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Arts and Culture: A Necessary Component to Address Unmet Social Needs and Advance Individual and Community Well-Being

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Abstract

U.S. healthcare institutions increasingly integrate screenings for social needs into standard care, and help meet those needs by referring patients to community-based resources. However, community arts/culture assets are not commonly included among those resources. Given growing evidence of the positive health impacts of arts/culture, and given that access to these benefits remains inequitable, this article argues for the integration of arts/culture resources into healthcare referral networks. It highlights two early models, the CultureRx initiative in Massachusetts and Creative Forces, both of which piloted this integration with promising results. It also offers suggestions for better utilizing local arts/culture assets, emphasizing that these existing community resources can and should be applied to advance whole-person strategies and better address social drivers of health.

Keywords

social determinants, community care, arts and culture, social care technology, community referral

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Introduction

Identifying and addressing social needs such as food, housing, and social connection have been shown to improve population health outcomes.[1] In response, healthcare organizations have increasingly integrated social-need screenings and referrals into their standards of care, which has been found acceptable to both providers and patients.[2] This process allows providers to connect patients with nonclinical resources via community referral networks; network organizations then address social drivers of health (SDoH) by providing assistance with food and housing, education, employment, transportation, and more.[3-5]

While screening and referral processes facilitate beneficial connections to local services, these services typically do not include arts and culture resources. Yet accumulating evidence points to the importance of arts and culture in positively influencing individual and population health outcomes. Experiences such as dance classes, musical performances, museum visits, and a wide variety of cultural practices have been shown to address mental health concerns,[6] foster social cohesion,[7] reduce healing time,[8] improve access to care,[6] support mobility and movement,[9] promote longevity,[10] reduce stigma,[11] and support collective action toward shared health goals.[12] Health applications range from preventive to curative, and from clinic to community. Given these benefits, and given the World Health Organization's (WHO) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," we posit that arts and culture are critical ingredients in addressing SDoH. As such, they must be included among the resources typically curated for community health referral networks and practices.

Early Models in the United States

Two key examples illustrate both the value of arts/culture resources, and the opportunity to incorporate them into existing community-referral networks. Most prominent is the CultureRx initiative in Massachusetts, modeled after "social prescription" programs in the United Kingdom (UK). Formally developed in the 1980s, social prescription is a model in which healthcare providers prescribe community-based services for non-clinical and subclinical needs.[13] Notably, social prescription has traditionally included arts, culture, and nature resources among the standard community-based resources and experiences from which patients can benefit.

The CultureRx Social Prescription Pilot is the first statewide program in the U.S. to model this ability for healthcare providers to offer prescriptions to arts and culture experiences that support patients' health. Launched in 2020 as a partnership between 12 cultural organizations and 20+ healthcare providers, the program aims to enhance provider toolkits and improve population health via expanded arts access. Findings from a pilot evaluation indicate overwhelmingly positive responses from participants, and suggest that the program additionally supports providers' well-being by increasing their enjoyment and sense of efficacy regarding the care they are able to offer.[13]

A second model, Creative Forces (CF), was launched in 2011 as a partnership between the Department of Defense and the National Endowment for the Arts. It aims to improve Veteran health via access to evidence-based arts practices. CF draws upon studies indicating that creative arts therapies can facilitate recovery from traumatic experiences, encourage healthy coping mechanisms, and foster the ability to experience hope and gratification.[14] While most CF programs are facilitated by certified therapists in art, dance, music, or expressive therapies, CF is piloting the addition of community-based arts programs so that Veterans can continue accessing beneficial arts practices once their clinical sessions end.[15]

Because CultureRx and CF are newly piloting links between healthcare and community arts resources, program implementers have expended significant resources to build new partnerships and customized referral pathways. The initiatives have also relied heavily on healthcare providers as primary referral sources, whereas traditional U.S. referral networks are often multidirectional—allowing all organizations to refer participants to needed resources. For example, if CultureRx and CF were integrated into multidirectional care networks, their cultural organizations would be enabled not only to *receive* referrals from providers, but also to *make* referrals, when needed, to additional health and social care services. As

healthcare and public health increasingly recognize the value of arts and culture for advancing our goals, we should standardize integration of arts and culture into social care referral networks—rendering programs like CultureRx and CF even more feasible, sustainable, and effective.

Using Technology to Facilitate Connections to Arts and Culture

One way in which this integration could be pursued in the near term is via cross-sector technology platforms that support social care screenings and referrals. Without these platforms, the primary way providers refer patients to arts and culture resources is simply by making recommendations (eg, verbal mention, sharing informational flyers). This approach requires providers' personal awareness not only of art's potential health benefits but of specific resources available within their community. Another option, modeled by CultureRx, is to create new targeted care pathways between specific healthcare providers and specific arts/culture organizations. While effective, this approach is time and labor intensive, requiring each partnership to develop custom practices for referrals, follow-ups, and evaluation.

Meanwhile, many U.S. communities already use cross-sector collaboration platforms that involve a variety of local organizations. Adding arts/culture services to these platforms offers an immediate way to integrate such services with existing community care practices. This approach could provide health- and social care providers with immediate knowledge about (and access to) local cultural assets, and reduce the need to commit time and resources toward establishing new care pathways. In addition to facilitating referrals, technology platforms can help address specific challenges identified by the CultureRx evaluation, including the need for clear processes by which to make and track referrals, illuminate outcomes, and securely share patient information. These platforms also enable providers to refer to multiple resources at once: including arts/culture, food, housing, transportation, childcare, etc. This may have been helpful to the CultureRx pilot, during which transportation posed the primary barrier to arts/culture access, and providers' referrals to cultural resources had to be made separately from all other health or social care referrals.

Data from Unite Us, one cross-sector collaboration platform, indicate that community networks have interest in including arts and culture resources in their care coordination practices. Across 44 states, thousands of organizations on the platform offer at least one arts and culture-related program, such as social enrichment, classes in music or arts and crafts, and outdoor activities. These indicate feasibility and interest, but represent a small percentage of all programs offered. In addition, the current inclusion of various arts/culture resources is likely based on the perceived health value of specific programs rather than on a broader recognition that any community's cultural assets are also among its health-improving resources. In other words, there remains great opportunity to expand awareness and use of arts and culture assets as community health resources.

Considerations and Recommendations

As noted, the WHO's definition of health clarifies the need to advance not only the absence of disease but the presence of well-being. To do this, social care must expand beyond meeting basic needs to include equitable opportunities to discover, explore, and nurture one's interests, relationships, beliefs, and values. Most communities have arts/culture resources that could help individuals meet these critical needs, yet access to these resources remains inequitable. Models like CultureRx suggest that, given the opportunity, providers

make immediate use of arts/culture resources to support mental health, address isolation, cultivate family and social connections, foster curiosity, increase movement and mobility, and improve quality of life. Put simply, we can expand provider toolkits, deliver more direct health benefits, increase equitable access to community assets, and advance well-being. To do so, we must recognize the role of arts and culture in human health and thriving, and ensure that related community resources are not excluded from our collective efforts to address SDoH.

As arts and culture are added to community referral practices, research will be needed regarding uptake, effectiveness, and best practices. Future research should measure the health effects of increased access to arts/culture services, evaluate barriers to access, and examine varied approaches to referrals (eg, dose/duration, populations referred, platforms used, programs referred to). Additionally, arts/culture organizations participating in community health networks must ensure they are safe and inclusive for all people, which entails training for staff and facilitators in trauma-informed practice and in diversity, equity, and inclusion. Community organizations also need financial compensation and streamlined funding to sustain and grow their capacity to provide vital services. New policy and funding mechanisms (eg, Medicaid 1115 waivers, Medicare supplemental benefits) should be explored to financially sustain community partners, including those providing arts/culture services.

Conclusion

The contributions of arts and culture to human health are not new; humans have always developed and sought these practices for healing, connection, and thriving. However, it is not yet standard for healthcare practices in the U.S. to recognize arts and culture as critical components of effective community care. Fortunately, existing models and structures point to an immediate ability to support increased referrals and access to these resources. To materialize this opportunity, we must recognize arts and culture as community assets that help address health and social needs, and proactively integrate related organizations and services into existing referral processes. By making these changes, communities will increase their capacity to address SDoH and advance health and well-being.

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