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The Future for Arts and Health: a research paper examining the development of the arts and health sector and exploring conditions for its sustainability

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THE FUTURE FOR ARTS AND HEALTH: A RESEARCH PAPER EXAMINING THE DEVELOPMENT OF THE ARTS AND HEALTH SECTOR AND EXPLORING CONDITIONS FOR ITS SUSTAINABILITY.

INTRODUCTION

This study seeks to examine the development of the arts and health sector in England and to explore the conditions necessary for its successful future sustainability. In doing so, it looks at the political context for arts and health work and the role that several aligned agencies have had to play in creating a fertile environment in which an arts and health project can flourish. It explores the criteria that are fundamental to the sector's success. It concludes by detailing the key issues that the sector faces as it moves into its next phase and makes recommendations on how best to tackle those issues.

The methodology for this study has been a literature review, which has looked at policy developments over the last eight years and the effects that these developments have had on the arts and health sector. There has been a similar literature review of the current models of delivery for arts and health work.

With this information and combined with the personal experience of running an arts and health project and of local government and arts policy making, a number of success criteria for the sector's successful continuation and growth were identified and these have been explored more fully in a series of interviews with key sector players (see appendix two). Interviewees were selected to ensure full representation from across the arts and health sector and included policy makers, academics, project managers and health managers.

Analysis of the interviews produced a number of issues to be taken into account for the sector's future sustainability. These have been described and, bringing the work of this research together, the paper concludes with recommendations for the sector to address the issues identified.

As a number of other commentators have noted[1], the terminology involved in this sector is fraught with meaning and difficulty. For the purposes of this paper, the term 'arts and health' is used to encompass the different approaches in the sector, described at a later point, whether they have a focus on individual or community, on improving health or well-being or on building-based as opposed to work in the wider environment.

BACKGROUND TO THE CONTEMPORARY ARTS AND HEALTH MOVEMENT

In 1997, with the election of a Labour government, the United Kingdom saw a significant shift in policy development and practise. Tackling social exclusion became an explicit government priority and the Social Exclusion Unit was set up to assist in reducing social exclusion by producing "joined up solutions to joined up problems". This shift was to have a profound influence on the development of the modern arts and health movement.

The Policy Context – the Arts

In their examination of collaborative policy and practice *Creative Community Building through Cross Sector Collaboration*, the Centre for Creative Communities details the way in which this shift in policy influenced the future of service delivery in a number of sectors. This was to have a powerful impact in more closely aligning delivery of the arts to social policy objectives, which in turn allowed for the more strategic development of work across two previously unaligned sectors, namely arts and health. The starting point for this, post 1997, was the publication of *Bringing Britain Together* in 1998 which produced a national strategy for tackling excluded groups and neighbourhoods through "investing in people, involving communities and developing integrated approaches with clear leadership".[2]

Following this publication, 18 Policy Action Teams (PAT) were set up. Each Team was made up of officials from Government Departments, experienced practitioners and academics. PAT 10, led by the Department of Culture, Media and Sport produced a report which looked at the role of arts, sports and leisure in contributing to neighbourhood renewal and concluded that these areas '……can make a real difference to health, crime, unemployment and education in deprived communities'[3].

The Arts Council of England, in response to PAT 10, stated that in their opinion the primary role of an arts funder was not in combating social exclusion and poverty and that to 'set out to use the arts for instrumental purposes only is to undermine artists' work. However we also recognise that some artists have always worked within the context of what is currently termed "social exclusion". It is this work that this plan seeks to recognise and enhance.' [4] As a direct result, the Arts Council adopted a definition of social exclusion that took low-income areas as its starting point and launched a series of activities and programmes designed to define and suggest methodology for measuring impact. This focus on the role that arts could play in addressing social exclusion was a new departure.

In 2002 the Arts Council was substantially restructured and a new manifesto for the arts was published. It was clear in placing the artist at the heart of its work, but also committed to creating more opportunities for people to experience and take part in life-changing artistic experience, reflecting the manifesto of its sponsoring body the Department of Culture, Media and Sports.

> 'It is our central belief that the arts have power to transform lives, communities and opportunities for people throughout the country.'
>
> *Ambitions for the arts 2003-2006*, Arts Council England

The Policy Context – Health

Simultaneously the drive to tackle social exclusion was affecting health policies. The government green paper *Our Healthier Nation* announced the aim of improving the health of the worst off in society and therefore narrowing health gap. The paper highlighted "a new balance – a third way - linking individual and wider action and for the first time the phrase 'wider determinants of health' began to appear.

> **"**Our new approach is rooted in precisely that balance. We believe that individuals can, should and do affect how healthy they are. But we believe too that there are powerful factors beyond the control of the individual which can harm health. The Government has a clear responsibility to address these fundamental problems. Striking a new balance - a third way - linking individual and wider action is at the heart of our new approach. "
>
> Saving Lives: Our Healthier Nation, Department of Health, 1999

Figure 1: The wider determinants of health

Source: adapted from Dahlgren (1995) [1].

Health Action Zones (HAZ) were developed through 1998 and 1999, establishing local partnerships between the NHS, local authorities and communities. There was no national guidance here to use the arts as a tool, but in specific regions, these HAZ provided a fertile ground for arts projects that sought to address health inequalities.

An example of this approach was the Luton Social Needs Awareness Project (SNAP), a community-based arts initiative working with young people excluded from mainstream activities due to age, gender, lifestyle, ethnicity, socio-economic status, lack of education achievement or residence. HAZ funding went towards activities include workshops with vulnerable young people (homeless/drug addicts) covering photography, video making and lyric/music making. These workshops aimed to enable participants to develop confidence and self-esteem through involvement in a group work process and provide them with pathways into education, training and employment. Interestingly the Department of Health was able to offer many such examples of best practice, but was less confident of the evidence base that could reliably demonstrate which projects and interventions were effective and the project itself found it hard to measure participants' drug use on starting the programme to provide a baseline measure. [5] This difficulty in measuring impact is a subject to be considered throughout this paper.

In 1999 the vision of Healthy Living Centres, funded with Lottery money, advocated new and imaginative ways of dealing with the overall well-being of local communities.

> "Healthy living centres will focus on health in its broadest sense, providing opportunities to improve quality of life and enable people to achieve their full potential"
>
> *1999 Health Service Circular*

Perhaps the best known of these is the Bromley by Bow Centre, which provides a GP practice and ancillary services in the heart of East London, but is also a major community care provider for Social Services. There are artists' studios on site and the Centre promotes social enterprise as a model for community well being, having launched numerous local businesses. It runs a large number of volunteer projects and works through a wide range of partnerships and networks including with the education sector. The physical surroundings are dominated by visual arts - and arts and participation in the arts is a key focus. "Arts is used in most of the centre activities as a powerful tool for boosting self confidence, improving health and beautifying the environment" [6]

The Health Development Agency was also set up to tackle inequalities by focusing on not only physical health, but also the environment, housing, transport and poverty.[7] The role of arts in

delivering these solutions to these health inequalities was implicit rather than explicitly stated. However for many working in the community arts sector, the policy was perceived to have caught up with actual activity and in some cases provided funding for projects that had existed for years.

In 2000, the Government published *The NHS Plan: a plan for investment, a plan for reform* which outlined its vision for a health service designed around the patient and also signalled a major investment in NHS facilities. This emphasis on a holistic view of healthcare and on the patient environment was to have a profound influence on work in the arts and health sector with hospital arts projects in particular beginning to flourish. The policy shift in the Plan has been continued with the recent publication of the NHS Improvement plan.

> "The NHS will be able to concentrate on transforming itself from a sickness service to a health service. Prevention of disease and tackling inequalities in health will assume a much greater priority in the NHS. With the NHS working in partnership with others and with individuals to support people in choosing healthier approaches to their lives, real progress will be made on preventing ill health and reducing inequalities in health"
>
> *NHS Improvement Plan 2004*

Recent Development of the Arts and Health Sector

The historical context for the development of arts and health work has been well documented from the first cave paintings through to patronage and philanthropy of those installing art into the first major hospitals in England to the emergence of landmark organisations such as Paintings in Hospitals and Hospital Arts in Manchester[8].

There are a number of more recent key developments, made in response to the policy shift in both the arts and the health sectors which have helped to bolster the arts and health field and move it someway to a more mainstream position. There has also been a growing awareness of the importance of the healthcare environment and in the number of high profile supporters of the role that the arts can play in addressing this issue.

In 1998, the Department of Health[9] indicated that attractive design, and art was mentioned specifically, was to be encouraged and the message was continued in the NHS Plan, which committed to providing better, less run down and more modern facilities.

The King's Fund, set up in 1897 by Edward, Prince of Wales as a charitable foundation to improve the health of Londoners, has been a key player in moving the arts and health sector forward. It supported the creation of the National Network for Arts and Health (NNAH), which emerged as a registered charity in 2000 which, with the setting up of London Arts in Health Forum (LAHF) alongside, both funded by Arts Council England, demonstrated an emerging professional and lobbying support for the sector.

As well as seeing the need to provide strategic and policy support for the arts and health sector, the King's Fund also wanted to create an action learning model that could inform best practise within the health sector. Launched in February 2001 by HRH The Prince of Wales, President of the King's Fund, the 'Enhancing the Healing Environment Programme' (EHE) was the largest single investment, (approaching £2.25 million), that The King's Fund had ever made in London's hospitals. Its aim was "to increase the well being of patients by improving the environment in which they are treated. "[10] The programme was hugely successful[11] in raising the issue of hospital environments more widely and influenced, and was influenced by, a growing sense that there was a role for the arts in that debate.

In 2002 NHS Estates – the agency responsible for the health sector's buildings - published two guides to using the visual arts in healthcare under the banner of *Improving the Patient Experience*. Highlighted benefits for such an approach included 'breaking down barriers between hospitals and local communities; improving health outcomes and improvements to the physical environment'[12]

As a result of this increase in activity, there has been an increased recognition that the 'arts have an important role in helping to determine people's health, whether it's through participation, using art to convey important messages or improving the everyday environment of individuals and communities.'[13] Medical evidence that patients stress levels were 48% lower after exposure to visual arts and that two thirds of staff had indicated that an art programme had influenced their decision to stay or apply for a job[14] has also helped to make a persuasive argument, and in August 2004, Arts Council England contributed to an ongoing acceptance of the role that arts had to play in health by publishing for the first time a review of medical literature. They also signalled their intention to develop a national arts and health strategy, due to be published in 2006.

These positive developments indicated a growing confidence in the sector and with it, throughout 2005, came an increased coverage of arts and health stories in the media, not all of which were equally supportive. The announcements of increasing difficulties in the balancing of

hospital budgets and the perception that funding for the arts was draining valuable resources from the NHS coincided, not withstanding the factual evidence that the majority of funding for arts programmes came from charitable sources and public arts funding. A question in the House of Commons[15] revealed a £9million spend on art in hospitals which The Sun newspaper derided in a front page headline '*Taking the Picasso'* [16]. Although this was countered with more thoughtful editorial and considered responses from the public and programme managers, the need to continue to make the case and explain the role of arts within the health environment was clearly articulated.

Conclusion

Whilst undoubtedly beneficial for individual arts and health projects and local settings, the policy developments here had some unforeseen implications, which are further explored in this paper.

Firstly, by aligning the arts to social policy, there was for the first time the possibility of funding for dedicated arts and health work from the arts sector, but there was no framework developed to evaluate the impact of this public funding and, in an increasingly accountable world, this was to become a stumbling block. This was mirrored in the health sector, which had identified the potential of non-traditional health interventions in tacking the wider determinants of health, but again was at a loss to measure the impact and value of arts to health.

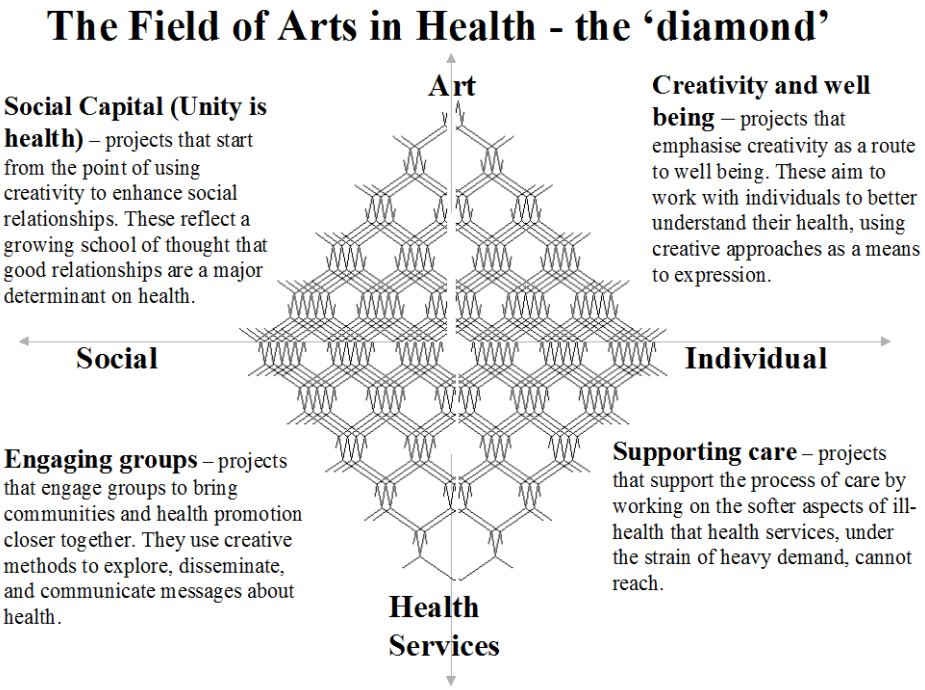
Secondly the role of arts in health was still *implicitly* supported and valued. Individuals had spoken in the sector's favour, including government ministers, but there was little formal policy to support the work – and where it existed, the indications were that this work was desirable, but this did not translate into explicit recommendations or mandatory actions. It remained hard for arts and health projects to make the case for support against competing legislated priorities. This lack of visible support also impacted on the media coverage. With no formal position statements from either the public arts funders or the Department of Health, arts and health projects continued to be easy prey and a vicious circle of misinformation could be maintained.

Lastly, because the growth of the arts and health field has shown to be organic and unstructured, it becomes clear that the leaders in that field have come through less traditional routes, with no formal training and different motivations for the work that they do. There are obviously strong and accomplished leaders who have driven the work through. There is, however, a need to formalise their work, create a stronger sector by developing a set of shared messages and build credibility in both arts and health by addressing the different political and managerial imperatives of both.

CURRENT MODELS OF DELIVERY

As hinted at earlier, the arts and health field encompasses a variety of different projects in different settings and working with different groups and approaches. This diversity of application is both a strength and a weakness. It has enabled the sector to be develop a portfolio approach to funding, an ability to seek and justify funding from a number of different sources, long before the rest of the arts world had been told that this would be the future. But it also means the sector can sometimes seem incoherent. It is hard to describe what is meant by arts and health and even harder for those outside the sector to grasp its scope, this becoming absolutely fundamental when looking at the role that evaluation has in determining how the sector moves forward.

The diamond, reproduced here with kind permission from Tom Smith's *Evaluation Report for Common Knowledge (2001)* gives an excellent visual shape to this range of possibilities and the benefits claimed by the different projects. It should be recognised that many projects do not sit neatly within any one quadrant, a fact that makes meaningful evaluation of their impacts even more complex.



Another way to consider the projects is to describe them in terms of their infrastructure and host agencies.

Art in hospitals

These projects are often initiated in response to a building or refurbishment programme and are concerned to create a healing environment through public art interventions. “The resulting artworks range for the contemplative and calming works in individual treatment rooms to large scale works supporting wayfinding and orientation within the building.”[17] The programme then branches out to provide arts activity, such as touring music, to distract and entertain patients. These projects are wary of claiming clinical benefit as it proves difficult to quantify the impact of artwork against the competing interests of design and treatment, but there is a growing body of work that demonstrates that the arts can contribute to an improvement of environment, the effect overall of which is an improvement in the patients’ experiences of hospital. Current award winning examples of such projects would be *Vital Arts*, based within Barts and the London NHS Trust, and *Artscare* working in Salisbury NHS Foundation Trust, both winners in 2005 in the Building Better Healthcare Awards sponsored by NHS Estates.[18]

Arts in mental health settings

These projects use the arts in a variety of mental health settings. They often have a stated aim to support and empower people with mental health problems and use the act of participating in the arts to allow users to grow in confidence and independence, enabling them to play a more active role in community life. These projects may also have stated explicitly or implicitly a desire to involve users more in decision making about their treatment and care. In such projects, the emphasis is on a ‘social’ model of disability, working to address the barriers and stigma that those with mental health problems face and the use of arts is not usually associated with clinical or therapeutic work. *Start* in Manchester is considered to be a leader in the field[19]. It takes referrals from the community mental health teams and places an emphasis on using arts as a tool to rebuild and reinforce good mental health.

Arts and healthy communities

These are often health promotion projects: the arts are here seen as an effective, often highly visual, medium to deliver health messages and engage local communities in debate about the conditions for and solutions to creating better health. The projects are also concerned with the wider determinants of health, making links with other agencies involved in for example delivering transport and housing infrastructure, in tacking crime and in the provision of education. For example Walsall Council’s Creative Development team focuses on health promotion delivery through the themes of sexual health, mental health, healthy ageing, maternal well being, drugs, healthy eating and physical activity, health care settings and PSHE (personal, social and health education). Project work is developed in partnership with Walsall Primary Care Trust’s public health development officers, National Service Framework leads, community public

health facilitators as well as a number of external organisations and local authority departments. The health living centre model might also fit into this category.

Art therapy

Encouraging self-expression through the medium of art, art therapy is a distinct field of practice itself. The art therapist is not primarily concerned with making an aesthetic or diagnostic assessment of the client's image. The overall aim of its practitioners is to enable a client to effect change and growth on a personal level through the use of art materials in a safe and facilitating environment. This definition may seem closely aligned to the work of those for example working in the arts and mental health field, and indeed there are art therapists who work in those settings, but there is a significant tension between the two schools with the emphasis on the therapeutic processes and relationships being the clear definer. Art therapists need to have a postgraduate diploma and be registered with the Health Professions Council. Their work may be funded through the NHS, Social Services, Special Education budgets and they are often employed on a sessional basis.

Medical Humanities

Here the work described is the use of the arts in medical education, as well as practice. Often the arts are used to offer insight into the human condition to enable a more empathetic approach to treatment, but projects can also look more specifically to work on softer skills such as reading visual clues, developing self reflection and understanding hierarchies and relationships. The Medical Humanities Unit based with the Department of Primary Care and Population Sciences at the Royal Free and University College Medical School and The Centre for Arts and Humanities in Health and Medicine (CAHHM) are leaders within the academic sector for this area of work.

Funding

In the same way that the definition of arts and health is complex, and the range of benefits the programmes aspire to is diverse, so too are the funding structures for such programmes. The range of funders for arts and health work spans local authorities, Lottery, Single Regeneration Budget, Strategic Health Authorities, NHS Health trusts, Arts Council, Charitable trusts, business sponsorship, developer and planning gain contributions and public donation. Each of these funders will have their own specific aims and, since any one project may receive funding from more than one of those listed above - the so-called portfolio approach - this diversity can be seen as a contributor to confusion about the project’s objectives and the effectiveness therefore of any evaluation.

It should also be noted that much of this funding would be attached to specific programmes or pieces of work and would not support the core costs for an arts and health project such as staff salaries or office accommodation. This lack of core funding stems from the desire of funders to demonstrate the impact of their support with something tangible such as a sculpture or musicians on the wards, particularly when they are unsure of the generic evidence of benefit being produced. They are less willing to support the unseen – the project management support, the community liaison without which the programmes would not exist, but which are hard to justify in terms of immediate impact. Some of this cost can be offset by in-kind host organisation support – the allocation of 'free' desks and computers, for example – but the case for professionalisation of arts and health managers becomes more apparent if core funding in the future is to be delivered.

James Aldridge: *Twilight.*
Waiting room in Barts Breast Care Centre

Karina Thompson: Helping hands
Plastic Surgery Outpatients waiting areas, Salisbury District Hospital

Patient at Gamelan workshop
Evelina Children's Hospital

FACTORS FOR SUCCESS

From the interviews for this research and the literature review a number of factors have emerged which are felt to be vital for any arts and health programme's success. Interestingly although many correspondents mentioned the on-going state of funding as a concern, none felt that this was a key success criterion it itself. Sarah Waller, Director of the Enhancing the Healing Environment Programme, summed up the issue, indicating that the issue of funding was often the first thing cited by arts projects leaders, but the reality was somewhat different. "You know it [lack of funding] is always held up, and I've found certainly with the projects that we've been supporting here, that if someone has a bright idea, that they're really enthusiastic about it, that they talk to the decision makers and that they can put a good case together, then somehow or other the money usually follows."

There were then other factors that were deemed to be far more influential.

Community involvement

There was a real sense that, without engaging the health community in its widest sense in any art programme, it was hard for programmes based with the health sector organisations to succeed. This involvement took many forms and was perceived to produce many benefits from a commitment at senior management level to the programme's continuation to better maintenance of artworks by the staff who had been involved in their selection or making. Jane Willis of Willis Newson, consultants in the field, felt so strongly about this that she believed that true engagement could provide an interesting measure of a project's success. A model for evaluation might address "staff ownership and involvement, particularly the ownership issue. What happens at the end of a project, what they choose to continue, if anything……and levels of commitment…….not just do they turn up for meetings, but how actively involved are they in meetings? How proactive are they in putting forward their views and opinions? Do they challenge what the artists are coming up with? To look at the project and see if there is that two way communication rather than what I call the Harvey Nics personal shopper approach."

Sarah Waller of the Kings Fund went even further suggesting that, without that engagement, there was a very real danger that a project would be susceptible to collapse if those running the project were to leave. "The sustainability is about people getting the organisation engaged. And I don't think that happens because I don't think the arts coordinators know how to influence people a lot of the time. Where you've got something like the project at Salisbury……you will get sustainability because if somebody goes, they will probably reappoint somebody. But a vast

majority of projects may well go when people leave, particularly if they are funded on soft money."

There was a concern that in order to achieve this sense of ownership one had to be appreciative of the time and resource implications. Jane Willis felt that this was a clear factor in projects that had failed, "underestimating the time and cost to achieve this kind of involvement. So for example perhaps the kind of thing I am thinking of is where you are wanting an artist to actively engage and consult staff in order to develop designs and you underestimate the amount of groundwork needed to get staff involved. So that's making the assumptions that staff will automatically want to get involved and that they don't need weeks of warming up and giving the artist enough time to do that."

Integrated architecture and art

There was consensus amongst those interviewed that early artistic interventions rather than retrofit were a key component to a successful capital project. This was dependent on many things – and usually indicative of the project architect's support and enthusiasm for the contribution that artists could make, which in itself was a key factor. In many cases interviewees felt that for this type of arts and health work, it was actually counterproductive to separate out the design, architecture and art elements in any evaluation context – that in a successful project the elements should be seamlessly interwoven. The drive for an integrated approach was the same as for any other public art programme – that, by involving the arts team at the earliest stage it is easier to build consensus about opportunities for artwork and for involving artists in the process; it becomes cost effective and saves time by adjusting the building works to the requirements of the artists, for example strengthening ceilings or installing lighting; as members of the design team it allows for the building of really solid relationships with the contractor's site management personnel; it allowed architects to play a collaborative role to ensure true integration.

High-level NHS management support

The importance of support from the senior management team of the hospital or health care setting could not be underestimated. It gave legitimacy to the project, which enabled doors to be opened, and fundamentally gave staff 'permission' to engage in the process and participate in activities. It was also seen as important that the expertise and professionalism of the arts and health practioners was valued as specialisms and not something that could be replicated by others. The feeling that the health service had over the previously twenty years, denuded itself of all those who could have made the case for consideration of the environment – architects[20],

interior designers and even matrons who could take an overview - made the case for education of health managers one for consideration.

Realistic life cycle costings

Many arts and health projects have grown organically from one artist's early intervention to become much larger programmes of work. The informality of these beginnings had benefits in enabling the projects to find their home in the health service without threatening the status quo and to develop the personal relationships to support the project growth, but the counter to these benefits is that few projects have any formal protocols in place with regards to the maintenance, insurance or the ownership of art works (often funded through private donation). Although Mike White felt strongly that arts and health projects benefited from being sited within the NHS, this was one area where an agreement with an external agency was useful. "I think that I'd like to see a greater move towards ownership and delivery of programmes within NHS Trusts. I think in the development era it's fine to work with an external public art agency or whatever to get advice through the arts funding system but the more the hospital is in a sense taking ownership of all aspects from concept through to delivery the better…… I think that what is important, though, particularly around ownership and in relation to the long-term maintenance of a work, is that there is an arrangement with some external agency…… There was one work which had to be removed completely at a considerable cost in order for it then to be reinstated in amended design, bringing the artist back in. That wouldn't have happened if we hadn't had that agreement to say you just can't get rid of it."

Revenue as well as capital funding in place

This was an issue that was seen as specific to the capital arts and health programmes and may have particular resonance as the government's building programme starts to impact. The need for an identified revenue stream to support an on-going art programme was an essential part of any sustainability issue. Lara Dose of the National Network for Arts and Health was clear. "I think that the argument has been the importance of incorporating the arts at a design stage and that the arts bring a vibrancy to a building and that it's that vibrancy that was going to help make the life of these public structures over the 25 to 30 years what they need to be in order for the NHS to recover their investment. But that actually it's not enough to just incorporate art at the design stage. That the actual vibrancy of a hospital is a programme ……where it is a sustained programme and you are looking at changing exhibitions and you are looking at bringing the life of the arts into the building…..and to just have the arts at the design stage isn't going to give a building that 'wow' factor for the 25 to 30 years that particularly PFI and LIFT projects need. So it is incredibly important that we begin to identify the resources of funding that can sustain hospital arts programmes in the future." There is a suggestion that a sustained

revenue stream could partly be used to address the life cycle costings (see above) but considered more important was that the on-going programme would also maintain a value and profile for arts, as time passed and staff changed and the initial community involvement and ownership became less meaningful.

Leadership from within the arts and health project

From all sides there was a recognition that leadership from within the arts and health project was crucial and that the range of skills that this implied – communication, political and strategic thinking – was not necessarily delivered by those with a natural tendency to want to work in the sector. Jane Wills neatly summed up the issue: "The range of people doing this kind of work goes from people who could be quite senior arts managers in any other arts context who have a good grasp of strategic thinking, political thinking, financial thinking as well as the creative skills to develop and deliver projects to people who have had a general vague knowledge of the art world and are very well meaning but actually don't have any of those skills. In the most positive sense I think that what the arts and health field offers to people who have those skills is a very exciting arena to work in because the NHS in a huge institution and a huge employer. If you're interested in organisations and how they operate, if you are interested in arts and change management, if you are interested in delivering projects on a big scale, then it's a very exciting arena to work in. And there are lots of challenges which are about strategic thinking, that are about politic, that are about persuading people and changing culture. So on the one hand I think it is attracting people from other branches of the arts, but at the same time, historically it's not been part of the mainstream health service. It's not been well paid. You know, pittance sized salaries with appalling working conditions have been offered and therefore you are going to attract people who wouldn't command higher salaries anywhere else. And also there is another side of working in the field which is more about the do-gooder side of it, which is that it's a nice thing to do and you, know you put art up in hospitals and it helps make people better. ……. (which) attracts a certain kind of person as well."

Evaluation and Evidence

In 2004 Arts Council England produced a review of medical literature that aimed to "strengthen existing anecdotal and qualitative information demonstrating the impact that the arts can have on heath"[21] The work identifies a number of medical areas in which research studies have shown clear and reliable evidence that clinical outcomes have been achieved through the intervention of the arts such as reducing stress and anxiety amongst cancer patients[22], significantly reducing the length of stay in neonatal intensive care[23] and reducing the use of medication to reduce pain after surgery[24]. It also concurred with the Health Development Agency who in 2000, had concluded that for community based participation projects it was

‘impossible to give precise details of improved health, particularly in the light of the fact that so few projects directly provide information on health, or social matters relating to health, which are based on formal methods of measurement’ [25].

Projects and managers across the sector have grappled with the need to be able to demonstrate the success of a project in terms that funders understand and appreciate. The clinical based evidence is expensive and hard to gather and there is a sense that the evidence already produced, as cited in Arts Council England review, has not made the case with the health sector at all, maybe because it is not perceived to be convincing enough since the study samples are quite small and the longitudinal evidence base virtually non existent. There is also sector recognition that it is hard to evaluate the impact of the arts without considering the wider setting and that much more carefully consideration should be given to the setting of objectives for projects within this context, tacitly acknowledging that a current tendency to exaggerate the impact of arts and health work does little to benefit the sector in the long term.

There was a feeling that the arts and health sector should develop its own shared and consistent language for meaningful evaluation. Mike White from the Centre for Arts and Medical Humanities reflected, “I am feeling a lot more that there are allies to be found out there for maintaining this stance that qualitative evaluation is terribly important and that we are not going to dispense with it for this sake of going down a harder quantitative epidemiological base method”. He believed that the arts and health sector could usefully ally itself to the public health sector ”because you don’t have to make arguments about the efficacy of using arts within a medical model. It’s all there within their acceptance of there being psycho-social determinants of health. And the fact that public health is struggling for an evidence base as much as we are, I think there could be very interesting collaborations on the research front to try and find new applicable methodologies for it”

“I know that Arts and culture make a strong contribution to health, to education, to crime reduction, to strong communities, to the nation’s well being, but I don’t know how to evaluate it or describe it. We have to find a language and a way of describing its worth. It’s the only way we’ll secure the greater support we need.” [26]

This emerging thinking from within arts and health sector chimed with external thinking. In response to Tessa Jowell’s question “How, in going beyond targets, can we best capture the value of culture?’[27] John Holden of Demos argued in *Capturing Cultural Value* for a language that was capable of reflecting, recognising and capturing the full range of values expressed

through culture. He argued that culture does have an "instrumental value, but that instrumental value on its own does not give an adequate account of the value of culture, and that, moreover, better methodologies need to be found to demonstrate instrumental value in a convincing way." A similar conversation was underway in America[28] with an argument that the way to win the advocacy battle was to shift the focus away from the supply of arts and towards a cultivation of demand, believing that by introducing greater numbers of Americans to engaging arts experiences, the benefits of the arts would be spread far wider.

"Pitting the arts against other causes IS a trap. For a healthy society, it should be a both and not an either/or. Many in the past have asked us to prioritise how we spend money rather than asking us to describe the characteristics that comprise a healthy society. If we could look at the latter, there would be room and a necessity of a creative approach to policy – one that seeks to promote a more holistic sense of national health in which the arts must be counter – rather than the traps of competing causes"

Ben Cameron, Arts Forum Journal: A Better Case for Arts?' 2005

Rusholme Lives: textiles commissioned from Start arts and mental health project for health centre

Officina Humana worked with children at the Royal London Hospital School to produce positive self images to deal with their experience of being in hospital.

KEY ISSUES FOR THE FUTURE

The fieldwork and literature study for this paper have raised a number of issued which need to be addressed in addressing the needs of the arts and health sector in its broadest context. This paper identifies these and makes recommendations to address them.

Arts Council of England (ACE) policy issues and NHS policy issues

A number of respondents called for a joint statement of support for arts and health work from the Department of Health and Department of Culture, Media and Support and indeed throughout the writing of this paper, there have been on-going discussions about the possibility of this. The highlighting of recent economic difficulties within the NHS and the change of national leadership seemed to suggest that the preparation of such a statement would no longer be a priority, but recent intelligence suggests that a Joint Prospectus will be launched in October 2006. Arts Council England's emerging arts and health strategy, put on hold during the recent negotiations, will now be taken forward. Both of these moves are to be welcomed in giving the role of arts in health a validity that can be recognised by both sectors, a "permission" for such activity to take place. But any optimism should be tempered by the fact that no additional funding has been allocated to take forward the recommendations of both documents. The health service is in perceived financial crisis and the Arts Council is bracing itself for a tight spending round in 2007, which will lead to a fall in real terms in grant aid. Arts and health, whilst broadly supported, is not seen as a priority area for either sector.

The value that this joint approach could bring to arts and heath is in advocating at the highest levels across the sectors for the role of arts in healthcare settings and in beginning to find a language to articulate that value and to counteract the negative media by building a public understanding of what is being achieved.

There should also be recognition that arts and health work delivers to the agenda of both the Arts Council and the NHS. It would be helpful if agreement as to the nature of this impact could also be consistently articulated. The Arts Council is tasked, along with other cultural agencies to remove barriers to access. Interestingly current initiatives to address this have increased the numbers, but not the range of people attending [29]. One way the Arts Council might need to redress this is by engaging people in arts activity in non-arts public spaces. The use of arts in 'democratic' health settings is well placed to achieve such access.

The NHS also faces challenges in responding to the continuing modernisation agenda. It is required to demonstrate how it is effectively communicating with patients, which can be done

cost effectively with artists' interventions. It also faces the reality of patient choice where the ambience of the hospital environment will become an important factor in maintaining a 'competitive' market position. "I saw an advert for BUPA the other day who talked not only about infection control. They also talked about coming to a nice environment. And if waiting lists are no longer an issue then your choice of hospital may well be affected by the way it looks."[30]

And in the 21st century, heath centres, and hospitals to a lesser extent, are being promoted as at the heart for the communities in which they are set and key to community well-being – a vision that could be turned into reality by creating flexible spaces and opening the doors beyond surgery hours to dance classes, choirs, gallery space, all of which address physical and mental well-being, referencing both the medieval vision of health care environments and the successful healthy living centres piloted more recently.

Influence of predicted demographic change

The increasing number and proportion of people over 65 in England could profoundly influence the delivery of healthcare and arts, with the health sector increasingly looking to prevention rather than treatment in an attempt to stem the rising bill for age-related health treatment.

Although this is only one area in the breadth of work undertaken in the name of arts and health, this is an area where impact can be demonstrated and a case for cost efficacy made. "Contrary to popular belief, health promotion services are popular amongst older people, with a strong evidence base for effectiveness in producing good health outcomes and reducing pressure on services and families by reducing impairments and disabilities. Activities such as exercise classes and dancing, promote not only health and independence, but also increase social interaction leading to improved emotional well-being."[31]

Across the board, in hospitals and health centers, in health promotion and mental health services, the arts and health sector should take the opportunity to make the case as effectively as the sports sector currently does in addressing this agenda. Arguably the health benefits of moderate exercise and social interaction are more likely to be delivered through softer arts interventions and the opportunities are on-going.

Visual Literacy

There is a need for the arts and health sector to recognise where a wider issue mirrors its difficulties in advocating successfully. Society's lack of visual literacy, which suffered even more when the National Curriculum, introduced in 1988, formalised an emphasis on numeracy and literacy that pushed visual art to the sidelines. [32] The lack of value placed on the environment

and our surroundings has a huge impact on the work that arts and health practioners are trying to do, articulated by Sarah Waller. "I think in this country we expect a bad standard of environment in the realm of our public buildings and public services and it's the enlightened people who understand that a better environment can actually improve health outcomes and a whole range of other things which are now pretty well proven in the research but unfortunately that's not something which is shared with many. And there are still no training for clinical or estates staff about the importance or and impact of the environment. "

The most successful projects use the arts as a tool to kick start a wider consideration of the whole health care environment and the arts and health sector must align itself to a broader consideration of the public realm, working with public art agencies, planners and architects to put public education and visual literacy on the agenda.

Finding a new language – a step on from evaluation

For the future, there is a clear direction being set that the arts and health sector should not duck the issue of talking about why it exists, in order to educate and increase public interest in and support for the arts in health settings, nor should it overplay the benefits. There is also a sense that the fear of poor media attention sometimes detracts from public opinion which is already largely sympathetic to the common sense rationale that arts can be a good thing for health. If the sector can win the public value argument, it may finds that it has less need to create a 'hard' evidence base. In addition there is a real sense that "the change in clinical perceptions about arts and health will come when colleagues are talking about it, not because of policy guidelines. The critical mass shift so that to becomes the 'social norm'"[33]

Professional development and support

There is a need to consider what makes a successful arts coordinator and to recognise that the skills and experience they bring can be critical to a project's success, this rather than where a project was sited was seen as crucial. Sarah Waller's experience of the 'Enhancing the Healing Environment' project was interesting here, as one of its key objectives was to offer professional development to those who took part. "I think it's more about *how* somebody manages and the sphere of influence they've got in the place, rather than who they're actually employed by. So I think it's more about the person influencing and the importance given to the arts in the environment necessarily rather than who's actually paying the bill. I think what you want is somebody who is robust and somebody with experience who can street fight occasionally." This is by no means an arts and health issue alone.

‘To help improve the business impact of cultural creativity, the Government will provide £12 million over two years from 2006/07 to Arts Council England and others to promote excellence in management and leadership within the cultural sector. This will ensure that a larger number of talented high-flyers in cultural organisations will be able to develop commercial and business leadership skills, encourage the leadership talents of leading ethnic minority figures in the arts, and create new opportunities for business–arts collaboration.’

Rt Hon Gordon Brown launching the Cultural Leadership Programme 2006

The creative and cultural sectors have recognised that running any programme today requires a range of skills and expertise that are not formally taught and funding has been made available to address these concerns. Arts Council England should take a lead in ensuring that arts leaders in community settings, and in this context in health settings, have equal access to the opportunities for career development, recognising that arts and health managers are at more risk from lack of support because of where they sit and the way in which the sector has grown.

Jane Willis argued for a more across the board approach, which would offer “training for arts and health managers, training for artists and essentially training for healthcare workers” suggesting that in order for the sector to thrive there is an imperative to create well-informed health managers who understand the benefits that arts could bring to addressing their agenda and to attract the very best quality artists who may yet be unaware of what they could bring to a health setting. This would seem to suggest once again a link to a more mainstream education agenda.

Kate Maestri: Corridor between wards and operating and X ray

Barnet and Chase Farms NHS Trust

CONCLUSION

In researching this paper and in talking to leading policy makers and practitioners in the field, it has become clear that the last ten years have been a period of enormous and exponential growth for the arts and health sector. However, in the rush to take advantage of the opportunities presented by the developing policy context, a number of the underpinning principles for the sector's sustainability have been ignored or misunderstood.

The need to become more professional is uppermost. Amongst those leaders in the field, those described as best practice in this paper, there is an understanding that contracts and maintenance agreements are essential if artwork is to be valued in the future; that quality training is vital for those that run arts and health organisations and those that commission them; that there is a requirement to ensure that time and resource are appropriately allocated to allow for true ownership for and commitment of the programme and its outputs. There is a role for those leaders to play here as mentors, in encouraging colleagues to equip themselves and in generously sharing their experiences – the learning from failure and the templates for success. The sector needs to be more prepared to acknowledge that whilst each project will have its unique elements, there is efficiency and strength in recognising similarity.

More fundamentally the arts and health sector is fragmented and all the weaker for it. As it is has grown, it has failed to become more than the sum of its parts. There is a need to develop a common and easily understood language to describe the arts and health sector and what it *does*. Without this, the advocacy argument and all that leads from that will never be won. There is an imperative to find a method of assessing its *value.* Without this the funding and political support will always be ephemeral. There is a role here for those with an overview – be they funding or lobbying bodies – to take a lead in the strategic development of the sector. This will require real leadership, to move the arts and health sector along the continuum to a more mainstream position.

As the economic climate changes, as growth slows and the sector moves to maturity, these factors need to be addressed. In doing so the sector will prepare itself for the new challenges it faces and the possibility, as the understanding of health becomes more sophisticated and the drive for prevention rather than treatment at the forefront, that arts will at last become core to the delivery of the health agenda, and health an equal consideration in public funding of the arts.

Moira Sinclair

July 2006

[1] In particular Tom Smith in the Evaluation report for Tyne and Wear's Health Action Zone project 'Common Knowledge' and Dr Rosalia Lelchuk Staricoff in 'Arts in Health: a review of the medical literature'

[2] Bringing Britain Together: Report by Social Exclusion Unit, 1998.

[3] Arts and Sport, A report to the Social Exclusion Unit, Policy Action Team 10, Department of Culture, Media and Sport, 1999).

[4] Social Exclusion – A response to Policy Action Team 10 from the Arts Council for England, ACE 2000.

[5] Department of Health, Tacking Drugs with Vulnerable Young People: examples from Health Action Zones. October 2001

[6] Bromley by Bow website http://www.bbbc.org.uk/html/centreactivities.htm

[7] On 1 April 2005 the Health Development Agency joined with the National Institute for Clinical Excellence to become the new National Institute for Health and Clinical Excellence (to be known as NICE).

[8] The Arts in Health Care, first published in 1997, remains an excellent starting point for those interested in this historical context and seeking to make the case for the use of arts in a heath setting.

[9] Department of Health, 1998, Health Building Note

[10] Enhancing the Healing Environment: A guide for NHS Trusts, Kings Fund 2004

[11] In 2005 Sarah Waller and Hedley Finn, the programme's directors won an NHS Building Better healthcare award for their Outstanding Contribution to the Healthcare Environment and the programme has received extensive media coverage.

[12] Improving the Patient Experience. NHS Estates 2002.

[13] Melanie Jones, Minister for Public Health 2003

[14] Interim results from Chelsea and Westminster Hospital Research

[15] House of Commons Hansard, 24 November 2005: Column 2280W

[16] The Sun Newspaper, 26 October 2005

[17] Leading the Way Art map, Gloucestershire Hospitals NHS Foundation Trust, November 2005.

[18] Vital Arts for 'Best Patient Care Environment' for the Barts Breast Care Centre and Artcare for 'Outstanding Use of Art'

[19] Winners of the UCL (University College London) Arts in Health Award for 2004 and quoted as leading model of practice in England by a report for the Social Exclusion Unit compiled by the Centre for Arts and Humanities in Health and Medicine (2003).

[20] "We found three architects employed by the NHS in the whole of the 94 Trusts that we worked with which is not a high proportion" Sarah Waller interview

[21] 'Arts in health: a review of the medical literature', Dr Rosalia Lelchuk Staricoff, Arts Council England 2004

[22] For example Smith, M., Casey, L., Johnson, D., Gwede, C., Riggin, O.Z (2001) 'Music as a therapeutic intervention for anxiety in patients receiving radiation therapy' 2001.

[23] For example Schwartz, F.J (1997). 'Perinatal stress reduction, music and medical cost savings,' Journal of Prenatal & Perinata Psychology & Health, 12, 1, 19-29.

[24] For example Nilsson, U., Rawal, N., Unosson, M. (2003). ' A comparison of intra-operative or post-operative exposure to music – a controlled trail of the effects on post-operative pain'. Anaesthesia, 58, 684-711.

[25] Health Development Agency review (2000)

[26] Estelle Morris, Speech to Cheltenham Festival of Literature, 16 October 2003.

[27] T Jowell, 'Government and the Value of Culture', DCMS, (2004)

[28] Kevin F. McCarthy at al, 'Gifts of the Muse; Reframing the Debate About the Benefits of the Arts, 2004'

[29] MORI report, The Impact of Free Entry to Museums (2003) "while the number of people coming through the door might have dramatically increased, the profile of a typical 'population' of museum or gallery visitors has remained relatively stable, and firmly in favour of the 'traditional' groups."

[30] Sarah Waller interview

[31] Department of Health. A New Ambition for Old Age. Next Steps in Implementing the National Service Framework for Older People. 2006

[32] Argued cogently by Robert Hewison and John Holden in *The Right to Art*

[33] Sarah Waller interview

Appendix One

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Appendix Two

List of interviewees and questions asked

Lara Dose	Director, National Network for Arts and Health
Karen Drezgnic	Social Inclusion Officer, Arts Council England
Meli Hatzihrysidis	Arts and Health Officer, Arts Council England
Peter Senior	Director of Arts for Health, Manchester
Sarah Waller	Enhancing the Healing Environment Programme Director, King's Fund
Mike White	Centre for Arts and Humanities in Health and Medicine (CAHHM)
Jane Willis	Director, Willis Newson arts consultancy

Interviews conducted between February and April 2005

1. What do you consider to be the main issues for ensuring the sustainability of arts and health organisations in the UK over the next 10 years?

2. What would you consider to be useful measures of achievement/success in arts and health work?

3. What do you think are the factors in projects that have failed in your opinion?

4. Where should or does the funding come from?

5. Where are arts and health projects best sited?

6. What do you consider the most relevant areas of work to pursue?