proposed focus

In light of the evidence, it is proposed the review:

- Focuses on the impact of arts, leisure and culture on mental health and wellbeing
- Focuses on both the impact related to:
  - promoting good mental health and wellbeing (i.e. preventative activity); and
  - treating mental ill health
- Particularly considers the impact on specific target groups at greater risk of poorer mental health e.g. certain ethic groups, people suffering from loneliness and isolation