An interim evaluation of the 'Arts For Well-being' social prescribing scheme in County Durham

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1. Introduction and methodology

The study was conducted between May and October 2010 by Mike White of the Centre for Medical Humanities (CMH) at Durham University with CMH Research Associate Esther Salamon, assisted by Mary Robson (CMH's Arts in Health and Education Associate) who facilitated the artists' meetings and Jess Pountney who prepared the statistical profile. The CMH is an interdisciplinary research unit set up in 2008 to examine the divergence of scientific and experiential views of human nature, health and flourishing, and the effects of this divergence on clinical medicine and health policy. With support from The Wellcome Trust, it is engaged in long-term research aimed at understanding the human side of medicine, exploring the relationship of health and medicine to wider notions of well-being, and examining the place of creativity in contributing to healthy lives (www.dur.ac.uk/cmh). The Centre for Medical Humanities has a long-term supportive interest in both the delivery and research of arts in health and is itself a hub for the dissemination of best practice internationally in this field.

In spring 2010, we were commissioned by County Durham Primary Care Trust to do a formative evaluation of *Arts For Well-being* that would provide an interim assessment of how effectively the 'willing provider' service model was working, informed by the nature and extent of intermediate indicators of benefit identified by service users participating in the arts activities. To that end, three research questions were identified:

1. Does the overall model work, and does it suggest a 'natural selection' of which individual arts in health initiatives work best?
2. What can be learned about user experiences and impact, drawing on data from the Warwick-Edinburgh Mental Well-being scale that is currently being administered to participants and from process evaluation data?
3. What do users' comments and narratives about the service suggest about its wider impact?

The demographic data is based on the Durham 'Area Action Partnership' areas and from referral sources. We also reviewed data from the monthly updates provided to the steering group, from the six-month collation review, and from a forum of the artists in April 2010. In our final report we are invited to make recommendations on how the service should be continued, based on our assessment of the arts intervention impacts, delivery model, user satisfaction, workforce development and mission. Our methodology for the study has comprised:

- A contextual review to place the *Arts for Well-being* service within current thinking on social prescribing and arts participation for well-being
- Desk-based analysis of data provided by the co-ordinator at Pioneer Care Partnership (PCP)
- Focus groups with a sample of service users, past and current – aiming for 6–10 in each group

- Two facilitated focussed conversations with artists and referrers using techniques of reflective practice applied in a workforce development context
- One-to-one interviews with carers and facilitators conducted either (i) in person, or (ii) over the telephone, or (iii) during service users' focus groups.

We anticipated being able to work within the protocols for the service agreed between the PCT and PCP, and PCP already had a procedure for obtaining informed consent from service users to participate in research. We considered that the parameters and aims of the study required no need for us to specify individuals' clinical status. Our conclusions from the study have been largely drawn from generic types of categorised evidence that we assembled and all participants' comments have been kept anonymous. The evaluation milestones were:

May

- Attend review meeting with providers on 30 April
- Conduct a review of 'arts on prescription' referral initiatives
- Formulate semi-structured interviews
- Prepare first round of focus meetings with assistance of PCP

June

- Sift, categorise and analyse the data assembled to date by PCP
- Run first focussed conversation with artists and referrers

July

- Run first two focus groups - determined by geographical area or by art forms
- Run second focussed conversation with artists and referrers
- Conduct phone interviews with carers/participants unable to attend focus groups

August

- Run another two focus groups

September

- One-to-one interviews with key stakeholders – PCT, PCP
- Run final focus group
- Prepare interim findings

October

- Draft final report

January 2011

- Final report

2. The *Arts For Well-being* scheme

This evaluation covers the first half of the scheme in its 18 month pilot phase, which commenced in September 2009. It aims to support 400 individuals over that period, and by July 2010 there had already been 608 referrals.

In 2009, the PCT's Public Health Portfolio Lead for Mental Health made a successful bid for funding a social prescribing scheme from within the Annual Operating Plan, including additional funds to support Darlington Art Studio for mental health referrals. The trust's 5–year strategy has acknowledged the scheme as a priority. The PCT looked at precedents in competitive market development and innovation projects and the 'willing provider' model was chosen because of the small scale of contracting and with a view to encouraging flexibility and responsiveness to user choice. This was already used for smoking cessation services, and makes payments per client rather than per session.

The Service Specification (2009) produced by the primary care trust for the arts providers states that the scheme is a primary prevention service and is not intended to be a therapy service. The declared principles and values of the service are that it is preventative, social, non-medical, assessable, flexible, demand-led and evidence-based. Within an overall aim to increase resilience, the principal evidence of benefit sought is the increased confidence and self-esteem of service users. The scheme is managed under a 'willing provider' model by a co-ordinating body, Pioneering Care Partnership (PCP), and commissions services from an approved list of around 20 artists and arts agency providers who offer delivery of activities in a block of six sessions. The co-ordinator and providers are contracted by the PCT.

The person-centred focus for take-up of activity anticipates that some activities may be more popular than others. Flexibility and innovation are required from the artists as well as prompt adherence to client safety protocols and monitoring procedures. The principal measurement tool administered at the outset and conclusion of participants' referrals into the scheme is The Warwick-Edinburgh Mental Well-being Scale (WEMWBS), with the original 14-item version being replaced by the shorter 7-item scale in spring 2010 – this shorter WEMWBS presents a more restricted view of mental health, confined largely to psychological wellbeing, but it is still considered a valid measurement of mental well-being at population level (Stewart-Brown et al 2009). In *Arts For Well-being*, the WEMWBS is supplemented by a referral form to collect demographic data and an 'activity evaluation' form administered on completion of the sessions.

 It was determined that *Arts For Well-being* should focus on new parents, carers and those with long-term conditions that are in a maintenance or recovery phase – though other groups might be added later depending on the volume of referrals. On completion of this evaluation in October 2010, the PCT was considering a 3–year programme extension on *Arts For Well-being* led by up to three sub–county hub organisations from April 201l. The medium term aim would to engage with the new GP consortia, possibly in partnership with local authorities.

3. A contextual review of social prescribing

This review is in three sections considering firstly the policy context for social prescribing, then the development of arts on prescription schemes, and finally issues for evaluation of this field of work. Each section considers the implications for *Arts For Well-being* from the lessons learned elsewhere.

3.1 Social Prescribing

The rationale for the development of social prescribing reflects the changing context for NHS mental health services as set out in the *New Horizons* report (Dept. Of Health 2009), and which in turn built on the Mental Health Services Review (Social Exclusion Unit 2004). *New Horizons* was withdrawn by the incoming coalition government in 2010 pending its own policy review of mental health services, but as *New Horizons* was influential on the thinking behind *Arts For Well-being* it still merits consideration here. The Foreword to *New Horizons* proclaims that mental health is a 'major social issue' and says: "Good mental health is fundamental to the resilience of individuals, families, communities and businesses. It decides, in short, whether a society is flourishing or floundering." The terms 'resilience' and 'flourishing' have become commonplace in public health discourse and take the focus into community health as well as individual health. The annual cost to the UK of mental illness is now £77 billion when including lost productivity, and at 20% of the burden of disease, mental illness is higher than 16.2% for cardio and 15.6% for cancer.

These figures for mental ill–health are further confirmed in *Fair Society, Healthy Lives*, (The Marmot Review 2010), and are linked to inequalities of income and opportunity. Inequality in illness accounts for estimated productivity losses of £31-33 billion a year, lost taxes and welfare payments of £20-32 billion a year and extra NHS costs of over £5 billion a year. The report reminds that austerity should not have to lead to retrenchment here as austerity gave birth to the NHS. It declares "Well-being should be a more important societal growth than simply more economic growth". There are two policy goals:
- To create an enabling society that maximises individual and community potential
- To ensure social justice, health and sustainability are at the heart of all policies.

The review concludes "The physical and social characteristics of communities, and the degree to which they enable and promote healthy behaviours, all make a contribution to social inequalities in health", so improving community capital and reducing isolation and exclusion are priorities. The review says a broad indicator of well-being is required to help measure reduction in inequality, as well as life and health expectancy indicators. It calls for support for communities to find their own whole system solutions so that the top-down approach is reduced and to "avoid drift into small-scale projects focused on individual behaviours and lifestyle". Partnership working can scale up interventions to prevent such a 'drift'.

Mental Health, Resilience and Inequalities (Friedli 2009) also confirms that mental health takes the biggest slice of NHS expenditure, with a third of GP consultations concerning mental health, but it is not taken as seriously as physical health so it needs to be at the heart of future policy making. Inequalities create stress and mental health requires social as well as individual solutions. It notes that partnerships to improve access to non-medical support can develop arts opportunities within social prescribing and it concludes "Only through

implementing policies that help to reduce inequalities within our society and build the resilience of individuals and communities will we engender the social, economic and health benefits that are the hallmarks of a healthy society."

A CSIP North West *Briefing Document on Social Prescribing* (2006) offers a thorough definition of social prescribing as **"**a range of non-clinical interventions, which recognize that many mental health problems are not purely bio-medical phenomenon, but are influenced by a myriad of social factors. Social prescribing is an innovative approach to tackling health inequalities, which involves using partnership work to address determinants of mental ill health. It involves signposting and referring to various agencies and initiatives which tackle some of these social causes." It contends that social prescribing supports the growing emphasis on recovery as a central principle in mental health care. Recovery is both a conceptual framework for understanding mental illness and a system of care to provide support and opportunities for personal development.

Key themes in the *New Horizons* report include 'strengthening transitions', 'empowerment' and 'innovation', all of which themes lend themselves to culturally based interventions. Consultation responses to the report also indicated that the education system is key to early intervention and that 'natural support networks' through the voluntary sector are value for money. The definition of 'quality' in treatment should include recovery orientation addressing wider social and environmental factors within a life–course approach.

The public mental health framework set out in *Confident Communities, Brighter Futures* (Dept. Of Health 2010) defines well-being as " a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and wider environment." Actions proposed include measures to:
- broaden the range and level of research funding across all sectors including charitable funding to ensure it is commensurate with the proportion of NHS resource spent on mental health (11%)

- increase the level of research on prevention

Across the 'life course' actions include:
- universal and targeted approaches for families, including those from high-risk groups, to build mental well-being and resilience in infancy and childhood. Key areas for intervention include pregnancy and the perinatal period, parenting and the development of emotional and social skills in infants and young children

- early identification and treatment of mental health problems in children and parents.

The report encourages volunteering by identifying "communities where volunteering can help to build stronger social links and contribute to cohesion by breaking down misconceptions of mental health and other service users" and workforce development to embrace cross-sector working and innovation is seen as important.

New Horizons concludes that "better information, particularly in relation to quality and outcome measurement, will be vital for effective commissioning." The report advocates new models of 'theory of change' measurement such as 'asset mapping' in communities and the *Recovery Star* model (Mental Health Providers Forum 2010). *The Recovery Star* is a tool for

supporting and measuring change when working with adults of working age who are accessing mental health support services. As an outcomes measurement tool it enables organisations to measure and summarise the progress being made by service users and the service being delivered through a project. *The Recovery Star* is essentially a working tool. It is designed to support individuals in understanding where they are in terms of recovery and the progress they are making, providing both the client and worker a shared language for discussion mental health and wellbeing.

At the same time as *New Horizons* appeared, CSIP published *Social Prescribing for Mental Health – a guide to commissioning and delivery*. (CSIP 2009) This report's definition of social prescribing is "a mechanism for linking patients with non-medical sources of support within the community" with aims for working across a wide spectrum of mental ill-health by:

- developing alternative responses to mental distress;
- a wider recognition of the influence of social, economic and cultural factors on mental health outcomes across the whole spectrum of disorders;
- improving access to mainstream services and opportunities for people with long-term mental health problems.

The sought-for short term outcomes are listed as:

- increased awareness of skills, activities and behaviours that improve and protect mental wellbeing – e.g. the adoption of positive steps for mental health;
- increased uptake of arts, leisure, education, volunteering, sporting and other activities by vulnerable and at-risk groups, including people using mental health services;
- increased levels of social contact and social support among marginalised and isolated groups;
- reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression, in line with National Institute for Health and Clinical Excellence (NICE) guidelines (NICE 2004);
- reduced waiting lists for counsellors and psychological services;
- reduced levels of frequent attendance (defined as more than 12 visits to GP per year).

Assessment of social prescribing outcomes include a combination of indicators designed to capture changes in:

- individual mental health;
- population mental health, e.g. within a local authority ward, prison or workplace;
- individual behaviour, e.g. physical activity, sensible drinking;
- quality of life;
- use of services, e.g. adult education, participatory arts, gyms, counselling;
- professional practice, e.g. prescribing patterns.

The following objectives characterise social prescribing:

- a shift towards services that are personal and sensitive to individual need, and

that offer choice and increased control over health;

- a strategic reorientation towards promoting health, independence and wellbeing, investing now to reduce future costs of ill health;
- a stronger focus on joint commissioning of services and interventions across health and local government, with a focus on outputs and outcomes;
- involvement of a much wider range of stakeholders than in a traditional health or social care model – including not just the third sector but also the business community, and education, leisure and other community services.

The Scottish Development Centre for Mental Health in its report *Developing Social Prescribing and Community Referrals for Mental Health in Scotland* (2007) recognised that social prescriptions, or more informal referrals, could be helpful for addressing needs of those reluctant to refer themselves into mental health services e.g. ethnic minorities, and also offer low cost alternative to medication and/or talking therapies (where demand outstrips supply). Short and medium-term outcomes which could provide a basis for assessing whether social prescribing works are almost identical to those identified in the CSIP report above. It is noted in particular that social prescribing can be useful in addressing psycho-social problems resulting in mild anxiety/depression, where direct referral into psychiatric services is not appropriate. The idea is heavily influenced by the quality of life and well-being agenda, and it is supported by Scottish government policy on arts and culture, (unlike DCMS in England), and the key themes are:

- Increasing participation among those most deprived and marginalised
- Reducing social exclusion
- Helping people to take more responsibility for actively managing their own health
- Promoting opportunities for physical activity
- Holistic views of health
- The relationship between the emotional wellbeing of individuals and communities and broader health and socio-economic goals for Scotland.

Common challenges are seen as:

- Maintaining up-to-date information on sources of voluntary and community support
- Cultural differences between medical and community development models
- The need for a skilled link worker (referrals facilitator)
- Concerns about voluntary sector capacity
- Concerns about increased GP workload, at least initially
- Agreeing referral criteria
- Recording and evaluating outcomes
- Accountability and liability for referred patients.

The report notes that there are currently no protocols for referrals to formal schemes, so informal advice on engaging people in pilot initiatives has been the norm and it may continue in that vein. It is more by recommendation than referral but indemnity requires that informed consent is sought of the patient.

Evaluations of other 'pilot' social prescribing schemes within primary care, e.g the use of talking therapies, stress the inherent complexity of the intervention in attempting to identify attributable benefit. Brandling's *Investigation into the feasibility of a social prescribing service in primary care* University of Bath (2008) concludes that focus should not be on reducing frequent attendance at GPs and secondary care referral, but on developing links with the third sector so that health services 'indirectly reach into public realm'. It recognises the drawback of social prescribing is short term funding, over demand and confidentiality issues, and a common barrier to initiating a scheme is lack of local knowledge. Social prescribing may also become geared to moving on what it terms the 'heartsink' patients, i.e. those repeatedly presenting chronic psychosomatic or 'mystery' conditions difficult to treat.

A literature review in Woodall and South's *Evaluation of the CHAT Prescribing Scheme in Bradford South and West PCT,* Leeds Metropolitan University Centre for Health Promotion, (2005) concludes: "Despite the weakness in the evidence base for social prescribing, there is sufficient research to indicate that it is a useful approach in primary health care, and can benefit patients through providing a holistic package of care (Bromley PCT, 2001)". Consistent and regular feedback for referrers was an integral part of the promotion of the scheme itself. Regular feedback aided the identification of patients whose referral to the voluntary sector has collapsed, and it kept the service constantly in the mind of staff. Semi-structured interviews were done with a small sample of participants. Key findings were that most patients expressed some form of positive outcome as a result of being on the scheme, including reduced isolation, increased confidence, and access to non-stigmatised support. This supports other research which suggests that social prescribing is a viable way of dealing with psychosocial problems (Grant et al., 2000). Several health professionals commented that they did not have the scope within their role to keep abreast of what was available in the voluntary or community sector. This is reiterated by others (Bromley PCT, 2001).

Implications for 'Arts For Well-being'

The Marmot Review has proved prescient in articulating the principles of 'The Big Society' and linking them to a fundamental challenge of addressing health inequalities that can be practically addressed in 'scaled-up' initiatives of social prescribing. The *CSIP North West report* (2006) emphasises that successful social prescribing involves 'signposting and referring' as a continuous process. This is essential both for maintaining throughput in the *Arts for Well-being* scheme and for onward referral afterwards to local health services for patient review and/or to the voluntary/arts sectors for continuing the recreational activity; this may be better delivered in a pro-active 'hub' model than a 'willing provider' model because it is the route and 'distance travelled' that are as important as the activity. A 'hub' model may also assist in filling the knowledge gap of the new GP consortia as to the nature and extent of local voluntary services. *Arts for Well-being* is well-placed to achieve the short term outcomes sought in the *CSIP report* (2009) and *Scottish Development Centre report* (2007), provided its referral pathways work effectively, and that referral is construed in the broader and more informal sense of 'recommendation'. The 'common challenges' identified in the latter report are all relevant to the development experience of *Arts For Well-being* so far and need to be addressed. Furthermore, the Bradford CHAT scheme exemplifies a two-way feedback that ensures the referral later loops back to the original referrer and is not simply a passing on, and if this could be procedurally adapted for *Arts For Wellbeing* it would strengthen its referral pathways.

The public mental health framework identifies families and new parents as key targets, and this was initially prioritised in the promotion of *Arts for Well-being,* but in practice the scheme has focused, at least until recently, on working predominantly with people with 'long-term conditions'.

As other pilot social prescribing schemes have identified the inherent complexity of the intervention, even in the 'talking therapies', then it should be acknowledged that arts interventions are likewise complex and require mixed methods of assessment in a longitudinal framework. The social rather than therapeutic model seems the way forward.

3.2 Arts on Prescription

Arts on prescription schemes were pioneered by Stockport Arts and Health in the early 1990s which arranged client referrals from GPs or other health workers to local arts organisations. The basis for this was that the main location for the presentation of common mental health problems is to the GP. Huxley's evaluation (2007) of the Stockport scheme, using the General Health Questionnaire (GHQ-28 version), noted a reduction in overall score from a mean of 14 items at time 1 to 9 items at time 2 and a reduction in the number of participants with a recognisable mental health problem at time 2. However, the sample is small (33 persons) and was only monitored over a 15 week period. Workers on the scheme have continued to use GHQ-28, however, to assess participants' progress, and have also used it alongside the Edinburgh Post-natal Depression Scale on a referral scheme for mothers. (Tydesley 2002).

MAPS, another Stockport-based arts in health initiative that runs an arts programme with North West MIND for both client referrals and self-referrals found, in a review of its membership, that of 25 members who had left the programme in 2002, 5 went on to employment, 5 to further education and 2 to other volunteering schemes. Of its current 98 enrolment on its arts programme, 23 work as volunteers on the project helping to assist and mentor newcomers, 17 also attend college and 7 aspire to find employment in the arts.

In the North East, arts on prescription schemes were piloted in North and South Tyneside in 2001-03 with the aim to link primary care services with art studios for mental health referrals. Also at that time, two Newcastle GPs initiated a scheme to provide tuition in South Asian music and singing for patients with mild anxiety. They used standard questionnaire SF-36 to measure patients progress, but noted most patients considered the questionnaire to be intrusive, stress-inducing and at odds with the relaxation aim of the activity. (Smith 2003).

A 2008 evaluation of *Good For The Soul*, an arts on prescription scheme begun in 2003 by Teesdale and Wear Valley District Councils, concluded that in order to understand the impact of the scheme on participants' creative development and artists' professional development, consideration should be given to monitoring their progression – notably, before participation, during participation and after participation in the scheme. Furthermore, consideration should also be given to commissioning independent evaluations that are longitudinal in order to better understand the factors that contribute to effective initiatives, provide insight into the

nature of change and highlight potential improvements. Securing suitable premises and transport were key issues for rural areas piloting such a scheme. The report also recommended comprehensive induction training to those intending to work on similar projects – including co-ordinators, managers and artists. A diverse group of trainers with expertise in the arts, arts development and health should be engaged to deliver the sessions. (Salamon 2008)

Sedgefield Borough Council's evaluation (2008) of its *Sing For Life* pilot in 2007-08 compared questions asked at the beginning of the programme and then repeated 4 months later. The research measured personal health improvements, aerobic fitness, increase in fitness, reduction in medication and repeat visits to GPs. The intermediate indicators of benefit for participants comprised mental health improvement in symptoms of depression, anxiety and stress, confidence and self image. Physical health improvement comprised better sleep/ posture/ breathing/ stamina, possible reduction in back pain, general improvement in well-being, outlook and social interaction, and increased levels of activity. As the project continued beyond the pilot phase, a 2009 evaluation noted that 30% of the participants taking regular medication stated that being involved in the *Sing For Life* programme has enabled them to reduce their medication. 40% of the participants highlighted the fact that they had visited their GP less than usual since taking part in the *Sing For Life* programme. Participants highlighted lifts in their moods as well as improvements in breathing and posture. They also commented on the positive benefits of interacting with like-minded people.

Taking Part Workshops is a recent arts on prescription initiative led by North Tyneside GP Dr. Ruth Evans in partnership with an arts development consultancy. Like *Arts for Well-being* it has multiple referral routes, but its courses are constructed around ten weekly sessions with a post-course assessment with the original referrer and onward referral routes into local arts activities and volunteering. Details from www.takingpartworkshops.org.uk

The CSIP guide (2009, referred to earlier, states that any evidence of effectiveness of arts on prescription schemes should address three key areas:
- the impact of participation in the arts on self-esteem, self-worth and identity;
- the role of creativity in reducing symptoms (e.g. anxiety, depression and feelings of hopelessness);
- arts and creativity as resources for promoting social inclusion and strengthening communities.

The report cites The Warwick-Edinburgh Wellbeing Scale as a measure of *group* (our italics) mental health improvement but identifies GHQ12 as the individual improvement measure. But it adds: "In spite of encouraging findings, however, much existing evaluation is based on short-term or intermediate outcomes, and many studies are anecdotal and based on small-scale surveys, lack a longitudinal dimension and fail to identify arts specific aspects of the programmes (Coulter 2001)". It concludes that: "Social prescribing may be of particular value because it addresses the social and economic context for the psychological skills and attributes that make up 'positive mental health' (Friedli, in press)".

New Horizons recognised the efficacy of deploying patient self-assessments – and *Arts For Well–being* has elected to use the Warwick-Edinburgh Well-being Scale. But Callard and Friedli (2005) have also identified a complexity inherent in arts in health evaluation as:

> In co-developing indicators with stakeholders, what became clear was the enormous importance of indicators that capture process. The in-depth interviews turned repeatedly to moving and powerful descriptions of how the project had taken place: it frequently seemed to be the quality of the experience itself that was foremost in descriptions of if and why the project was valuable. And it is, of course, enormously difficult to translate complex psychological processes and reactions into the abstractions favoured by social scientific evaluations. Can one, for example, link a participant's intense enjoyment of and investment in a particular project to a more general, measurable enhancement of that individual's self-esteem and enjoyment?

These difficulties are reiterated and reflected in recent UK studies of arts and mental health that have highlighted the complexities for evaluation and the importance of networking to build a community of both practice and research. The UK's Health Development Agency's report into community-based arts in health (HDA 2000) noted there are "no established principles and protocols for evaluating outcomes, assessing the processes by which outcomes are achieved, and disseminating recommendations for good practice." The report, however, noted three emergent approaches to evaluation:

- Health based approaches testing what the arts contribute to self-esteem and its effect on qualitative self-assessments of well-being. (Argyle 1998)
- Socio-cultural approaches derived from recent assessments of the social impact of the arts. (Matarasso and Chell 1998)
- Community based approaches adapted from social capital theory on health improvement. (Campbell, Wood. and Kelly 1999)

Whilst it is sometimes possible to classify an arts in health project under just one of these approaches, in many cases you find that two or all three approaches are intertwined and have an inherent complexity that may be better understood in longitudinal study of outcomes.

Implications for 'Arts For Well-being'

The *Sing For Life* pilot shows it is possible to gather data on medication use, but *Arts for Wellbeing* does not do this, possibly due to its emphasis on being a non-medical intervention. However, gathering such information might attract more GPs to making referrals. On the other hand, in a social model of health *Arts for Wellbeing* is collecting qualitative testimony from participants that confirms the CSIP guide's identification of three key areas for finding evidence of effectiveness. CSIP also calls for longitudinal programming and research. Callard and Friedli's recognition of the difficulty in measuring the intensity of the art experience requires attention to process and the qualitative testimony of participants

Transport issues have been highlighted in earlier pilots so it is surprising that the mobility budget available within *Arts for Well-being* has hardly been accessed, suggesting it is not

flagged up in the promotion of the scheme. It could also help address reducing the waiting list of clients if transport can take people to the desired activity outside their local district.

3.3 Recent UK studies of arts and mental health

A national study in the UK has evaluated arts and mental health projects that are using these combined approaches in an attempt to identify both health and social outcomes (Hacking et al 2007). This study grew out of a government review of Mental Health and Social Exclusion (Angus and White 2004), to which Durham University's Centre for Medical Humanities contributed a literature review of arts and mental health. The two year study, carried out by researchers at Anglia Ruskin University and University of Central Lancashire, aimed to identify appropriate indicators & outcome measures from arts interventions in a range of mental health settings, and to develop and implement an evaluation framework.

Indicators of improved mental health were identified as increased levels of mental wellbeing, decreased mental distress, reduced levels of primary and secondary care service use, and reduced medication. Indicators of increased social inclusion were higher levels of social contact likely to build both bonding and bridging forms of social capital, reduced levels of perceived stigma and discrimination, and higher levels of engagement in employment and education. 'Distance travelled' indicators to measure empowerment included increased levels of confidence and self esteem, enjoyment of arts participation, learning/skills gained, and pride in work produced.

The research developed a combination of its own and existing measures for an outcomes study across 22 projects, at baseline and after six months, assessing levels of mental health, social inclusion and empowerment through a framework that attempted to reflect the 'distance travelled' through a project by each participant. Six projects were also selected for qualitative case study. Triangulation of results suggested that there was very strong evidence for empowerment, with less strong evidence for improvement in mental health and social inclusion, though the report concluded that the results justify support for arts and mental health work from statutory services. It also cautions that arts provision for people with mental health needs is not a case of 'one size fits all' and this needs to be taken into account when designing projects.

Three processes were important for most participants at all six projects that provided qualitative case studies:

1. Getting motivated inspired hope and reduced inactivity and so improved mental wellbeing and decreased mental distress.
2. Focusing on art provided relaxation and distraction, which again resulted in improved mental wellbeing and decreased mental distress.
3. Connecting with others in a supportive environment decreased social isolation and increased confidence to relate to others, thus combating social exclusion and mental distress.

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A further three processes were important at some but not all projects:

1. Self-expression promoted catharsis and self-acceptance, and provided alternative ways of coping – benefits that decreased mental distress and reduced social exclusion.
2. Connecting with abilities gave a sense of pride and achievement, which improved mental health/wellbeing.
3. Having time out helped alleviate worry and responsibilities, thus decreasing mental distress.

Two processes were important for some participants in all projects:

1. Rebuilding identities was associated with increased self belief, external validation and moving beyond a service user identity, thus combating social exclusion and mental distress.
2. Expanding horizons led to wider aspirations and opportunities and to enhanced self-esteem, resulting in reduced social exclusion and improved mental wellbeing.

The six case studies concluded that it is not meaningful to attempt to measure changes in medication and levels of service use, but the contribution of arts participation to 'recovery' is worth pursuing. Arts should not be reduced to just individual psychological and therapeutic benefits, as user-led notions of recovery place the activity in a social rather than medical model. It is not necessarily all about medication, symptoms and services post-discharge but about individuals being able to live the kind of lives they want to live. Key common themes in recovery include:

- Finding hope, meaning, purpose and value
- Finding new coping mechanisms
- Developing new identities within and beyond mental health.

It is precisely these aspects that arts in mental health projects seem to do best, yet these are particularly hard to standardise and measure.

It is impressive that this first UK nationwide study has attempted to engage with the complexity of arts in mental health and has successfully brought a large number of projects into a common evaluation framework that allows statistical significance to be drawn from a wide range of identified outcomes. There are some problems, however, in both methodology and results. The authors of the study have acknowledged in a separate review article the difficulties in distinguishing between psychological and social empowerment, clarifying whether outcomes were indicative only of passive adjustment or constituted genuine social empowerment. (Secker et al 2008). The research's qualitative case studies adopt an interpretative stance that seems at odds with the highly rigorous approach to data in the quantitative analysis, suggesting that combined measures for this work may produce perspectives that are difficult to reconcile. In the survey results on the empowerment issue it is interesting that a question about 'mutual aid' did not score to statistical significance. If it had, it would have had bearing on demonstrating social empowerment. Yet projects scored highly on that question at baseline. Presumably one possible reason for this is that participatory arts are the core of the activity, so it would have been useful to consider how similar or dissimilar the six projects were, what affect their participatory ethos had on participants from the outset, whether communal as well as individualised outcomes were realised, and most importantly whether a multi-disciplinary network of staff was developed to deliver and help assess the projects. The Arts For Health centre at Manchester Metropolitan University undertook a 3-year research project from 2004 to develop a delivery network for

arts in health in the North West, funded by the UK Treasury's *Invest To Save* initiative. Six projects were chosen for in-depth study in this programme, covering mental health, older people, and health culture and environments. Bringing people together from different disciplines, they used appreciative enquiry to "discover what is, dream what might be, design change and find destiny/destination." Two kinds of well-being were identified: that which is hedonic (feels good) and that which is eudemonic (incites change). The communal reflection days which were central to the evaluation aimed to assess people's confidence in both the approach and process. This critical reflective practice is essential as there may be an inherent bias in the appreciative enquiry model to identify and assert positive outcomes.

The project's final report (Kilroy et al 2007) is strong on measuring impacts on individuals but there is almost no consideration of effects on groups and communities which a holistic model might want to address. The study used standard measurement tools such as the General Health Questionnaire and Hospital Anxiety Scale, though these have been shown to be too generalised for assessing the effectiveness of arts in health projects. The sample is limited as regards statistical significance, especially on job satisfaction issues where only a handful of staff were sampled using a control model. There is also bias in the sample – 98% white, 59% over 55.   But despite flaws in methodology, overall there is often an intellectual depth and challenge in the report with a real insight into practice which is lacking in many evaluations.

Implications for 'Arts for Wel-lbeing'

These UK studies are indicative examples of how current research in arts and mental health is moving beyond single project studies that attempt to measure therapeutic impact to multi-site studies using combined methodologies in a 'theory of change' model to assess the social and environmental as well as clinical dimensions of benefit. This approach allows case comparison but is averse to applying the empiricism of randomised control testing because the variables are so complex. Evaluation will need to refine definitions of key concepts of social inclusion and empowerment, and resolve problems of reliable attribution of benefit to the effect of arts interventions. But what is clear is that capacity building is becoming a central factor in the practice of arts in health, and so in respect of staff involvement it can be evaluated as a learning programme. The quality of professional partnership is a crucial factor that is so far being under-examined in evaluation of arts and mental health. This is why our study of *Arts For Well-being* has included consultations in a workforce development framework with both providers and referrers.

4. Addressing the first research question – what do the providers tell us?

The first research question asks does the overall model work, and does it suggest a 'natural selection' of which individual arts in health initiatives work best?

4.1 The providers' assessment

The research team's first contact with the providers was at a review meeting in April 2010 at Collingwood College in Durham. Discussions began tentatively with reference to 'teething problems', followed by a positive affirmation of the project's successes to date, as evidenced in already exceeding all its first year targets. A provider-led exercise invited written responses to the question: *What can we learn from what has happened and what possibilities can we explore?* The responses were then clustered into the following groups:

- Excited and enthusiastic about *Arts for Well-being* and being chosen to participate - Feedback from participants has been great - Let's not lose the original philosophy and we need to stay user focused

- Regular reflective sessions needed to share ideas, thoughts

- Improve selection of clients for specific activities - Can we be all things to all people? - Complex menu of options and too many choices? - Do we need 'tasters' or 'pick 'n' mix' courses to engage people in the fuller range of the arts?

- Need to promote the service to wider health service audience - Providers promoting wider project - What works well? What can others do?

- Improve communication – Information overload? - Arts Coordinator needed

- Improve systems - Weekly emails not effective - Agree cancellation period between PCP and Provider re venue bookings etc. - Providers arranging own venues is problematic

We (the researchers) felt this review meeting did not go far enough in exploring what makes for an effective model. The meeting confirmed for us that we should begin the evaluation by convening two sessions with providers and referrers to explore together in a more reflective way what needed to be improved. A 'consensus workshop' method was used at both sessions. This method involves a five-step process that guides people from generating and collecting ideas, through organising those ideas into meaningful groups, to reaching agreement on the question they are facing and identifying some next steps to move forward. It aims to draw out and weave together everybody's wisdom into a clear and practical consensus. (see www.ica-uk.org.uk for more details)

4.2 First consultative meeting with providers and referrers 7 June 2010

Seventeen providers and referrers participated in this session. The session began with a facilitated 'focused conversation' in response to an agreed guiding question - *From your experience, what are the required elements for delivering an effective arts on prescription scheme?* The following points were raised:

About the delivery of the scheme…

- There needs to be a robust co-ordination structure capable of managing the scheme
- They need more contact with other providers – to provide peer support, exchange information and knowledge etc.
- The quality of materials provided for the sessions is high due to effective budgeting and sufficient funding being made available. It results in high quality work ("looking professional not amateur") which, in turn, gives participants greater self-esteem and recognition
- The scheme has allowed participation & inclusion of disenfranchised people
- Providers feel most confident about the delivery of workshops because "we're in control of that"
- Poor or limited promotion has resulted in low numbers attending some activities. Promotion needs to be continuous and enthusiastic. Promotional material needs to be produced in collaboration with providers, and communication needs to be better so that providers know whether they are able to promote, to whom and how.
- There seems to be a lack of knowledge and understanding of the role and working processes of a freelance creative professional.

About participants' experience…

- It was observed to be a transforming experience for some, e.g. impact on self-confidence, but six sessions is too short and one cannot build self-esteem, skills, etc in the timeframe (several expressed this concern). "What has happened to the people who finished the scheme?"
- Many participants have expressed disappointment that they need to wait six months before participation can resume
- Many find it frightening entering the workshop on their own, not knowing anyone
- The opportunity has enabled some participants to rediscover "the art experience", an experience they loved in the past

About confusing or 'unfair' elements of the scheme…

- Providers were confused as to who is defined as the 'client' – PCP, PCT, participant, provider?
- Providers have been offered participants on a first-come-first-served basis following a Friday e-mail bulletin on new course availability. This was thought to be unfair and the selection process needs to be clearer.
- There should be opportunity for the potential provider to meet the group leader beforehand to determine the provider's ability to meet the clients' needs
- It was asked "How many GPs are aware of the scheme?"
- "Providers need to be communicated with constantly, to be kept involved and in the loop as we are quite disjointed and isolated." There was felt to be a lack of contact between 'organisers' (PCP) and providers and a lack of mutual understanding
- There is some confusion regarding each partner's understanding of the scheme's purpose, their role and responsibilities. These need to be more clearly defined
- Although providers are paid per client, there was an (erroneous) perception by some that other providers were being paid per session
- Providers sometimes do not know where their referrals were coming from as referrers sometimes do not complete that part of the referral form

Additional points made in the 'clustering' session during the consensus gathering were:

- Models of good and ethical practice are needed to ensure "uniformity of delivery" – reference was made to the Centre for Medical Humanities' *Guidelines for Good Practice* (2009).
- There is need to identify the "progression route", i.e. what happens or what should happen after the 6 sessions?
- Celebrate participants' achievements with exhibitions, performances etc.

The guiding question to the meeting produced the following responses arranged in the summary table below:

Question: From your experience what are the required elements for delivering an effective 'arts on prescription' scheme?

1. Active and effective promotion	2. Responsive financial processes for providers	3. Integrated training and development	4. Sessions to meet ongoing needs of participants	5. Responsive and efficient administration	6. Positive participant outcomes	7. Robust communication channels	8. Evaluative and reflective partnerships
On-going planned, targeted and appropriate promotion	Artists paid at same rate (plus materials)	Ongoing training and development for providers	Appropriate length of participant involvement (is 6 weeks enough?)	Experienced Arts Co-ordinator to manage the scheme	A means of celebrating and exhibiting artwork	Use the strengths within the scheme	A means of celebrating and exhibiting artwork
Programme promotion and awareness	Review system for attendees payments and venue rent	Develop uniformity of delivery	Client support and after-care	Full-time dedicated support worker in PCP	Positive client experiences	Good relationship between PCP, clients and providers	Expectations managed of potential participants, providers, co-ordinators and hosts
Self promotion by providers	Artist time paid for	Ensure skilled, experienced artists for client groups	Identified progression route for the activity to continue	Well-thought out system to manage the scheme	Delivery is pitched at appropriate level for participants	Effective communication at all levels of the process	Evaluation of the project from PCP
Ongoing 'tasters' and A4W events	Review fairness of first come first served system for providers	Ongoing reflective sessions for artists (paid for)	Appropriate length of time of intervention	Streamlined paperwork on referral forms	Client accessibility and enjoyment	Good quality communication	Use the strengths within the scheme
Widespread targeted promotion		Regular artists forum		Good admin processes	Appropriate ratio of tutor to participants		
Accessible publicity							
Wider audience for publicity – e.g. GPs							
A means of celebrating and exhibiting artwork							
Specific titles for courses available, rather than generic							

4.3 Second consultative meeting with providers and referrers 16 July 2010

Fourteen providers and referrers participated in this session. The session began with a facilitated 'focused conversation' in response to the summary table (see above) that was produced at the first consultative meeting from the consensus gathering exercise.   Many said they enjoyed that first meeting and found it a "constructive and positive process". When asked 'what jumps out from the summary table?' the following points were raised:

- The importance of self-promotion and learning how to do it
- Retaining the focus of the project, i.e. providing positive client experiences
- Length of each block, i.e. are six sessions long enough?
- The importance of good quality communication between commissioner, referrers and providers
- Fairness, i.e. is the 'first come first served' system of awarding contracts fair?
- The importance/impact of organising exhibitions to celebrate the work produced

They were then asked 'What's missing from the previous session's summary table?':

- The importance of monitoring and evaluating in order to improve practice
- The need to gather ongoing feedback from participants during each 6-session block
- Understanding the views of referrers, e.g. GPs
- How to promote the scheme to GPs as not many participants were referred by them?
- How to involve the isolated and those who have never participated in arts workshops? Several believed many participants of the scheme were already familiar with the arts having participated in arts workshops prior to this programme

The facilitated 'focused conversation' then moved on to consider the agreed guiding question for this second session - *What impact has 'Arts for Well-being' had on your practice?*

- There has been impact on practice in having to adopt a flexible client-centred approach. Artists have not been aware of clients' needs prior to them arriving to their session and only discover these when the participant walks through the door. The artists have had to become more adept at thinking on their feet, being flexible and willing to change the day's plans at, literally, a moment's notice. They are learning new skills as a result

- There is a personal and professional sense of fulfilment when participants benefit/enjoy/respond to the workshops. One feels the practice is validated when the participant benefits. Artists experience a sense of achievement

- There is less time to develop own practice due to bureaucratic/administrative requirements (as opposed to running the workshops)

- The challenge is to find the balance between working with/enabling others and developing one's own practice

Question: What impact has *Arts for Well-being* had on your practice?

1. Capacity building	2. Enriches the client-centred approach	3. Opportunity to reflect on our artistic practice	4. Developed project management and processes	5. Created challenge to our work	6. Achievement of self-discovery and well-being for all
Validating arts as a promotion for healthy living	Working with new client groups e.g. Sure Start	Opportunity to reflect on nature of practice	Increased promotion of organisation	Limited impact due to difficulty accessing clients	Important project that's good for the soul of both client and provider
Allowed delivery of more effective service	Developed more experience in A4W	More time for own artistic practice	Helped to pull together policies and procedures	The structure for outreach is missing	Helps give deeper meaning to our work
Increased financial gain	Better understanding of specific health conditions	Less time for own artistic practice	New equipment of excellent quality	Lack of referrals means less confidence	
Became more settle and secure organisation	Using clients to help promote A4W		Development of working processes	Missing link between provider and co-ordinator	
Networking opportunities to work and meet nice people	Encouraged particular client-centred approaches		Increased amount of admin		
New skills development	Expanded practice to take more creative risks with people with disabilities and learning difficulties		Showed up weaknesses and gaps in project management		
Kudos & status raised by being part of A4W	Avenue for new people to access services				
Created more work	Raised aspirations from having better equipment and materials				
Leveraged other sources of funding					

The second consultative meeting also asked providers and referrers "Who are the participants?" Responses revealed a wide range of conditions in the participants including:

Chronic health conditions

Autism

New parents (mostly female)

Elderly in residential homes and day centres

Alzheimers

Physical/sensory disabilities

Stroke patients

Brain and/or neurological disorder

Day care service users

People with mobility problems

Arthritis

Multiple sclerosis

Severe complex needs

Learning disabilities

Mild mental health issues

Depression

Terminal illness

Providers and referrers were also asked "How are they referred?". Referral routes comprise:

Referrals via PCP (original sources identified on referral form)

Self-referrals (inc. via word-of-mouth recommendations and flyers)

Care centre managers

Voluntary group leaders

Community Centres

From Tessdale's *Good For The Soul* project

Arts For Wellbeing launch event

Therapists

Sure Start networking breakfast

Connexions

Providers

4.4 The 'natural selection' issue

The original research question from the PCT posed whether there is a 'natural selection' of which individual arts in health initiatives work best. Our view is that, aside from making comparative assessments of whether arts in health interventions are done well or badly, there are too many variables in the delivery of the work to make possible a 'natural selection' of which initiatives work best.   One is rarely comparing like with like. It is not just the art form that matters; the personality and technical skills of the artists, the setting and context, the quality of partnership working, the direct and indirect effects of arts participation, the ability of the artists to share their processes, the matching of clients to the appropriate activities and artists, and a variety of aims and outcomes are all equally important to the unique success of each project.

Some activities, of course, are more popular and accessible than others, but this does not mean necessarily that they are the ones that work best. PCP's report on the waiting list, produced at the time of the six month review in March, shows Arts & Crafts and Painting & Drawing to be the most requested activities (116 and 104 on waiting list respectively) with Drama and Circus Skills the lowest (34 and 19). Music & Singing are third highest (80). Visual arts activities in general account for six of the thirteen activities offered.

Our observations of a sample of *Arts For Wellbeing* activities were limited to visual arts and dance projects, but they did in all instances discover that participants valued the activity highly, and they held the artists/tutors in high regard in respect of both technical skills and communicative personality. Many participants felt cared for and that their contribution to the activity was valued.

A research report for Arts Council England (2004) by Rosalia Staricoff recommends more research into the specific effects on health of individual art forms particularly in clinical settings; but whilst this might reveal interesting correlations in specialist areas such as neurology and psycho-immunology, it could confine research to investigating art as a mode of treatment within a medical rather than social model of health. We think it is better to look at arts in health as a generic field of activity, albeit one that has expanded in recent years into diverse practice that includes work in hospitals, primary care, respite care and rehabilitation, public health, social services settings, community based organisations, schools and places where arts therapies are practised. Furthermore arts in health has an acknowledged role in addressing a whole range of social policies. The practice of arts in health is not a single professional role but a skills partnership of people who come together in their distinctive roles to engage the public in creative activities that aim to improve health and well-being. The term 'practitioner' or 'provider' may refer not exclusively to artists but rather to anyone who has a professional role in the preparation, delivery and evaluation of the work. The term 'participant' may refer to patients, clients, service users, staff members, carers, or any person in a community taking part in an arts and health project. The Centre for Medical Humanities at Durham has defined arts in health as *'creative activities that aim to improve individual or*

community health using arts-based approaches, and that seek to enhance healthcare delivery through provision of art works or performances' (White 2010). We have looked at programmes of arts on prescription not as delivering separate art forms but as a distinct area of activity operating mainly outside of acute healthcare settings that is characterised by the use of participatory arts to promote health.

Developing innovative approaches to achieving effective participation in arts in health make it a learning process for all involved, and it is from a multi-sector dialogue that the characteristics of practice may be best determined. As practitioners themselves may acknowledge, however, some adverse characteristics of practice need to be improved or eradicated, and project reports frequently indicate the difficulties of defining the roles and responsibilities of stakeholders and getting agreement on the benefits sought from the activity (Angus 2002). Yet lessons learned from both success and failure have informed the impetus in recent years to scale up the work and establish whole system programmes for the delivery of arts in health, their target areas determined by human geography or specific health issues, rather than just being focused on local projects in isolation. Indeed, a primary characteristic of this practice is that it is extraordinarily ambitious despite a slim research and resource base.

In 2009 the Centre for Medical Humanities produced *Guidelines for Good Practice in Participatory Arts in Healthcare Settings*, commissioned by Waterford Healing Arts in Ireland. This document sets out an ethical framework for practice and is intended for practitioners who already undertake, or aim to engage in, participatory arts in a range of healthcare contexts. The guidelines are intended as a platform for ongoing dialogue and debate around promoting best practice, and are therefore recommended for use in *Arts For Well-being*. It is hoped that the document will encourage practitioners to become active contributors to the promotion of best practice within the field. The guidelines are structured around the following five headings:

1. Participants come first
2. Responsive approach
3. Upholding values
4. Feedback and evaluation
5. Good management and governance

(The guidelines document can be downloaded at http://www.waterfordhealingarts.com).
The full text of the guidelines is also added to this report (Appendix 2). Copies were given to all the providers in *Arts For Well-being* who attended the first review meeting in April 2010.

5. Addressing the second research question - What does the data tell us?

The second research question inquires about user experiences and impact, drawing on data from the Warwick-Edinburgh scale that is currently being administered to participants and from process evaluation data

5.1 Statistical profile of people referred to Co Durham "Arts for Well-being".

Regarding methodology for the profile: for the demographics, descriptive statistics were used (i.e. mean median and mode). For the evaluation forms the responses were codifiedusing Grounded Theory and then used Content Analysis (frequency of responses). Responses entered in a wrong section were counted to ensure that the researcher had not attributed certain sections with higher frequencies than was actually the case. This also revealed that participants wrote comments that they felt strongly about; it is interesting that no one answered Section 4, possibly because many participants did not draw a link between arts participation and employment.

Problems identified with the Warwick-Edinburgh Mental Well-Being Scale forms were:
- The statistical researcher could not tell from the hard copies which was the first response and which was the last; so could not perform a strictly verifiable statistical analysis without that information. PCP attempted to remedy this situation by producing 'before and after' data verified by log entries of when the forms were received at their offices. Their data shows individuals' percentage scores for feeling better or worse, however, rather than showing change across the scheme's population which is what Warwick-Edinburgh is designed to measure.
- Very low return rate i.e. very few people had submitted both forms; where only one existed it could not be ascertained which was the first and which was the last
- Issues with getting them to artists on time (forms were sometimes sent after the course finished, but this was remedied as the scheme progressed)
- Participants' responses to forms: some filled them out very quickly and with not much thought, others didn't understand why the NHS wanted to know if they were happy (suggesting association of the NHS with ill health, not positive emotions?)
- The process was time consuming
- If these forms are filled out on session 6, you do not find out the longevity of the effects.

All information derives from the 222 referral forms that were accessed in July 2010.

1) Gender

Of 220 participants (2 were withdrawn) there were 70 males and 150 females.

2) Age

18-19	2
20-29	16
30-39	27
40-49	48
50-59	46
60-69	44
70-79	14
80-89	11
90-99	5
no response	9

Average= 52.8826291

Median=52

Mode=46

3) Target Group

NP= new parent LTC=long term health condition

NP	5
NP+carer	2
NP+LTC	1

NP+carer+LTC	1
LTC	168
LTC+carer	25
carer	15
no response	5

4) Disability status

no	46
yes	19
physical impairment	36
mental health condition	41
sensory impairment	1
physical impairment+mental health condition	7
physical impairment+sensory impairment	7
learning disability	40
prefer not to say	4
learning disability+physical impairment	4
learning disability+physical impairment+sensory impairment	1
no response	13
mental health condition+ physical impairment+sensory impairment	2
learning disability+mental health condition	1

Where it says " yes" this denotes the number of people who stated that they had a disability but did not stipulate what kind. It does NOT convey the total number of people with a disability. This is arguably a somewhat subjective assessment of disability. Some people who ticked the long term health condition box would write in brackets why they considered themselves to be disabled (e.g. fibromyalgia, anxiety, depression, arthritis) and others who may have had the same conditions may have selected "no".

5) Employment status

FT employment	15
Seeking employment	7
Retired	62
Benefit claimant	78
Otherwise unemployed	22
prefer not to say	21
no response	15

2 people created their own categories:

disabled	1
full time mother	1

For those who ticked multiple boxes (n=4) one category was chosen. E.g. retired+benefits was categorised under retired.

FT= full/part time work

6) Referral sources

The first chart conveys the different referral sources as defined by the participants. The second chart groups together the referral sources into different categories. It should be noted that these categories are not discrete; Durham County Council is a category but a project run by them is under " community health services." Some of the charities run services for disabled people so "charities" and "disabilities" have some cross over. Where it says " artists" this refers to one artist, RT Projects.

PCP	9
Sure Start	1
Counselling	10
Self	18
Carers Support Groups	18
Job Centre	2

Artists	22
Charities	28
Disability Services	12
Community Health Services	26
Other	8
Durham County Council	19
No referral source	52

There is some anomaly in the earlier referral forms (before April 2010) where it is not always clear whether the referral is being activated by the artist/deliverer or by PCP.   This may be because the forms were from before the April 2010 meeting when artists sought permission from PCP to recruit. In the earlier period of the pilot it is possible that some participants would not have been formally enrolled on a course (which may explain the lack of WEMWB forms). The first referral was 13 July 2009, by November 300 people were on the service waiting to be assigned to a course, and the first course was December/January 2009/2010. The incomplete forms therefore may represent that backlog. After April, a rise in artists' names in the referral box could be seen; whether the backlog started to diminish is unknown. This could have an impact on the evaluation as it affects understanding of the types of people accessing the course. e.g. health workers may refer individual people onto the pilot and they end up on the database, compared to, say, church congregations who may be targeted by artists because they constitute an already existing group.

These are the figures PCP gave in July:

604 people referred, of whom:

198 people were waiting

108 were active

291 had completed a course

7 withdrawn

However, PCP reported a delay in updating details so these will not be accurate figures.

PCP's estimation of recruitment was a 60:40 ratio of artists referring: other sources referring.

5.2 Evaluation Forms

The number of evaluation forms (88) was not substantial for a statistical profile, so again results have to be treated with caution. However, the results of the perceived benefits gained, depending on why and how the person came to the course, should be addressed for future research. The evaluation forms were coded and then the codes counted. This process was repeated multiple times until the data were saturated.

Codes	Frequency
Accessibility	4
Equipment	2
Building	4
Positive relationship with artist/teacher	26
Patience	4
Helpful	10
Relaxing	9
Enjoyment	25
Positive experience with group	5
Meet more/meet new people	3
Help socialise	3
Learned new skills	6
Confidence	6
Therapeutic Effect	7
Course length	18
Improved concentration	2
Positive anticipation	2
Distraction	1
Feel needed	1
Comfortable	3

Course length- noted the number of complaints that 6 weeks was not long enough

Therapeutic Effect- any participant who stated that the arts programme helped with a physical or mental condition. This could be overtly stated such as "before beginning the course I was diagnosed as having depression and panic attacks. I was able to totally loose [sic] myself in the work I was doing and feel needed again…" or where people stated that it helped them. This was differentiated from statements surrounding arts practitioners being helpful when teaching art. Comments surrounding helpful nature of teaching came under "helpful".

Patience. This refers to participants who felt that the teacher was patient with them.

Positive Anticipation. This was where participants stated that they looked forward to the arts classes

NB: Two sets of evaluation forms were omitted. One was the comments from a group of adults with severe learning disabilities. As the comments were made on the participants' behalf, the priorities of the support staff were reflected, rather than the participants. Although a substantial effort was made to fill in the forms, the majority of comments focussed around wheelchair access, rather than the participants' well-being.

The other set of omitted evaluation forms were owing to the almost identical comments, written in very similar handwriting. It was not clear whether someone had written the comments on the participants' behalf or whether the group had had a collective feedback session.

5.3 Evaluation forms results

Despite the section titles, suggesting feedback areas, themes were not evenly distributed between sections in the evaluation forms; 3 themes related to Section 3 (Positive relationship with teacher, patience and helpfulness) and 0 themes related to Section 4.

Number of comments made

Section 1: Information and advice :   16

Section 2: The Tuition   32

Section 3: Room and facilities   12

Section 4: Next steps and progression 2

Section 5: Additional comments   28

19% (17/88) of answers were in the wrong section. This had little impact on content analysis of the 32 responses in Section 2 (the tuition section) 26 related to positive relationships with the teacher- the other 6 were to do with other aspects of the scheme. Only 2 comments were in Section 4 and neither of these related to future plans. Rooms and Facilities was also an underused section with only 12 comments. Section 5 was the 2nd most used section with 28

comments; this section was often used to relate to personal medical histories of the participants and included factors which mattered most to the participants e.g. course length or positive relationship with teacher. This suggests that people wrote the impressions that were the most important to them, rather than adhering to the layout of the evaluation form.

5.4 Analysis

Grounded theory elicited two categories of benefits:

Category 1 "hedonic".

These participants tended to cite positive qualities

e.g. positive relationship with teacher and group, learned new skills

Category 2 "therapeutic"

The benefits stated were also positive, but it was apparent from the way they were expressed that participants had not enjoyed these benefits prior to the course. e.g.

distraction

improved concentration

gaining confidence

had only just become comfortable by the end of the course

cope better with illness

Both categories praised the teacher.

The difference between the 2 categories was subtle and only revealed after iterative coding processes. "Socialising" was split into 3 categories: "positive experience with group" "meet more/new people" and "help socialise". Both categories discussed enjoyment of being part of a group, however Category 2 specified this process as *helping them* to socialise, suggesting previous isolation or difficulties in this area. The benefits enjoyed by Category 2 were particular to them e.g. improved concentration. In addition many people across the 2 categories discussed how the teacher had helped; however there was a distinct difference between Category 1 who would be referring to their art and Category 2 who would be talking about how the art helped *them*.

At the end of the evaluation form was the question: do you think the course has helped retain/return to work?

Few people filled this section in (n=33) with the majority stating no (n=9) or don't know (n=15) or not applicable (n=1).
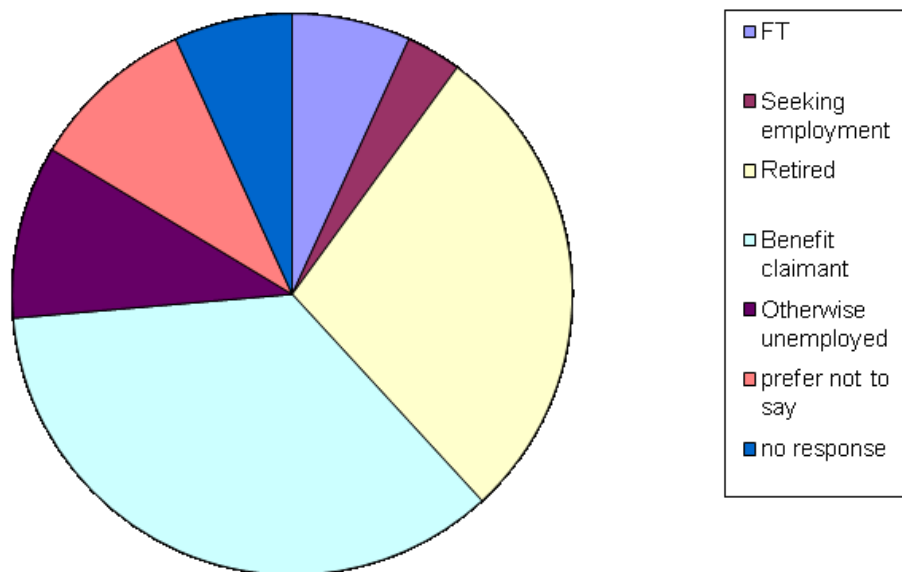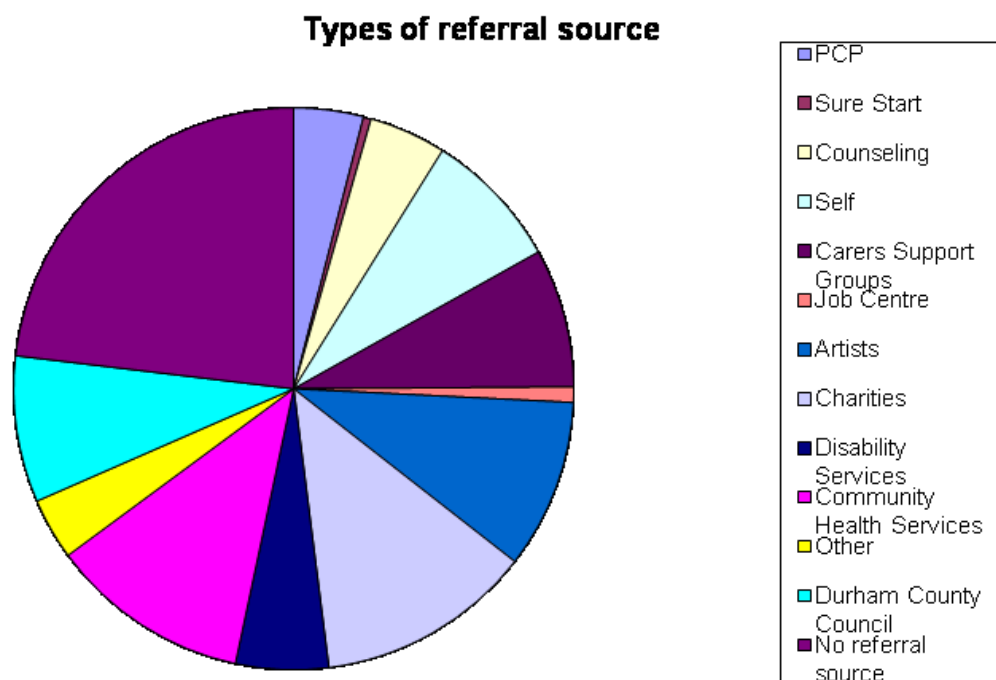
Gender

Age

target groups
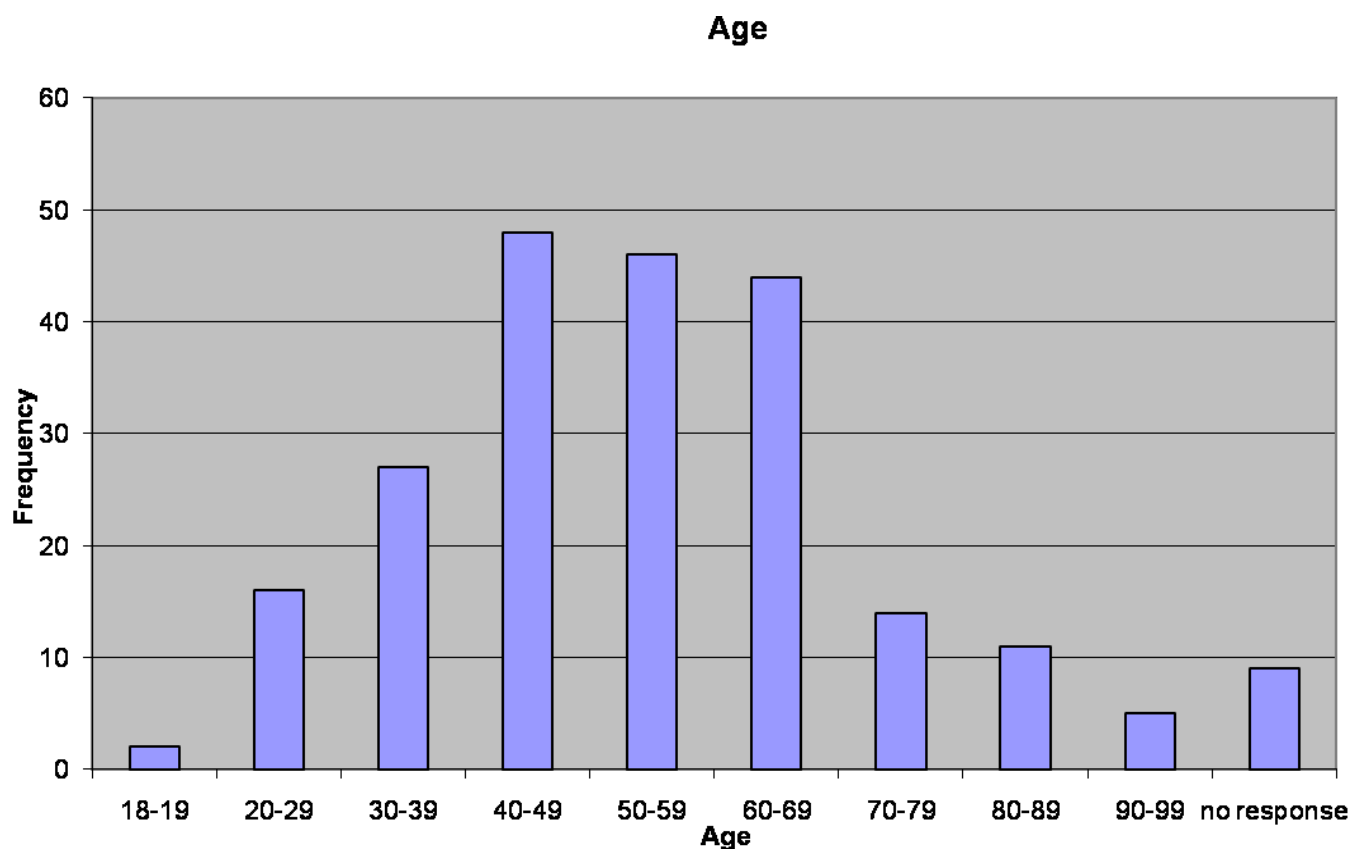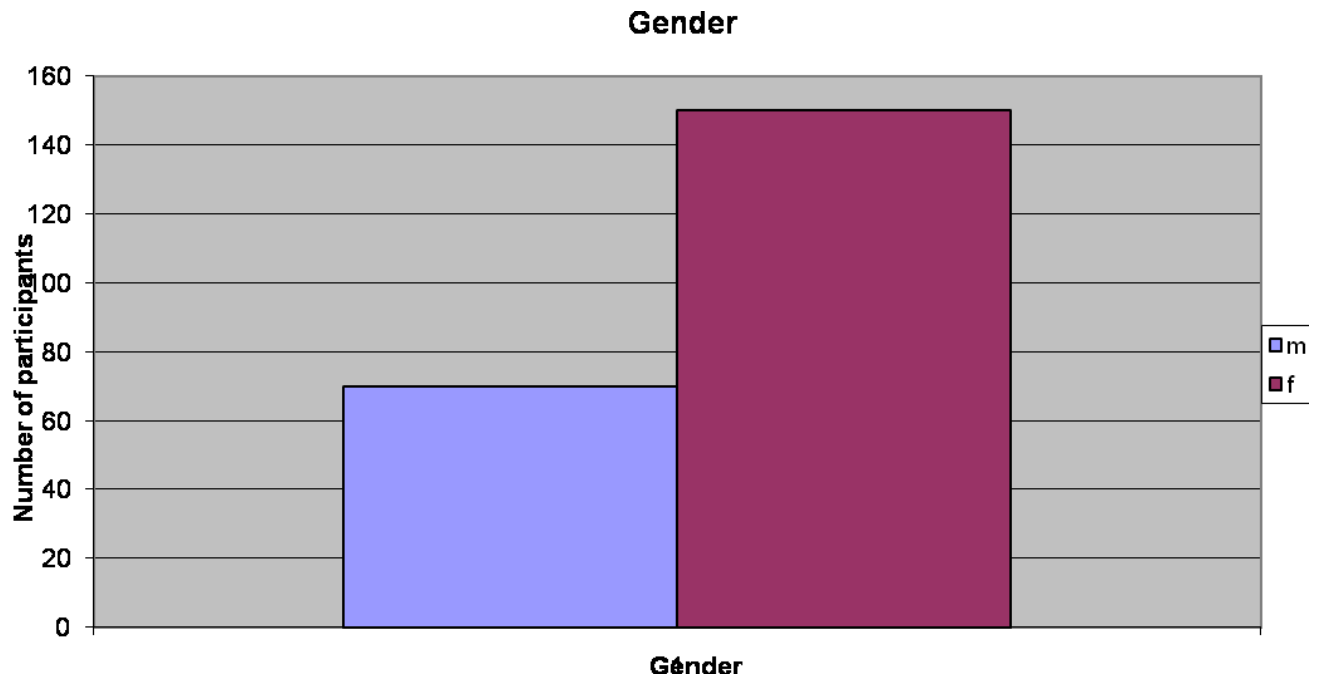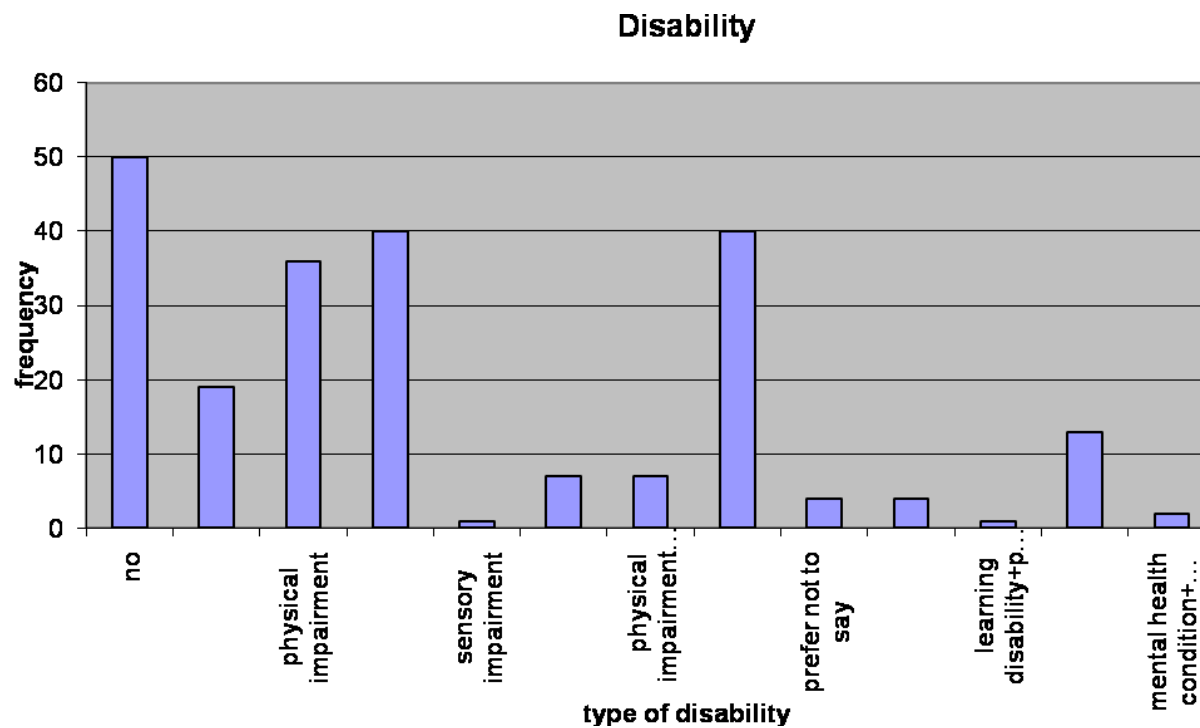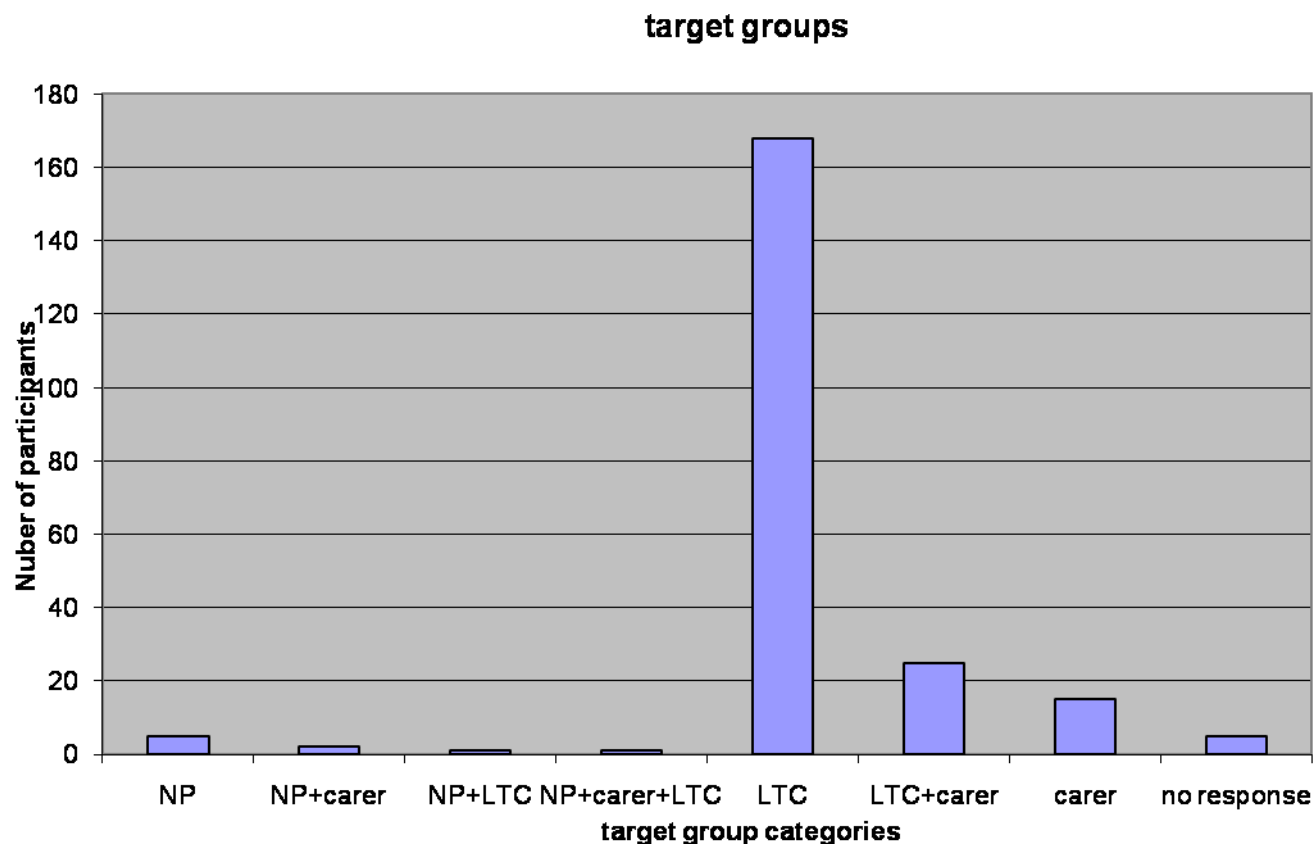
Disability

Disability status – as per referral forms

No declared disability	50
Yes, disability declared	19
Physical impairment	36
Mental health condition	40
Sensory impairment	1
Physical impairment+mental health condition	7
Physical impairment+sensory impairment	7
Learning disability	40
Prefer not to say	4
Learning disability+physical impairment	4
Learning disability+physical impairment+sensory Impairment	1
No response	13
Mental health condition+ physical impairment+sensory Impairment	2
Learning disability+mental health condition	1

Employment status

Legend:
- FT
- Seeking employment
- Retired
- Benefit claimant
- Otherwise unemployed
- prefer not to say
- no response

Types of referral source

Legend:
- PCP
- Sure Start
- Counseling
- Self
- Carers Support Groups
- Job Centre
- Artists
- Charities
- Disability Services
- Community Health Services
- Other
- Durham County Council
- No referral source

5.5 Some observations on the data

Arts organisations often find middle age people difficult to engage in participatory arts, yet the majority of those in *Arts for Wellbeing* are 40-69 years of age.

The scheme has had significant success in targeting people with long-term conditions but does not distinguish between health condition and disability. The disability arts field considers it prejudicial to regard people with disabilities as being in chronic ill-health.

Just over one third of participants claim benefits and just under a third are retired, and this will have implications for introducing a fees tariff for the continuation of an *Arts for Well-being* activity. It could still require considerable subsidy.

Referrals are coming from across the spectrum of welfare services but not from primary healthcare. For almost a quarter of referrals the source is not defined – but needs to be.

PCP data shows two thirds of participants improved against the WEMWBS points 'I've been feeling useful' and 'I've been feeling relaxed'. Coding of the assessment forms shows 'positive relationship with artist/teacher' and 'enjoyment' to be the most frequently cited responses.

6. Addressing the third research question – What do participants tell us?

The third research question asks what do users' comments and narratives about the service suggest about its wider impact?

6.1 The focus groups

Although it is not within the scope and intention of this study to provide a conclusive understanding of this project's impact on the end user (the intervention period is too short), the results provide an informative snapshot of its intermediate effects on participants. Via an e-mail to the artists and referrers, we informed the focus groups' participants in advance that County Durham Primary Care Trust had commissioned the Centre for Medical Humanities at Durham University to evaluate the *Arts for Well-being* project. We explained that our questions would ask why they agreed to participate in the workshops, whether they enjoyed them and why, how they benefited from them and how they believed the project could be improved if it was extended. We said we would write-up our findings in the form of an evaluation report. We would not use people's names in our report, so that whatever people told us could remain private and protected. If they agreed to take part in the evaluation, but then changed their mind at any time, that was not a problem.

Fifteen questions were posited for the focus groups (see Appendix 1); some of these took the form of open group discussion, and others were opportunities for individual (confidential and anonymous) responses written on 'post-it' notes. The same questions were asked of participants in individual interviews. The questions asked of support workers and carers were modified. The users' and carers' comments about the service are summarised and consolidated below. Passages in italics indicate direct quotes.

What follows are the results of five focus groups involving forty two people, two written testimonials and two telephone interviews (one with a carer and one with a participant) that were conducted between July and October 2010. As one of the focus groups involved people with learning disabilities, neurological disorders and brain injury who had difficulty communicating their views, support workers (carers) were interviewed individually. Due to the composition of this group, and related communication difficulties, observations of the workshop were also made. A similar approach was taken with another focus group that included people with dementia and speech loss due to stroke. So only in three of the five focus groups was it possible to maintain our set questions to prompt semi-structured interviews.

At a tangent to this study, an open interview to produce an article for an arts magazine was also conducted with two staff and two users at Waddington Street Centre to set that organisation and its participation in *Arts for Wellbeing* in a wider context of arts and mental health (see Appendix 3).

6.2 General conclusions

The evidence provided for this study suggests that the project succeeded in benefiting the participants and carers by providing opportunities for them to:

  i.   Develop new artistic skills and further develop old ones

  ii. Develop their inter-personal skills and social networks

  iii. Become absorbed in a stimulating and creative activity, which provided them with respite from their stressful daily lives and their illnesses

In addition to these, the involvement in the project appears to have increased participants' self-esteem and self-confidence and provided them with an enhanced view of their own capabilities, artistically and socially. The activities also provide a positive, and different, topic of conversation with others – notably between carers, support workers and their charges.

All of the participants, carers and support workers paid tribute to the providers of the scheme, noting their artistic skills and knowledge and their ability to share those skills with others, their patience and communication skills – *I feel more confident in my artwork and my abilities to interact with others, this is primarily because of the relaxed atmosphere and patience of the tutor.* One respondent thought that *the concept of Arts for Wellbeing is brilliant and it could save taxpayers' money*

Participants also expressed great disappointment when the workshops came to an end after six sessions. One participant's comments encapsulated the feelings expressed by virtually all of the respondents – *I was at a bit of a loss when it finished. Felt I was on the brink getting somewhere. Felt I was just turning a corner when it finished and came to an end.*

Although participants, carers and support workers overwhelmingly believed the project was of benefit to them, none of the respondents, whether involved in the focus groups or in individual telephone interviews, had discussed these benefits with their clinicians. Although one person was referred by her counsellor she had no contact with her once she started attending the workshops. The need for a 'feedback' pathway as well as a referral pathway is a vital point which needs to be addressed in future.

The importance of the venue was highlighted by several respondents as playing a significant factor in the project's success with most appreciating the fact that the sessions were provided in independent community-based venues – for example, in arts organisations, voluntary/community settings, churches – and not in medical centres or formal educational institutions. One respondent commented that ...*I'm not necessarily interested in qualifications. Trying to learn with people who are fit and well is no good; you need to go at your own pace.* Although happy with the venue, one of the participants suggesting working in an artist's studio that was fit for purpose and equipped with easels, sinks and good light would benefit participants

It was thought by carers that consideration should be given to offering bespoke training for providers on working with people with additional requirements, e.g. those with hearing impairments, learning difficulties, neurological injuries, etc.

6.3 Summaries of responses to the questions

> **i. Location of participants' home** – The locations of the five focus groups were in Bishop Auckland, Stanley, Stanhope and Durham City (Framwellgate Moor and Gilesgate). Participants and carers came from a wide cross section of County Durham's communities – West Rainton, Newton Aycliffe, New Kyo, Stanley, Consett, Pity Me, Framwellgate Moor, Newton Hall, Gilesgate, Coxhoe, Stanhope and Chester-le-Street.
>
> **ii. Art disciplines engaged with** – Most of the art forms were visual arts-based - painting, ceramics and photography - with one artist providing dance workshops, which were regarded by several participants as an effective way of keeping fit and cited this as the main reason for participating in the sessions.
>
> **iii. Reasons for participating in the scheme** – Most of the respondents cited similar reasons for wanting to participate in the arts workshops and cited more than one reason. The majority 'wanted to try something new'[1] or 'wanted something to do'. A large number of the participants added comments to the researchers' pre-designed list of possibilities – in particular they *wanted to meet new people, enjoy being part of a group.* Several people cited that they had 'done it before and liked the experience'. Four of the respondents participated in *Arts for Wellbeing* because it was 'part of treatment', with one person being referred by her counsellor. Although not using the word "treatment", several persons thought participation would improve their mental health.
>
> **iv. Attendance** – Of the forty two participants involved with the focus groups, two-thirds (twenty eight) attended each of the maximum allowed six sessions, and fourteen attended between two and five sessions. In addition, of the two individuals interviewed separately, one had attended all six sessions, while the other attended five.
>
> **v. Expectations** – Participants' responses to this question were very similar to those in question 3, i.e. they anticipated that they would learn new skills, meet new people, be distracted from the stresses of everyday life, *produce a piece of art* and *enjoy a social activity.* It is worth noting that the majority of those who participated in the dance workshops saw the sessions as an opportunity to keep fit, exercise and improve their agility, as opposed to signing up purely to experience the art of dance. All of the participants' expectations were met and,

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[1] This is one of six suggested reasons posited by the researchers for the focus groups to consider. There was also an opportunity for the respondents to add to this list. Please see Appendix 1 for the full list of questions.

in some instances, exceeded their expectations, including *learning a new hobby*, *feeling stronger*, becoming *so engrossed in the subject that I forgot my problems temporarily*, being *stimulated*. One carer remarked that the sessions took *my mind off of my carer's responsibilities and stimulated me intellectually and artistically*. Two people expected that they would be *unable to cope*, or would have *little individual help*. The respondents noted that these particular expectations were not realised, as the providers and the group ensured they were appropriately supported during the sessions, and the activities were individually tailored to meet capabilities.

vi. Barriers or difficulties which affected participants' involvement in the workshops – Of the barriers cited, all were idiosyncratic and due to individual circumstances. For example one person with special needs required the assistance of a carer and was not able to attend occasional sessions due to staff shortages. Two experienced some difficulty due to their physical illnesses – one had MS and another had a profound hearing impairment – and two cited the lack of self-confidence which caused them to be nervous/reticent about attending the first session. Another acknowledged that she would have been prevented from participating had she not had anyone to look after her small child. During the focus group which involved people with learning and physical disabilities, including neurological disorders and brain injuries, it was noted that participants were often frustrated due to poor eye-hand co-ordination, communication skills and limited attention spans.

vii. Arts experiences prior to involvement in the project - Most of the respondents who participated in the dance workshops had not been involved with the arts prior to the project, although two mentioned membership of choirs and one had taken dance lessons. Of those who participated in the workshops that were organised by RT Projects, two-thirds had not previously experienced working with artists, whilst everyone who participated in the focus group at Age Concern Derwentside had previously experienced either painting, crafts, music and/or drama.

viii. New arts activities as a result of involvement with the project – Whilst most of the respondents had not tried new arts activities as a result of *Arts for Wellbeing*, a significant number aspired to do so - notably dance, ceramics, music, singing, drama and drawing. However, several others had undertaken new activities following their involvement with the project. An example cited by one person included the purchase of a new *expensive* camera and another bought watercolour materials with which to continue the activity from home. One person joined a mosaics group, whilst another joined local arts groups that were inclusive and accessible to people with learning difficulties. One of the carers, who had not previously painted, has continued to paint once the workshops ended. Although not all of the subsequent activities cited were arts-

based - for example one person enrolled on a computing course, whilst another signed up to become a volunteer - the respondents associated these with their enhanced self-confidence and renewed interest in acquiring new skills as a result of the *Arts for Wellbeing* project – one person remarked *...always looking for something to do now...*

ix. Changing views about the arts/creative activity – Although most of the participants' views of the arts and creativity did not change as a result of participating in the project, they cited the pleasure and self-satisfaction they experienced, notably because it enabled them to:

- meet new people
- discover they were able to have fun, socialise and communicate with others
- succeed in learning new skills – *thought I had two left feet, but Joo-Lee[2] enabled everyone to participate and succeed*
- participate in an absorbing activity which required complete concentration – one respondent believed that art made her forget about her illness
- realise that art was more than a diversion in that it *...renews a sense of productivity*.

Several of the carers observed that their clients benefitted greatly from the sessions and were grateful for them being included in stimulating and creative activities in safe and accessible environments.

x. The least enjoyable aspect(s) – The overwhelming majority of respondents thought the six sessions were not long enough due to, broadly, four different, but pertinent reasons:

1. *It takes time to adjust to the activity*
2. *Not long enough to explore different techniques*
3. Sustaining the self-confidence to actually leave the house – *I saw it as a challenge but was dying to come as it made me feel better psychologically*
4. Missing sessions due to ill-health

xi. The most enjoyable aspect(s) – The overwhelming majority of respondents believed that at least one of the four most enjoyable aspects of the project were:

1. Being given the opportunity to meet and socialise with other people and make new friends
2. Learning new creative skills and/or developing old ones
3. The help and support they received from their particular provider
4. Getting out of the house

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[2] Joo-Lee was the dancer who led the dance workshops in Framwellgate Moor, Durham City.

One carer remarked that the most enjoyable aspect was *seeing what I was capable of producing and seeing my wife's delight and sense of accomplishment when she finished a piece of work*

xii. Suggested improvements to the project – Virtually all of the respondents agreed that the workshops should be longer than six weeks, with many suggesting they be extended to ten weeks, or (ideally) that they should be offered permanently.

Several believed that the workshops should be more widely advertised in order to attract more people, particularly those who were isolated and/or were frightened of new experiences. Three suggestions were posited:

1. Organise 'taster' sessions, as these might attract those who were uncertain of the activity
2. Invite potential participants to observe sessions
3. Produce easily accessible flyers/information and post these in a wide-variety of venues, including GP surgeries, hospitals and chemists

xiii. Perceived changes to wellbeing – All of the respondents believed their sense of wellbeing improved as a result of the project[3] – *I feel more confident going amongst people, I've learned to participate, I feel more confident that I can do something..., ...I don't go out as a rule but it gets me out..., feeling you still have something to achieve, ...feel better within myself mainly because of having new skills and knowing one can do something new, Workshops give me something to look forward to... wellbeing is about feeling good about yourself, and when I came to the exhibition* [of the work produced] *I felt proud to see my work framed*

However, most also believed that their sense of wellbeing deteriorated relatively quickly due to two key reasons: (i) the perceived service structure, i.e. the six-week blocks of activity. It was felt that any momentum for wellbeing was broken by only six weeks' activity – *At the end of the 6 weeks I stopped immediately doing art and have now reverted to my depressed state again*. One of the interviewees commented that *I was at a bit of a loss when it finished. Felt I was just turning a corner when it finished and came to an end*, (ii) the resumption of 'normal' day-to-day life, and all of the complications and stresses associated with this for many, once the participant left the session.

All of the carers and support workers interviewed believed participants benefited greatly from the project, finding the experience enjoyable and appreciating the opportunity to socialise and meet new people. They also thought the experience added a certain excitement to the lives of those in institutional care. One support worker also observed that *several users with clinical depression don't cry as often when the*

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[3] What follows are quotes from individual respondents.

arts activity is here, and that *the artist is able to get them to join in, a task the staff often find challenging.*

xiv. Perceived changes to self-knowledge – Respondents overwhelmingly believed that the project resulted in a greater sense of self-knowledge. They invariably linked this to an increased sense of personal satisfaction and pride at having successfully engaged with people, fostered new friendships, tried new activities and produced artworks worthy, in one instance at least, of a public exhibition. One respondent discovered a love of painting and that life was not as lonely as once thought to be.

7. Making sense of the findings – conclusions and recommendations

From all the information collected in the exploration of the three research questions, key issues from providers', participants' and carers' interviews and focus groups were identified for discussion with the PCT lead at a meeting to review progress in September. As noted earlier, the project has already exceeded all its pilot phase referral targets.

7.1 Key issues identified by providers:

- Retaining the focus of the project, i.e. creating positive client experiences.
- Length of each block, i.e. are 6 sessions long enough? Need to identify "progression route" to develop a programme(s) after the initial 6 week block.
- The importance of good quality communication between commissioner, referrers and providers.
- Fairness, i.e. is the first come first served system of awarding contracts fair?
- The importance/impact of organising exhibitions, performances etc. to celebrate the work produced.
- The importance of monitoring and evaluating in order to improve practice.
- The need to gather ongoing feedback from participants during each 6-week block.
- Understanding the views of referrers, e.g. GPs.
- How to promote the scheme to GPs as not many (if any?) participants were referred by them? How to involve the isolated, those who have never participated in arts workshops or those who might be too fearful?
- Impact on practice – artists have had to adopt a flexible client-centred approach as they have not been informed of clients' needs prior to them arriving to their session and only discover these when the participant walks through the door. The artists have had to become more adept at thinking on their feet, being flexible and willing to change the day's plans at, literally, a moment's notice. They are learning new skills as a result.
- Personal and professional sense of fulfilment when participants benefit/enjoy/respond to the workshops. The practice feels validated when the participant benefits. Artists experience a sense of achievement.

7.2 Key, and recurring, issues identified by participants and carers:

- High regard for the artists leading the workshops, without exception. Participants found them to be supportive, accessible, inspiring, sensitive, intuitive, interesting and skilled.
- Disappointment when workshops came to an end and the realisation that there was no opportunity to continue with the experience until an amount of time had elapsed.
- None of the participants appeared to have been referred by their GP.
- Several participants have aimed to try new arts activities and/or continue developing the skills learned during the project.

- Virtually all of the participants believed that their sense of wellbeing, achievement and related self-esteem and self-confidence grew as a direct result of participating in the workshops. Participants valued the stress-free, friendly and supportive environment.
- Participants valued the socialising and the camaraderie that developed with the other participants.
- Participants appreciated learning new skills (or developing old ones).
- Several participants found producing artwork totally absorbing, requiring complete concentration and providing appreciated respite from their illnesses.

7.3 Conclusions and recommendations for 'Arts For Well-being'

1. Discontinue the 'willing provider' model

The model has created mistaken expectations of guaranteed employment for artists admitted to the providers list. It has only had slight success in creating a small competitive market out of a 'natural selection' of artists who are most engaged with the scheme, but the arts practitioners' ethos tends to be resistant to that market approach. It cannot be about comparing like with like on price and availability, as there are many variables around the quality and the context of the work that are crucial too.   The 'willing provider' model, as adapted from schemes like smoking cessation, has also locked *Arts For Well-being* into bureaucratic and unnecessarily costly contracting arrangements. It has revealed a weakness in having too many providers (over 30 now) for a client-centred programme and so some artists have been disappointed not to be offered work. This adds considerably to an administrative burden on the scheme

2. Invite new tenders for (maximum 3) hub delivery services - determined by geography, demography or health issue.

This approach allows promotion, administration, delivery and accountability of the scheme to be undertaken by single organisations directly contracted by the PCT. It creates incentivised ownership of the initiative and a flexibility of approach in developing the referral pathways. It permits a more focused remit for delivery at sub-county level but it should require a development strategy to achieve a county–wide service within three years – to this end the selected hubs need to work in partnership with each other and avoid duplication. If hub organisations also take responsibility for securing appropriate venues, in consultation with the artists/providers, it could provide economies of scale on venue hire and avoid confusion/duplication. Hubs should also ensure that attendance registers and both formal and informal feedback are maintained. Arts management experience would be preferable.

3. Be clear and agreed on the presentation and language of the scheme

There was some dissatisfaction among the providers about the design of publicity for the scheme and they felt the terminology used was unclear and misleading. The new tenders

should make clear that publicity and promotion is the responsibility of the providers but must accommodate the guidelines and requirements of the PCT.

4. Sustain a mix of rural and urban services

Even if the scheme is unable logistically and financially to offer local provision across the county, there should still be a mix of rural and urban *Arts For Well-being* initiatives to reflect the demography of County Durham and for the scheme's effectiveness to be assessed. If the (so far under-subscribed) mobility budget is retained, it should be more vigorously promoted, particularly to those in rural areas.

5. Offer fewer but more generic arts activities

At present the scheme has a plethora of arts activities and is over-specialised. This contributes to the length of the waiting list, and also leads to some artists feeling they miss out due to the 'first come first served' basis of selection. Offering fewer but more broadly defined activities may increase required enrolment levels for the take-up of courses, and 'taster' sessions might also be offered to help clients choose their activity. The provision of quality materials in the pilot phase has contributed to both artists' and participants' satisfaction with the scheme. It is recommended that the hubs hold the budgets for these activities and can respond flexibly to participants' requests, but remain accountable for the use of all funds to the PCT as part of the regular review process.

6. Provide joint induction programme for hub providers and referrers

The two consensus workshops for providers and referrers that were conducted as part of the evaluation identified the factors that would make for good practice and improvement, and also met a need for ongoing contact around a sense of collective endeavour. It is vital that the new hubs are committed in partnership to the protocols and good practice of the scheme and apply techniques of reflective practice to the development and assessment of their work.

7. PCT and its successor organisation to contract direct with the providers

This should improve communication and accountability. Agreed performance indicators will assist ongoing monitoring and future evaluation.

8. Fee rates should be determined by sessional costs (and in accordance with union/guild recommended pay rates for artists) rather than per participant

It is unnecessary and costly to base the payment per participant; it results in disparity in payments to artists across different groups, and without first-hand monitoring the fairness and accountability of this arrangement could be open to challenge. Arts workshops are normally run on a sessional rate plus hire and materials so the baseline consideration should be whether there are a minimum number of attenders for the session to go ahead. A hub model also makes it possible to isolate general overheads from session costs.

9. **Sustained and focussed promotion to both priority referrers (e.g. GPs) and under-represented target groups (e.g. new parents)**

So far, *Arts For Well-being* has not successfully engaged with GPs and primary care services as was originally envisaged and a significant proportion of participants are guided self-referrals (often through artists). The viability of the scheme in the longer term must be on well-used referral pathways from health services. Targeting has to date focussed predominantly on a wide-ranging group of people with various long-term conditions. The new parents priority group has not been engaged and this needs to be at least piloted in each hub and assessed for potential rollout.

10. **Maintain the throughput of clients achieved in the pilot.**

The scheme has successfully met its numerical targets to date on participation, and the hub model should be able to sustain these rates of take-up. The cohort needs to be classified to distinguish between disability and long-term health condition. Assiduous management of both the referral and activity evaluation forms is essential for monitoring the throughput of clients and these forms would benefit from some revision and re-design in the light of findings in this evaluation.

11. **Establish a clear referral pathway before intervention and a feedback pathway afterwards.**

The referral source was not clear on 25% of the initial referral forms. It is possible that many of these were 'guided' self-referrals via the providers but the absence of a source makes assessment of eligibility and monitoring more difficult. Referral pathways from primary care are vital to demonstrating the effectiveness of the initiative, particularly with the imminent re-structure of primary care. There needs to be a feedback pathway so that the impact of the initiative can be communicated by the participant and assessed by the referrer. It is 'the 'duty of care' of the scheme to ensure this happens.

12. **Increase length of scheme from 6 sessions to 10, and initiate pilot follow-up sessions that are part subsidised/part subscribed.**

The most common complaint from both providers and participants is that six sessions is insufficient time to settle into an activity and adequately experience its benefits. An extension to ten sessions in most cases would be welcome. Any extension of the activity after 10 sessions needs to be on a charged tariff at rates that are affordable to participants or may attract some taper subsidy from the PCT in recognition that the majority so far of *Arts for Well-being* participants are retired or in receipt of benefits. Providers are also recommended to identify an onward route for participants for continuation of the arts activity beyond the *Arts for Well-being* term in the arts, voluntary or education sector, whether led by themselves or others.

13. **Correctly administer the evaluation instrument (WEMWBS), and consistently use other methods to gather raw data that may assist the assessment of outcomes.**

It has been frustrating to discover that the Warwick-Edinburgh Mental Well-being Scale forms used in the scheme cannot be properly validated because of a technicality on how they were dated. The changeover in spring 2010 from using the 14 point to the 7 point

version should not have occurred either, as consistency in the scale is important. Providers also needed more induction of the importance of administering the WEMWBS and the PCP-designed participant evaluation forms – only 88 of the latter were available for examination by the researcher in July, and many of those were not filled in correctly or completely. It may be worth considering a re-design of the assessment form using a framework of questions based on the 'five ways to well–being' currently being used in PCT health promotion strategies, namely 'connect, be active, take notice, keep learning, and give'. All these 'five ways' readily relate to participatory arts practice. A recent report from Liverpool has trialled this approach to assess arts and well–being initiatives in the north of the city (Matarasso and Moriarty 2010)

14. Trial alternative evaluation instruments in a 'recovery' model – especially if the scheme were to be extended to those clients receiving mental health services

The Recovery Star is a tool for supporting and measuring change when working with adults of working age who are accessing mental health support services. As an outcomes measurement tool it enables organisations to measure and summarise the progress being made by service users and the service being delivered through a project. *The Recovery Star* is essentially a working tool on the model of a journey. It is designed to support individuals in understanding where they are in terms of recovery and the progress they are making, providing both the client and worker a shared language for discussion mental health and wellbeing. A version of *The Recovery Star* adapted for arts use is currently being trialled by Pioneer Projects Ltd. who run Looking Well Healthy Living Centre in Bentham, N. Yorks.

15. Avoid 'first come first served' take-up of referrals

Some providers have felt this rather ad hoc arrangement could be perceived as unfair and contrary to ensuring quality and appropriateness in matching provider and clients. A hub-based model should be better able to select and induct what would probably be a smaller number of providers to deliver the scheme in appropriate settings.

16. Offer opportunities to move from session-based activities to community-based projects that use arts for inclusion and integration

It is appropriate governance for *Arts For Well-being* projects to work with at risk and vulnerable people in a discrete manner with a client-centred focus. Referral routes onward from the *Arts for Well-being* sessions, after seeking the views of the client and ideally the referrer, could also include possibilities for client engagement with community-based arts activities e.g. local festival, drama society or choir. Participatory arts practice has a proven strength in delivering social integration and inclusion as well as therapeutic benefits, as recognised in the Department of Health's own review (2007). This would also provide relevant illustration of the *'Big Society'* concept, and could provide avenues for accessing locally devolved funds and deploying individual mental health patient budgets.

17. Aim for effective handover to GP consortia and/or local authorities as future commissioners of social prescribing schemes

A crucial priority in any extension of the *Arts for Well-being* scheme must be to advocate and align the service to the priorities of the new healthcare arrangements proposed in the government White Paper *Equity and Excellence: liberating the NHS.* The scheme clearly needs to target primary care referrals, possibly piloting these initially with a small number of interested GPs who would attempt to peer influence others – cf. the North Tyneside arts on prescription model developed by Dr. Ruth Evans. The transfer of the public health function into local authorities suggests an enhanced role is to be played by local government in supporting social prescribing schemes - County Durham has already supported the 'Sing Up' programme of The Sage Gateshead in parts of the county and undertook an audit of arts in health practice this summer. The hub organisations should be urged to explore partnership arrangements with the unitary authority.

18. Make providers/artists aware of their contractual obligations and the need to engage with commissioners

Some providers/artists have not been mindful of their contractual obligations and this has led to unnecessary confusion and friction in the administration of the scheme. Providers/artists should be sub-contracted to the hub organisations who in turn are contracted to the commissioners with a clear (and periodically reviewed) statement for all contracted parties of the protocols and responsibilities required by the commissioners. It is suggested that guidelines for good practice that are specific to *Arts for Well-being* are drawn up – and these could be readily adapted from the Guidelines appended to this report (appendix 2)

19. Introduce joint monitoring for both effective communication and review – providers, commissioners and participants (user group)

Joint monitoring needs to be done in a climate of reflective practice, appreciative enquiry and positive regard as the *Arts for Well-being* initiative is a learning experience for all – it should equally involve staff in the commissioning, referral and provision of the scheme and set up a user group for separate (but occasionally joint) meetings. Induction to the scheme through the new hub arrangements needs an inter-professional workforce development approach so there is a common ownership process – this could have prevented misunderstandings and problems that have arisen to date. There needs to be a specifically designed induction programme to ensure familiarisation with each sector's values and protocols, and a consensus reached on the roles, responsibilities, aims and purposes of the scheme. Maintaining a successful scheme merits this investment and joint monitoring should assist objective internal evaluation.

20. Overall, the pilot scheme has been successful

All these recommendations and suggested improvements should not diminish the fact that the *Arts For Well-being* scheme has had some exemplary successes in meeting its targets and assembling an impressive body of evidence for its support from referrers, providers and participants with intermediate indicators that it motivates positive social engagement and health gain. Given the challenge of getting vulnerable people to participate in arts activities there has been an astonishingly low drop-out rate - there have only been seven withdrawals and none of those for arts reasons.

Appendix 1

Questions for Participants' Focus Groups

1. Which village/town/city do you live in?

2. What type of artist did you work with/what art form? – *Group discussion*

3. Why did you agree to go to the workshops? – *Post-its*

       3(a) Part of treatment

       3(b) Something to do

       3(c) Done it before... and liked the experience

       3(d) Wanted to try something new

       3(e) Felt obliged to do it

       3(f) Other reason (please explain)

4. Did you go to all of the 6 sessions? - *Group*

       4(a) Where were the sessions held?

5(a). What were your expectations of the 'Arts for well-being' project? – *Post-its*

       5(b)Which of your expectations are being/were met?

       5(c)Which of your expectations are not/were not met?

6. Was there anything that made it difficult for you to participate in the workshops? – *Post-its*

7. What arts projects/activities were you involved with before 'Arts for well-being'? – *Group*

8. Have you tried any new arts activities as a result of this project? – *Group*

9. How have your views about the arts/creative activity changed since you participated in the project? – *Group*

10. What did you enjoy the most about Arts for well-being? – *Post-its*

11. What did you enjoy the least about Arts for well-being? – *Post-its*

12. How do you think the project can be improved? – *Post-its*

13. Has your sense of well-being changed? How? – *Post-its*

14. What, if anything, have you learned about yourself as a result of taking part in the project? – *Post-its*

15. Anything else you'd like to add? *Group discussion and/or Post-its*

Appendix 2

GUIDELINES FOR GOOD PRACTICE

for artists and healthcare professionals engaging in participatory arts practice in healthcare contexts

1. Arts in health practitioners are committed to putting participants first

Keynote: Practitioners of participatory arts in healthcare recognise that the well-being of participants in the creative activities they facilitate is paramount. They remain primarily attentive to this in respect of the arts activity's context, delivery, development and evaluation.

1:1 Attention is maintained to appreciate the unique identity of each participant and fellow practitioner in an atmosphere of mutual respect that seeks to bring out the best qualities in people.

1:2 Personal development is a desired goal, and each participant's achievement in the arts activity is promoted with regard to that person's independence, exercise of choice and dignity.

1:3 The arts activity seeks real contact and engagement with participants so that they feel respected and valued.

1:4 Practitioners should understand the aims and objectives of the activity, and be able to communicate them to participants.

1:5 Participants' responses to the activity should inform and help re-assess this Code of Practice and how it is implemented.

2. Arts in health practitioners are committed to maintaining a responsive approach

Keynote: The practitioner always attempts to draw out the creative potential of participants, challenging and motivating them whilst exercising professional judgement on the reasonable expectations from the activity.

2:1 Practitioners propose the vision and structure for the arts activity but retain an open mind for collaborative, friendly working that respects the skills, advice and contribution of others.

2:2 The arts activity is a response to needs assessment conducted by the practitioner with participants, and is developed so far as is practicable as a communal interest in which every participant's voice is heard and acknowledged.

2:3 Practitioners aim to keep the activity on an agenda of health and well-being relevant to t he aims and purposes agreed with fellow practitioners and/or participants.

2:4 The approach to the arts activity has to be appropriate to the setting and practitioners should try to create a congenial and secure space in which participants can work and relate comfortably with each other.

3. Arts in health practitioners are committed to upholding values which are implicit in the approach, and these may be described as follows:

Keynote: Mutual trust is sought between practitioner and participants in order to generate a collective creative process which develops a commitment to the activity from everyone learning and experiencing together.

3:1 Participants should be offered a quality experience in which the integrity of the artistic process is maintained throughout the life of a project, with an emphasis on productive and (preferably) enjoyable work using good quality materials.

3:2 Practitioners are aware of how to take creative risks responsibly in the production of art works, without harming or compromising the dignity of participants.

3:3 Practitioners must exercise flexibility, good listening and non-patronising communication appropriate to the context and content of the activity.

3:4 Inclusiveness, equality and sensitivity to others are key to participatory arts, and fostering understanding, positive regard for others, and inter-professional dialogue are essential to effective practice.

3:5 Each participant's contribution to the activity is nurtured in a manner which is fair and equitable, and inclusive of difference, status and ability.

3:6 The practitioners should do their best to ensure that all those taking part share the limelight in any public appreciation of the arts activity.

4. *Arts in health practitioners are committed to gathering feedback and evaluation*

Keynote: Practitioners recognise the importance of independent evaluation and their duty to contribute to it by encouraging honest feedback from themselves, participants and other staff.

4:1 Practitioners are open to the use of both qualitative and quantitative methods of appropriate evidence gathering that have the consent of participants, and with ethics approval as may be required by the healthcare setting.

4:2 Practitioners undertake documentation of the work in process with attention to the quality and accuracy of its presentation

4:3 Practitioners encourage self-evaluation of the activity with the involvement of participants and other staff by consent.

4:4 Practitioners are concerned that the correct and appropriate messages from the activity and its evaluation are disseminated to the target audience, and that practice is adjusted where necessary in the light of evaluation.

4:5 Supported reflective practice should be at the heart of continuous personal and professional development in participatory arts in health, enabling practitioners to review the direction, purpose and processes of their work.

5. *Arts in health practitioners are committed to ensuring good management and governance*

Keynote: Practitioners work to an agreed code of practice supplemented by adherence to the policies, protocols and ethical procedures of the organisations supporting the work, and of the institution or setting where the activity takes place.

5:1 There has to be good communication between practitioners as well as to participants and relevant external agencies in order to normalise open conversation, transparency in decision-making and sharing of experience. The documentation of a project should try to reflect how this happens.

5:2 Practitioners should be able to assess whether there is sufficient planning time, organisational support, funding and policy directive to deliver the activity and its intended outcomes, and to judge the suitability of the activity for its context, environment and participants.

5:3 Any requirements for support and supervision of practitioners are assessed at the outset of a project and reviewed throughout.

5:4 The activity has a timeframe and has either a planned conclusion or a strategy for its sustainable continuation established early on in the project.

5:5 There are clear ground rules for the activity with an awareness of the roles and responsibilities of each practitioner, and each organisation, within the partnership model for delivery, and these are summarised in any contractual relationships.

5:6 Partnership working to deliver the activity must be clear on roles and boundaries, setting realistic aims and objectives, with regular debriefing and an ongoing mutual support network that aims to improve everyone's practice through the activity.

5:7 Practitioners identify the key people who are important to the success of a project and seek open communication with them based on a shared understanding of the values, ethos and goals (artistic or otherwise) of the project.

5:8 Practitioners do their utmost to ensure the emotional, psychological and physical safety of participants and themselves during the activity.

5:9 Principles of confidentiality are known and complied with at all times. Exceptions to this may apply when the safety and well-being of a participant is at risk.

5:10 The purpose and ownership of art works produced from collective activity should be clarified and agreed with participants before completion of the work.

Appendix 3

LIVING ON THE FRONTLINE by Mike White - Mailout Magazine September 2010

Bertholt Brecht once said that "every art contributes to the greatest art of all; the art of living". Given the antics of the present austerity regime, this may soon be the only art left. An important measure of whether the so–called 'Big Society' has any quality will lie in its support for the mental health of the nation. For some people going through the mental health system participatory arts can be a lifeline, a means to recover the art of living.

Mental health takes the biggest slice of NHS expenditure, with a third of GP consultations concerning mental health, but it is not taken as seriously as physical health so it needs to be at the heart of future policy making. Inequalities create stress and mental health requires social as well as individual solutions. Partnerships to improve access to non-medical support could develop arts opportunities within social prescribing. The Mental Health Foundation has already noted that moving responsibility for commissioning down to GPs could open up opportunities for developing practice-based services provided by frontline professionals like counsellors and other specialists. Shortly after forming its coalition, the government announced its plans to continue to invest £70 million into psychological therapies designed to treat common mental health problems such as anxiety and depression. But why are only talking based therapies being supported? There are many arts in mental health projects that can make a credible call on crumbs of that budget to demonstrate their effectiveness in supporting community–based mental health recovery.

I have recently been evaluating an arts in prescription scheme in County Durham that was initiated by the soon–to–be–defunct primary care trust. One of the 'willing providers' in this scheme is the exemplary Waddington Street Centre in Durham city (www.waddingtoncentre.co.uk). This community mental health resource, established in 1981, offers creative life skills opportunities to people who experience enduring mental health problems. It is an independent, voluntary sector organisation where service users, volunteers and staff work closely together to improve the quality of people's lives, support recovery and self-development and make care in the community a reality. It is a Little Society writ large, what one user described to me as "a small community of like-minded souls". Its entrepreneurial growth has been impressive. From low–key beginnings in a church hall, it went on to acquire and reconstruct two adjoining houses from where it provides lifelong learning with many courses linked to New College Durham, social day care and a cafe facility. Extra–mural services include tenancies and caravan holidays. The development of a strong skills base of digital photography, graphic design and desk-top publishing has led to the establishment of a commercial print shop.

Most art forms are covered in the centre's activities, and there are about ten visual artists alone based in Waddington Street. The art groups are involved in outdoor painting activities, exhibitions, competitions, the production of an annual calendar and regular visits to galleries and museums. The Centre strongly supports and encourages the service user 'movement', notably through the SURF organisation - Service Users Reaching Forward.

I spoke with two regular users of the centre about what impact it had on their wellbeing. One was a musician and fairly new to attending the centre. She felt the wellbeing effect came

from the combination of finding a focus, being able to set goals, and open the mind to creativity – she spoke of the 'flow' and how a challenging group activity can also move banter into a quality conversation. Her sense of purpose and achievement has been noted by friends and family. She has revived her interest in playing and has found the confidence to join a choir outside the Centre. "It helps to gets things in proportion" she said "and you can choose your time to worry."

Another regular attender at the centre is a professional artist who has found that socialising there has gradually re-energised him after a serious burnout at art school - "I discovered creativity can come from a very negative place too" – and it has enabled him to function more empathically in social situations. He now leads an art class at the centre, and finds nurturing others' involvement in art has restored his confidence in himself and his work. He praised Waddington Street's management ethos, its support for the "lost and lonely", but asserted that a lot of fun is had there too. It has helped him to choose the kind of autonomy he wants out of his life, and from an employability view it has broadened his artistic skills into IT–based creativity.

One of the centre managers, Ali Lee, places the Waddington Street ethos firmly within peer support and a commitment to facilitating "positive occupation", whilst recognising that the recovery pathway can be long and irregular and so may not readily conform to the linear evaluation frameworks of the education sector and government. She sees it is important for the centre to teach transferable skills, to be about serious education as well as providing socialising opportunities, but she cautions about the complexity of getting people in the mental health system back into work. Both she and creative writing tutor Steve Urwin stressed to me the importance first of developing the volunteer resources provided by centre users as a practical means for them to realise their confidence, talent, and a right to realistic ambition.

We know the 'Big Society' will be cash poor so it needs to be resource rich, and an initiative like Waddington Street could be instructive to a new wave of social entrepreneurship, as and when the current tsunami of funding cuts has passed through. But Waddington Street has already been worryingly notified of reductions in its grants next year.

The resilience of the arts in mental health field is going to be crucial to addressing the bigger health challenges that lurk behind the current 're-structure' of primary care and public health. I am minded particularly of social geographer Daniel Dorling's recent book 'Injustice' which describes how the welfare state eradicated the social evils of ignorance, want, idleness, squalor and disease, only to have them replaced by the corrosive injustices of elitism, exclusion, prejudice, greed and, ultimately, despair. All of us in community arts have fought to mitigate the effects of that transition in the last three decades. Yet in ten years' time, according to the World Health Organisation, mental ill-health will be second only to heart disease as the major cause of chronic morbidity in Western nations. Despair on a mass scale can be a destroyer of culture as well as mental health. That is why arts in mental health is now on the frontline.

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