Observations and key points from proceedings

At National Arts and Health Dialogue Day 2011

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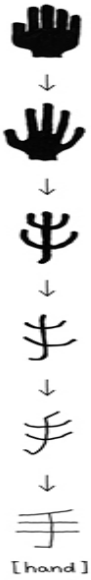

National I *Dialogue Arts + Health* was the final public event in a series of Art and Health dialogue sessions hosted throughout Ireland, in Galway, Offaly, Cavan and Limerick. These sessions took place over a four-month period and were smaller, intimate occasions at which in total over a hundred artists were estimated as having attending. This text refers to a larger event which was designed to expand on themes that had emerged from the countrywide sessions. The proceedings took the form of three panel discussions and a performance.

There was a range of personal responses and a broad span of opinions voiced at the event, so rather than a personal response, this text is an attempt to cluster essential points in a summarised text. Full details of the day's discussions have been podcast and are available from www.artsandhealth.ie.

The project was initiated by the Arts and Health Coordinators Ireland and funded under the Arts Council of Ireland, project awards. Regional I *Dialogue Arts + Health* series focused on the practice and conditions of artists' work in healthcare environments, and provided a framework through which to discuss successes, failures, risk, supports needed, critique and peer-to-peer exchange. The approach was to cross-pollinate artforms such as visual arts, theatre and music, but also to give space and a perspective from which to discuss the aspirations for such practices currently happening in Ireland. The idea of the project was to allow its participants to address four functions: a) to meet and share information on an informal basis, b) to carry out peer critique, c) to discuss opportunity, and d) to consider artists' professional identity in this sector.

National I *Dialogue Arts + Health* took the form of presentations and panel discussions during which over twenty people spoke. Topics were discussed by three panels which included arts workers, administrators, policy makers, health care specialists and artists who had experience of the sector. Three sessions focused on: 1) the challenges and opportunities of successful partnership, 2) ethical questions of ownership, and 3) collaboration and creative risk.

Partnership and Collaboration

Discussed: Who are we talking about?, Priorities and perspectives, Trust and language, Tension, What makes for a good marriage?

The conversation opened with a discussion on the importance of understanding who we are talking about when we refer to arts and health practitioners. There was an understanding that practitioners include artists, arts administrators and those who work in healthcare settings and the community and voluntary sectors. Success, it was suggested, was characterised by a good understanding of the priorities of different partners, and their needs being addressed by open, clear discussion. One of the challenges is to find compatibility.

Successful partnership supports a range of agendas and clarity arises as needs are expressed. There is a diverse range of stakeholders involved in health care settings and people have different levels of experience and different priorities. Healthcare professionals are often focused on enhancing individual and community health and wellbeing. In the various programmes and projects mentioned people are concerned with a range of issues; the challenge is to acknowledge and respect this. From an artist's perspective, the issue can be the production of work. From the healthcare perspective, the priorities are often that art can enhance the recovery model.

Good partnership doesn't just happen, it needs to be developed and cultivated, maintained and managed. Often there isn't a shared perception of the most important thing arising from a particular project. Understandings differ, and they need to be expressed frankly.

Possibilities for cross-sector partnership are wider than practice currently reflects; they can include the community and voluntary, business and technology sectors, all of which have enormous potential. The synergy comes about when the sum is more than the parts. Partnership means sharing risks, rewards and resources. It can also mean testing and pushing boundaries. This adds value and is positive and fundamental to the arts and health.

The language question was addressed through observations arising out of the countrywide dialogue sessions, where artists' descriptions of their own practices were diverse and complex. When this complexity of language is brought into the health sector, which has its own nuanced and specific language, conventions, meanings and understandings become even

more complex. Increasingly there is a convergence in language; with practice and collaboration there is an opening up of understanding.

There was a comment that people in the arts sector often work from a set of hidden assumptions, and can fail to define who they are, or what they are about. One panellist considered that there is a responsibility to be unambiguous about art practice, and commented that Regional I *Dialogue Arts + Health* offered an opportunity to think about this.

Time is needed to explain to healthcare staff what is going to happen. Workshops have been successful in introducing people to the intent and purpose of projects. Healthcare professionals need to get a sense of experiential learning; with *buy-in* from key personal, so that much more is possible. This is also about developing longer-term relationships and moving away from short-term interventions. What is important is to acknowledge the need for projects to be resourced with time and people.

Good partnership, or marriage, is an investment of energy from all parties and an acknowledgement of differing priorities. How does this work, as tension arises as there is bound to be tension? It is a very complex area. Healthcare staff concerns are for health outcomes and individualised care. For example, one panellist discussed a project that used sound and visuals in a way that people, he felt, weren't really ready for yet, but as the project had progressed they were able to discuss possibilities. This developed mutual trust. The artwork was understood as respectful.

The panel's aspirations for the future are that there will be a parity of esteem between sectors. Another aspiration comes

from observing similar work in France, where arts organisations and health organisations are working together, strategically and creatively, within each other's agendas. Observations were that this is a real collaboration between services. Finally, there was an expressed desire that key cross-sector partnerships are developed at a regional level and this will strengthen practice, dialogue and discourse in the long-term.

Co-production and Ownership

Discussed: Clarity, Duty of care, Consent, Balance of power, Patient vulnerability, Parity, Types of artistic practice.

The ethical implication of arts in a healthcare setting is a hot topic at the moment. This panel discussed working with older people, referencing a particular project with people in rural environments considered to be isolated, geographically or socially. The project referenced is not funded by the HSE but has links to it. These links were to the project's advantage, and offered access to a number of support structures and paved ways for approaching the context. For example, there were links to community care teams. Direction and advice from home helps and social workers was of benefit too. The artists were required to have Garda clearance.

A general concern about the balance of power between the project constituents was discussed and informed consent was considered as being of primary importance. This is relevant across the board, commented one panellist, and consent should always be given, so participants are fully aware of their role and the role of others.

From an arts perspective, there was a sense that artists may have an understanding of processes, of what they are bringing

to the project, but make the assumption that others will understand those things also. Awareness of language was mentioned again, and the recommendation made that care is taken in communicating needs and expectations to participants. Making assumptions about literacy skills, especially in marginalised communities, is problematic.

Negotiations are needed about the balance of power, and artists should be open when discussing their work, and need to be direct with those implicated in and connected to the project.

Ethical issues tend to be to the fore when work is made with people, but artwork is not always participatory; it can be about the healthcare context. There are number of research-driven projects in arts and health, and this work needs similar ethical consideration and focus. Documentation and research need to comply with existing guidelines.

What is most important is clarity about roles; the role of the artist is not that of a clinician. A balance is needed, and how to achieve this balance is the question. Art processes should proceed with enquiry and respect, while being mindful of the various perspectives of the people involved, including those of the service users and key workers.

There is a difference between types of practice and approach, such as recreational arts practices, analytical practices and critical arts practices. Artists were encouraged to consider themselves on that continuum, but also to consider that there is a range of relationships and users across healthcare settings, which have distinct characteristics also. One artist commented that the art should not be compromised to the point where it

is made banal, that if work that emerged was “poor art” this was disrespectful in and of itself.

The dynamics of power and the processes of decision-making should be equalised. How balance can be struck is to the forefront of arts and health. The healthcare setting is really very particular; the patient is at the centre and is often in a very vulnerable position. The artist should be well informed, and understand the implications of working within this setting. Healthcare users should remain at the centre of any work in this context, and treated with dignity and integrity. Artists should be willing to engage with them in a spirit of parity.

The healthcare setting is not just about acute situations; healthcare settings are as broad as arts practices. Appreciation and understanding of this continues to evolve. There were comments also that in a healthcare setting not all people are vulnerable. A counter-argument was that regarding people as vulnerable may result in an underestimation of their capabilities.

An artist commented that there are research-based residencies in healthcare contexts and in these cases the work may not involve direct engagement. He recounted an experience where issues arose with healthcare professionals about the type of imagery he was producing in a hospital context. There were strong concerns from the hospital about making this artwork public. However, this artist considered the healthcare environment his subject rather than the care-user or patient, and that his work was not focused on engagement or participation. The artist described his imagery as visceral and subversive. He expressed his concerns about artistic censorship.

There were suggestions arising from this experience which compounded previous comments about the clarity of the role and the approach of the artist – that this is part of a total duty of care. There was a suggestion that artists need to anticipate a range of agendas, and that there are very good practice guidelines available for artists.

The panel's aspirations were that this work, Arts and Health, continues to evolve. Another is that there should be a shift in alignment, moving away from a treatment model of health and towards a social model, one of community collaboration.

Creative Risk

Discussed: Perspectives, Mental health settings, Being pushed, The business model of care, Some benefits of self expression.

Coming from the organisational perspective of a service provider, a panellist (he is a senior healthcare manager working in mental health) commented that creative risk works on a number of levels. Many of these environments avoid risk and the standardisation of services is key. So encouraging creative process to happen in contexts which are risk-averse is in itself a risk. The unexpected is not what is wanted from a managerial perspective. Another element of creative risk he spoke about was from the perspective of people receiving or

supporting care in mental health contexts. They take a risk by engaging with the creative process. And the artist also takes on an element of risk as they consider the potential impact of the artwork on the individuals that they will encounter. This panellist considered that people (those receiving care in the institution he manages) are re-conceptualising their lives through a creative process.

There are questions about who are creative risk-takers in this context. The panel considered that they tended to be people who have heightened awareness, with a strong understanding of themselves in relation to the organisational structures at play. From a healthcare management perspective, it is not just about navigating a personal or artistic agenda. The system in and of itself is the most important aspect of negotiation. The person who has this awareness can make change. They need to have faith in their ability. Very often they aren't in this process for themselves. People engage with creativity for very different reasons.

A clinical manager observed that when clients showed their work, they had a revised view of themselves – seeing themselves as creative people. This was an important shift from the position of patient. Although there is a risk for the artist, there are also risks for the client or service-user and the organisation, and this is the key part of the process.

The business model of healthcare is about reducing re-admission rates – getting service-users out of the hospital and into the community, and keeping them in the community. The arts absolutely have a role to play and research was referenced which shows that people who characterise themselves as sick have much lower recovery rates and higher

readmission rates. In raw terms, the panellist commented, if you characterise yourself as a poet, who happens to be sick, seeing yourself as a person with creative abilities, then recovery rates rise. From a healthcare perspective, it is very difficult to find mechanisms that do this – in therapy there is still a patient model. The panellist saw that this creative process works to supports a business model. This for him was why, as a senior manager, he would support creative risk.

Other panellists commented that some artists have been responsive to the challenges of healthcare settings, and that they have made incredibly brave, imaginative and creative work within these environments. This is a real challenge where the articulation of risk within the healthcare setting is to the fore. She found artists' solutions in risk-averse contexts have been inspirational; how they have made work, evolved and adapted their practice is often very clever and engaging. The limitations of places like acute wards forced artists to respond with deeply considered work. This wouldn't really have any parallel for artists who are working in a studio practice. One core quality needed here is responsiveness.

Another comment was made by a representative of an arts and health organisation providing access to an open studio, which welcomes people with a range of abilities. Her observations were that in general artists are changing practices and approaches and working well in such environments. Artists need to be constantly risk-aware and risk-assessing. This is about trust and time – being open to understanding what works and what doesn't.

Aspirations of this panel were that art might become an integrated part of healthcare, and that medical students take

arts courses as part of their training. Finally there was a strong desire that this type of conversation continues into the future.

Panellists

Partnership and Collaboration

Mary Grehan – Arts Director, Waterford Healing Arts Trust
Aidan Warner – HSE South Representative for Arts and Health Principal Community Worker, South Lee, HSE South
Sheelagh Broderick –PHD Candidate at GradCam, NCAD, Dublin
Ann O'Connor –Arts and Health Advisor, Arts Council of Ireland
Kevin O'Shanahan – Music and Health Facilitator with MusicAlive; Creative Arts Co-ordinator with West Cork Mental Health Services

Co-production and Ownership

Nicola Dunne – Arts and Health Specialist, Kildare County Council
Katie Verling– Arts Practitioner Participant in the Open Windows Arts and Health project
Caroline Peppard– HSE Mid Leinster Representative for Arts and Health; Senior Health Promotion Officer
Deirdre Walsh –Visual Artist
Paul Maye–Visual Artist

Creative Risk

Sinead O'Reilly – Arts Officer, Offaly County Council
Claire Meaney –Artist and Assistant Arts Director at Waterford Healing Arts Trust
Dr. Ciara McMahon –Artist and General Practitioner
Ann Fitzpatrick –Services Manager, Leopardstown Park Hospital
Dr Paul Gilligan – Chief Executive, St Patrick's University Hospital