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Prepared For :

Mapping Arts and Health Across the Midands

WESTMEATH COUNTY COUNCIL
Comhairle Chontae na hIarmhí

Helium Arts
CREATIVITY CHANGES LIVES

WHAT

music generation
MAKING MUSIC EDUCATION HAPPEN

Anam Beo
Arts, Health & Wellbeing in Offaly

2021

The Partner Organisations :

Laois County Council aims to maximise participation in and access to a wide range of artistic experiences across art disciplines and according to the highest standards of excellence, and to work with local health organisations on arts and health programmes. Areas of activities include the Bealtaine programme which takes place in hospitals and features drama and music performances, exhibitions and workshops. https://laois.ie/departments/arts/

Offaly County Council is charged with developing and delivering a high quality, imaginative arts programme with and for the people of Offaly and its visitors. In doing so, the county arts office advocates for and clearly communicates the significant role that the arts play in enriching the wellbeing of society, of our citizens, and in enhancing the public realm. As a priority of Offaly County Council's Art Strategy, the Arts Office has worked in partnership with Anam Beo since 2005, to support Anam Beo to reach its full potential for the delivery of high quality arts engagement programmes in healthcare and other community settings. https://www.offaly.ie/eng/Services/Arts-and-Culture/

WESTMEATH COUNTY COUNCIL
Comhairle Chontae na hIarmhí

Westmeath County Council Arts Office promotes access, appreciation, awareness and enjoyment of the arts for all citizens of County Westmeath and also stimulates interest in and promotes the knowledge and appreciation of the arts throughout the county. The Arts Office provides support for the professional, voluntary, community and amateur arts sectors in Westmeath and provides information and advice to the community on arts related issues. Westmeath County Council works in partnership with Helium Arts on a number of health related arts projects. http://www.westmeathcoco.ie/en/ourservices/artsandrecreation/arts/aboutus/

Anam Beo
Arts, Health & Wellbeing in Offaly

Anam Beo is an arts, health and wellbeing organisation providing high quality creative workshops, projects and residencies in a healthcare and community context, including hospitals, health centres, residential homes, day care settings and community spaces in County Offaly. Anam Beo encourages self-activations, research and development, and empowerment through meaningful engagements with contemporary arts practices. Anam Beo envisages that the creative potential of older people is recognised and becomes an intrinsic part of healthcare and life. anambeoartscollective.com

Helium Arts
CREATIVITY CHANGES LIVES

Helium Arts is a national children's arts and health charity. Helium Arts' mission is to empower children living with illness through their creativity and the arts, inspiring those who care for them and supporting creative healthy environments. http://helium.ie/

music generation
MAKING MUSIC EDUCATION HAPPEN
LIBH FHAILÍ/OFFALY
IARMHÍ/WESTMEATH

Music Generation Offaly/Westmeath is a regional, county-council led, performance music education service delivering a range of high quality programmes and projects for children and young people across Offaly and Westmeath. https://www.musicgenerationoffalywestmeath.ie/

WHAT

Waterford Healing Arts Trust (WHAT) brings arts experiences to the bedsides of patients at University Hospital Waterford and other healthcare settings. WHAT supports the development of arts and health in Ireland and manages the national website www.artsandhealth.ie. www.waterfordhealingarts.com

Acknowledgements

Approximately ninety people were contact and just over half of those people were formally interviewed. The interviews were conducted on a confidentiality basis so it's not possible to thank everybody individually. It is important to say thank you to the many artists, nursing staff, doctors, officials in various agencies and the many experts in this field for their support, time and considerable insights.

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This project was funded by The Arts Council

(Pauline Stronge's Circle image from 'Still Lives, Still Alive' Anam Beo artist in the Community Project with Photographic Artist Veronica Nicholson)

INTRODUCTION

This project was commissioned by Laois County Council Arts Office, in partnership with Offaly and Westmeath County Council Arts Offices in association with their key partners Anam Beo, Helium Arts, Music Generation (Offaly/Westmeath), and Waterford Healing Arts Trust. The project was funded under the Arts Council Invitation to Collaboration Scheme.

The work was conducted from November 2020 through to May 2021. In keeping with health restrictions all interviews were conducted over the phone or on zoom calls and no site visits were possible. Throughout this period healthcare staff and artists were under extreme, if different, pressures and it is important to acknowledge their generousity in making themselves available for interview and comment.

The research findings were to be of benefit to each partner, to other local authorities, to the wider arts and health community, and the Arts Council.

The key question framed by the partnership and underlying this research was "How can we collaborate better?" The question touches on a range of issues from funding sources and business models, through modes of engagement and choice of art forms, and onto the vital follow up question, "in order to achieve what?"

One of the first interviews conducted in the course of the research produced the question "well, what are we actually talking about here? What do you mean by arts and health?"

The answers to both of these question are not straightforward, and are fundamental to any meaningful model of collaboration.

In, And, For

The language we use is important. And one of the first issues in the language is whether we are talking about "arts in health", "arts and health" or "arts for health" (interestingly nobody seems to have proposed "arts to health" or "arts with health" - yet). The choice of conjunction is important because it indicates the focus of the work. So for example, arts *in* health draws our attention to art in healthcare settings; arts *and* health focuses on the idea of partnership, (arguably because of the actual and real inequality that exists between arts and health practitioners in terms of both status and reward); and arts *for* health focuses on health outcomes - bypassing the issues of partnership, mutual acknowledgement and setting.

This is more than belligerent semantics. The term we choose shows where our focus lies (partnership, location or outcome) and therefore indicates what our understanding of our purpose is, which in turn shapes collaboration. From the strategic perspective of building a sustainable, collaborative delivery model the question of purpose is fundamental.

Given the existence of these different positions (in, and, for) this report will use the nomenclature arts/health throughout to allow us to move between positions.

Purpose of the Research

This research was concerned with mapping a landscape of practice and provision – a picture of what is done and how it is delivered. This involved teasing out a complex ecosystem of people, agencies, resources, policies and understandings. Our purpose in mapping this ecosystem was to answer the key question: "how can we collaborate better?" Effectively, our purpose in this research was to understand how the different parts of the ecosystem work together, and how we can change the way they work together to create an effective and sustainable arts/health sector across the midlands

This research was not concerned with celebrating and tabulating the extraordinary body of work that has been created in the Midlands over the last twenty years by a relatively small group of committed artists, working in partnership with carers, frontline medical professionals, and support organisations. That work is worthy of celebration, but this is not our purpose here.

Nor is it concerned with providing a body of evidence to demonstrate the efficacy of arts in a healthcare context. After nearly a half century of practice and 40 years of academic research the arguments in support of art/health are compelling and comprehensive. The continued resistance to that body of research, and the ongoing calls for arts and artists to "make the case" are themselves cultural phenomena, a "habitus"[1] of attitudes to professionalism, status, and creativity.

Definitions

The arts/health landscape is shaped by a number of slippery words. The meaning and value of these words can change depending on what part of the landscape we are looking at them from. "Art" can have very different meanings for a Director of Nursing and a Classical Violinist, just as "Health" can have very different meanings for a Patient and a Policy Maker.

Art

[1] *Habitus* is a term coined by French sociologist Pierre Bourdieu. It refers to the deeply ingrained habits, skills, and dispositions that we possess due to our life experiences. For example, Habitus can be used to explain why sports features strongly in Healthy Ireland polices, but Art does not.

Within the Irish policy environment the definition of art and the arts is set out in The Arts Act as

> "…any creative or interpretative expression (whether traditional or contemporary) in whatever form, and includes, in particular, visual arts, theatre, literature, music, dance, opera, film, circus and architecture, and includes any medium when used for those purposes;" (Arts Act, 2003)

The definition is at once both precise, in that it provides a list, and usefully vague in that it says we can include other things. It is also worth bearing in mind that the words "art" and "culture" have always been conceptually difficult to define, probably because art is both process *and* product (both art and culture), and because the term artist has shifted over time (it used to denote an achievement, but now denotes a career choice or practice).

Health

The World Health Organisation defines health as:

> "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 2006)

This definition indicates that health is both individual and social and emerges in a complex cultural relationship. The determinants of health identified by the WHO include inequality, access to housing, education and healthcare, integration into community, isolation, acceptance and trust, etc. (World Health Organisation, 2017)

All current government policy on healthcare uses the WHO definition and acknowledges the social determinants of health.

Arts/Health

The 2019 World Health Organisation report, *HEALTH EVIDENCE NETWORK SYNTHESIS REPORT 67 What is the evidence on the role of the arts in improving health and well-being?* (Fancourt and Finn, 2019) citing work by Davies et.al, proposes that, in the context of health research, engagement with the arts consists of five broad categories:

- performing arts (e.g. activities in the genre of music, dance, theatre, singing and film);
- visual arts, design and craft (e.g. crafts, design, painting, photography, sculpture and textiles);
- literature (e.g. writing, reading and attending literary festivals);
- culture (e.g. going to museums, galleries, art exhibitions, concerts, the theatre, community events, cultural festivals and fairs);
- online, digital and electronic arts (e.g. animations, filmmaking and computer graphics).

This report links the practices of arts and healthcare, stating that

"Arts activities can be considered as complex or multimodal interventions in that they combine multiple different components that are all known to be health promoting". (ibid.)

The report addresses the question of whether the arts are unique in their health impacts by stating that "While there are other activities that fulfil many of the categories listed above (e.g. gardening, cooking and volunteering), consensus research has suggested these may be seen as creative but are not generally considered as arts, particularly when cross-referenced with definitions from national arts councils (ibid.)".

('Still Lives, Still Alive' artist in the Community Project with Photographic Artist Veronica Nicholson, Taking it outside. An Anam Beo project).

METHODOLOGY

The research was required to produce the following outputs:

- A Map of Arts, Health and Wellbeing programmes in the Midlands, specifically in terms of
    - Content, Context, Methodologies of practice, Evaluation models and Gaps in provision in terms of locations, artform, health context, age, etc.
- An analysis of national and international models of practice
- Models of Collaboration based on national and international best practice frameworks
- Potential partners for collaboration
- Recommendations that support the development of arts, health and wellbeing in the midlands

The analysis and recommendations were required to

- raise expectations of what is feasible and deliverable through collaboration
- support the development of a replicable model for ambitious programming and quality engagement

The Research Design

The research design was primarily qualitative in nature, incorporating

1. **Desk research**
    a. An analysis of relevant documentation from the partners, including annual reports, project reports and evaluations.
    b. A Policy review - including national and local policy documents relating to the arts sector and the health sector. This review took the form of a discourse analysis, tracking occurrences of relevant words (e.g. arts, culture, health, wellbeing), and formulations in existing policy. Essentially looking at how often key words and phrases occur in specific policies, and how they are used.
    c. A Literature review. This was primarily a meta review (analysing existing literature reviews)2 to identify themes, practices, challenges, opportunities and trends within the existing research

[2] A range of individual pieces of research were considered alongside the existing literature reviews

2. **Semi Structured Interviews:**
    a. 90 key respondents identified by the partners were contacted by email and invited to a semi-structured interview over phone or zoom. The notes from the interview were typed and thematically coded in NVIVO

    b. Of the 90 people contacted 46 responded and were interviewed. A response rate of 50.1%
    c. Of the 46 respondents:
        i. 27 (58.6%) identified either as artists, arts therapists, arts managers, or experts in arts and health, and all had worked in arts/health in the midlands, with experience stretching back 20 years.
        ii. 19 (41.4%) identified as healthcare professionals including consultants, directors of nursing, nursing staff, and care staff.

3. **Online Questionnaires**. A Google Forms questionnaire was developed to engage a wider range of both arts and health workers and contribute additional depth to the data emerging from the semi-structured interviews. It was distributed via the partners' mailing lists and social media outlets.
    a. The questionnaire secured eight responses. It must be noted that concerns were expressed at the timing of the questionnaire (it was distributed in December 2000).
    b. The questionnaire was transferred to Survey Monkey and distributed again in April 2021 via the same channels and secured nine responses.
    c. An online questionnaire was distributed via the HSE to its internal staff mailing list. Again, without the size of the mailing list it is not possible to calculate the response rate. The questionnaire secured 53 responses.

4. **Case Studies**

The data gathered was further contextualized by the use of national and international case studies, and national and international examples. This included Arts in Health Australia; Americans for Arts in Health, Arts for Health at Manchester Metropolitan University, University Hospital Cardiff and Vale Wales, Arts for Health West Cork, and Kildare Arts in Health.

Notes on the research model.

Statistically it is difficult to establish a population size, and therefore we cannot estimate the relative size of our sample or the significance of the response rate. Consequently, the map that emerges may not reflect all of the activity across the landscape. However,

a. there is no significant deviation between the limited data captured by the questionnaire and the richer data captured by the semi-structured interview
b. the qualitative and quantitative data captured for this study is consistent with broader trends nationally and internationally.

This suggests that what we have captured is an accurate indication of the wider landscape.

EXECUTIVE SUMMARY

The Map of Arts and Health in the Midlands is bordered by an array of national and local policies and strategies and populated by a wide range of stakeholders. Within this landscape there is a tradition of excellent arts/health work reaching back to the ground-breaking work of Music Network, in collaboration with Laois County Council, at the turn of the century and followed by the emergence of Anam Beo in Offaly and Helium Arts in Westmeath. The resources of talent, experience and expertise in the region are considerable.

If these resources are to be developed to create real public value in health and wellbeing, then the key stakeholders need to be brought together in a joint policy and a joint framework for action. This framework must have the necessary power, urgency and legitimacy to act as a Definitive Stakeholder[3] and drive the practice and provision of arts/health across the midlands.

Stakeholders

The stakeholders on the Map of Arts and Health in the Midlands include the HSE Dublin Mid Leinster, Laois, Offaly and Westmeath County Councils and their Arts Offices, practicing artists and arts therapists, community workers, participants and patients, Athlone Institute of Technology, Anam Beo, Helium Arts, Music Generation, the Arts Council, Creative Ireland, and at least twenty-five state agencies and charities currently supporting and commissioning specific projects[4].

At present, these stakeholders act in isolation or in small ad-hoc partnerships to deliver arts/health projects of limited duration and impact. However, the combined expertise, influence, spend and impact of all these partners together is significant. A proposal on how these stakeholders can work together is set out in the recommendations.

Economic Context

The economic contours of this map present challenges and they need to be acknowledged. In 2019 the average local authority spend across the country on Arts Programmes was 1.5% of total local authority budget in any given county, or €15.82 per head of population. The equivalent numbers in the three partner counties were Westmeath €12.50 (1.44%), Offaly €6.64 (0.86%), and Laois at €15.14 (1.8%), all below the national average (Local Authority Finances, n.d.). The

[3] Based on the Salience Model of Stakeholder Analysis

[4]Acquired Brain Injury Ireland, Alzheimer's Society of Ireland, Alone, Age and Opportunity, Ballycumber Active Age Groups, Birr Mental Health, Community Foundation of Ireland, Diabetes Ireland, ETB, Healthy Ireland, Irish Wheelchair Association, Laois VEC, Laois Partnership, Laois Leader Programme, Longford Westmeath Mental Health Occupational Therapy Services, Mullingar Mental Health Association, Mullingar Mental Health Association, Mental Health Ireland, Nursing Homes Ireland, Offaly Local Development, Pobal, TUSLA

arts/health spend will be a small proportion of this total spend. These figures must be understood in the context of how local authorities themselves fund their budgets.

> the present local public finance system in Ireland is a product of history, politics and chance, and not necessarily shaped by sound, normative economic principles or designed based on a rational local government funding system. Like elsewhere, the sources of local government revenues are local taxes, user charges, intergovernmental grants and other minor forms of revenue. (Turley G. and McNena S. 2019, pg. 5)

In the context of Offaly, Laois, and Westmeath the first revenue from commercial rates from major sources such as the ESB and BNM has declined, whereas the others have a stronger commercial rates base from business distributed through large towns. The question of how to build wealth in local communities is beyond the scope of this report

In addition to the local economic context outlined above, Arts Council funding is low across the midlands, according to respondents.

The total HSE budget in 2019 was just over €16bn, and the Slaintecare report acknowledged that the HSE is underfunded and severely understaffed and requires significant reform and investment in the years ahead (Committee on the Future of Healthcare, 2017)

According to the CSO average annual earnings for artists in Laois and Offaly are below the national median, while earnings in Westmeath are close to the national median (Data.cso.ie, 2020)[5].

Artforms and Delivery

Against this background we can say the following about the type, quality and quantity of the arts/health work delivered across the midlands:

- The respondents worked on projects from 2009 to 2020.
- There were references to 36 projects across 23 locations.
- In general, the work is focused on older people, children in healthcare, and mental health.
- Visual Art and Music are the most common art forms accounting for 70% between them. This is consistent with national and international trends.
- Arts practitioners emphasise the importance of collaboration, process and participation when describing their work.
- 24% of the HSE respondents were aware of an arts/health project delivered by a professional artist in their place of work over the last six years.

[5] The national median income is approximately €13,000. Calculating it is challenging, as the CSO categorises artists into different groups including "Actors, entertainers and presenters (incl. Dancers and choreographers and Musicians); Artists; Authors, writers and translators; and Arts Officers, Producers and Directors)

- Almost 30% of the HSE respondents personally engage in an arts/creative practice in the workplace – staff choirs are most common, but visual arts and creative writing were also cited.
- Respondents spoke passionately about the physical and mental benefits to themselves and their colleagues of staff choirs. They also referred to the positive impact staff choirs have on morale, organisational culture and community relations.
- Social prescribing is growing. It's currently in its fourth year in Offaly and developing its own arts programmes because it cannot always identify a suitable pre-existing option.

Qualifications and Training

- 17% of the artists who responded reported relevant arts health qualifications.
- 22% of respondents had been offered training in relevant arts/health skills as part of their involvement in a project. The trainings offered were in trauma awareness, working with children, working with groups, vulnerable and older adults. The training was short term and project focused.
- 90% of HSE respondents had received no training in Arts and Health.
- The level of experience in arts/health varies considerably, with some respondents involved in over fifteen projects, and others involved in only one.

These statistics of arts/health specific training indicate the absence of a shared language between the arts and health spheres. In the absence of a shared language of skill and professionalism, partnership is inherently problematic.

Project Development, Budgets and Artists Remuneration

- 66.7% of respondents were involved in the development and planning of projects, and 75% of the projects took 1 to 3 months to develop.
- 60% of projects engaged with participants once a week. The most common length of a session was 1 hour, and the longest recorded session was three hours.
-

This structure of the work is shaped by available resources, by the project nature of the funding, and by the informal quality of the relationships between the arts and health spheres. Consequently, the majority of the work struggles to get past the level of an activity.

For arts practitioners this short-term project structure is experienced as inherently problematic and not conducive to quality work.

- The budgets for the projects discussed ranged from €3000 to €8000. It is important to note that the €8,000 budget was for a project duration of two years, and the €3000 for a four-month project.
- Given the average durations and engagements for projects these budgets are predicated on an unacknowledged investment of time, talent, and skill on the part of the artists.
- The reported payments to artists range from €1800 (+ expenses) to €2500.

Few of the respondents had any clear sense of how rates of pay are set. In general rates appear to be set against the anticipated size of a potential grant, and not against actual work done.

Payment rates can also be tied to unrelated payment scales and practices, ignoring levels of professionalism, development time, prep and reflection time, travel time, emotional labour, and a host of other hidden costs.

Official policies on the fair and equitable remuneration and contracting of artists exist (Paying the Artist, 2020). However, these policies have no influence outside of the arts context, and for non-arts funders what constitutes fair and equitable remuneration is not immediately apparent. Is the artist being paid for their time, or their talent, or the expected results, or for the engagement time, or the development, the hidden and emotional labour, the idea, or the expertise, or a combination of all of these? And how do we value each of these elements?

"Gate Keepers" and the role of Medical Staff

"Gate-keepers" play a pivotal role in project development. These are the staff member within the health setting who "get it", the person predisposed to the idea of arts/health because they are artistic themselves, or they have an artist in the family, or they are familiar with the theory and practice. Whatever the source of the pre-knowledge, in the absence of policy, their role is essential.

However, as the Slaintecare Report (op.cit.) identified, there are "…severe pressures on the Irish health service". Artists and medical staff interviewed for this report acknowledged this pressure within the healthcare system, and both groups stated that the continuing pressure and understaffing is leading to a decline in staff interest and involvement in arts/health projects, as staff are focused on purely clinical tasks.

This decline in participation by the staff has become a significant challenge.

Arts/Health is as much about the health and well-being of the medical staff as it is about the patients, and arts/health can play a major role in staff health and well-being, overall organisation morale, staff retention and development, and patient outcomes.

Evaluation

There is a tendency in arts/health to measure the work (is the art good?) and the responses of the participants to the work (did they enjoy it? did they look forward to it? did it made them feel "better"? etc). This gathering of subjective data is valuable, but effective evaluation needs to be wider and deeper.

- 60% of the respondents stated that the projects they worked on were formally evaluated and 66.7% of respondents stated that they were involved in the design of the evaluation.
- 66% of respondents said evaluation happened at the end of a project and 33% said throughout.
- The practice of evaluation itself is under-resourced across all projects, and rarely if ever included as a line item in the budget.

The responses on evaluation do not indicate an overly robust evaluation practice. Making the case for arts/health involves measuring impact and agreed outcomes and designing the evaluation with the health staff and with the participants where possible.

It is worth noting at this point that Athlone Institute of Technology is specifically mentioned in Westmeath's local development plan, with the ambition being that

> AIT will be a technological university distinguished by outstanding learner experience, international focus, distinctive regional contribution and high-quality impact of its staff, teaching, **applied research** and innovation. (p24)

AIT and its school of nursing should be considered a key stakeholder with a significant role to play in training both artists and healthcare workers, developing a shared professional language, and being a research and evaluation partner in the development of arts/health projects.

Policy and Purpose

Arts/Health is by its very nature a multi-agency, cross disciplinary practice.

The arts/health work in the Midlands is influenced by the Arts Council, Local Authority Community and development plans, and arts and culture plans, Creative Ireland, and The Department of Health primarily through Slaintecare and Healthy Ireland.[6]

The presence of so many institutional stakeholders creates a complex policy environment, and it is easy for arts/health to fall through the gaps.

[6] The majority of arts and culture policies and strategies defer to the definition of arts provided in the arts act, and the majority of health policies defer to the World Health Organisation's definition of health, and acknowledge the social determinants of health.

The specific statements and commitments on arts/health in Arts Policies are not reflected in the Health Policies. For example, there are very, very few mentions of arts or culture in Slaintecare or Healthy Ireland, and no direct mention of arts/health.

Likewise, there are no specific mentions of health or healthcare within the relevant county plans, but there is an emphasis on wellbeing and creativity. Offaly is an exception to this, expressly citing Anam Beo as a key strength in their arts strategy for their "…delivery of excellent in context arts in healthcare settings", and stating that they will support Anam Beo to "…reach its full potential for the delivery of high quality arts engagement programmes in healthcare and other community settings" (Offaly County Council 2018)

What is common across all policies is the idea and practice of multi-agency, cross disciplinary practice. Creative Ireland's *Creative Health and Wellbeing* initiative aims to strengthen collaboration between the sectors involved in arts, culture, creativity, social care and health. The core strategic aspiration of Éire Ildánach is "...to ensure a unified and coherent approach to cultural policy across government and to planning and provision across the cultural sector" (Culture 2025, 2020), echoing Slaintecare's (op.cit.) call for Health in All Policies (HiAP), and the Healthy Ireland Framework of Actions which includes partnership and cross-sectoral work, and long-term strategic partnerships and planning (*A Framework for Improved Health and Wellbeing 2013 -2025*)

All of this is important because policy ultimately decides what kinds of activities are valuable, what will be supported and developed, what partnerships and collaborations are favoured, and what funding will be allocated in an ongoing and sustainable fashion.

A common Policy between and within all the relevant partners creates a mandate, grants permission and delivers a non-discretionary budget line.

The success and growth of the arts/health sector in various parts of the world, measured both by the amount of work produced and the impact of that work over the last 20 years, has been built on sustained lobbying and advocacy at the highest levels of government resulting in simple and actionable memoranda of understanding, and in specific national policies.

Therefore, the development of arts/health practice and provision needs a single arts/health policy, starting with a memorandum of understanding between the institutional stakeholders that brings together the many interests and resources toward a single purpose.

An MOU has been agreed between the Arts Council, the HSE, Department of Health, and Creative Ireland, but has not been published at the time of writing. This is a national agreement and it paves the way for a regionally specific MOU between the relevant stakeholders in the Midlands.

The Evidence for Arts/Health

The landscape that emerged in the course of this research is in keeping with several themes that emerged from a review of the national and international literature, namely:

- The effort to prove the usefulness of the arts/health offering is ongoing, despite the growing body of evidence that the arts have an important contribution to make to health and well-being. This is despite a general sense of agreement that arts in health is a "good thing", and the emergence of various high-level partnerships and agreements. For many projects and practitioners on the ground the level of scepticism around the offering appears to be high and culturally embedded, and investment is minimal.
- Projects are initiated and driven by individuals with a passion for the work. This individual may be an artist, or it may be an individual within a healthcare setting
- In general projects are too short lived, creating a self-fulfilling prophecy around their perceived usefulness
- There is a hierarchy of professionalism: essentially the health side of the equation is perceived as being higher, having more realistic and measurable outcomes etc., than the artist side. Again, this is culturally embedded
- Arts in Health project partnerships tend to be built on personal and informal relationships
- Project budgets are low and, in many cases, unrealistic
- Artist pay does not reflect the time commitment or the professionalism
- Long term, equal partnerships are essential for quality outcomes and evaluation, but this is constrained by budget.
- Greater focus needs to be placed on high quality evaluation of projects and initiatives
- There is a need for appropriate longitudinal research

It is important to note that these themes have emerged from the *international* academic literature (and literature reviews). All of these themes were present throughout the research conducted across the midlands.

Collaboration

Within the complex system of socially determined health and wellbeing, and the culture that determines how healthcare is delivered within that system, there are dynamics of status, power and professionalism at play. For example, the arts are constantly asked to "make the case" despite 40 odd years of research and the imprimatur of the WHO.

Almost half a century of compelling international research has demonstrated the efficacy and impact of arts practice and provision on patient care, well-being and outcomes across a wide range of "conditions" and healthcare settings. A growing body of research demonstrates the cost savings and cost effectiveness of arts/health practice, demonstrating how it impacts on rates of drug consumption, lengths of stay, prevention of illness, recovery rates etc. Arts/health work has also demonstrated a significant impact on staff health and wellbeing, rates of retention, and levels of empathy. Empathy itself has been established as the only variable that maps consistently to patient outcomes.

According to several senior policy respondents the Pandemic raised the profile of the arts in healthcare contexts, and that the arts are now "pushing an open door". They further stated that the window of opportunity was limited, and it is now up to the arts to demonstrate the value of the work. Arts interventions were also said to be perceived from a health perspective as "fluffy" or as "hobbies" (not by everybody and not all the time).

Such comments in the face of such body of evidence indicates a deep cultural aversion to the ideas, assumptions and practices that underpin arts/health.

The question then is how do we cut through that aversion so that real collaboration is possible, sought after and effective?

Effective collaboration can only be built on shared purpose. The research and the case studies all suggest that the purpose of all arts/health work is to ensure that every person in a health care situation – staff, patient, carers and family - can enjoy the wellbeing and sense of self that is intrinsic to artistic practice and engagement at every step of their healthcare journey, and can experience the same cultural rights as the rest of the community.

Once the person in the healthcare setting is at the centre of policy and their wellbeing is the main point of the collaboration, then the problems around terminology, status and relative professionalism fade.

CASE STUDY I - ARTS FOR HEALTH AT MMU

Arts for Health at Manchester Metropolitan University (MMU) is an example of the value of strategic partnerships, and in particular the vital role that research can play in lobbying and advocacy.

It is the longest established Arts/Health organisation in the UK and has been actively involved in the development of the Arts/Health policy landscape in the UK, and internationally.

The development of Arts for Health Manchester was built on a relationship between Peter Senior and Manchester Hospital, and subsequently The University of Manchester (who initially offered him some space to develop his work in Live Arts around Mental Health).

There were a series of key steps that Peter involved himself in, including The Windsor Declaration, the Working Group at the Department of Health and then a collaboration between the Arts Council of England and the Department of Health that led to the Prospectus for Arts in Health, published in 2007.

The All-Party Parliamentary Group on the Arts supported the development of a National Network for Arts in Health, which brought together “people with teeth and feet on the ground”.

The subsequent development of Arts for Health is built on key partnerships and relationships at a senior level.

Their work is “all about people and place, and over the years we have worked with extraordinary people to influence the real-world impact that culture and the arts might play in people’s lives”.

Given that Arts for Health at MMU was born in an academic environment it's not surprising that its work includes research informed teaching at post-graduate level, and **research driven practice** that delivers projects with **robust evaluations and evidence driven results**.

Arts for Health at MMU is distinctive for the size and breadth of the projects it is involved with, for the range of partnerships it develops, and for the unapologetic political and rights-based philosophy that informs both its project and advocacy work.

This combination of a radical, provocative advocacy with a pragmatic and politic strategy is possible because of its academic core with its emphasis on robust evaluations and demonstrable impacts.

Partnership is at the heart of how they develop and deliver projects. They work with a “broad coalition of partners to better understand the impact of creativity, culture and the arts on health and well-being”. As we can see from the examples below, this model of an Arts for Health “project office” embedded in an academic institution is a highly effective model for regional development.

For example, *Dementia and Imagination* was a 3-year project funded by the Arts and Humanities Research Council and the ESRC with a budget of £1.2 million. The project created excellent arts experiences for people with Dementia, and produced a range of tools and publications.

They worked with St Helens and Knowsley Teaching Hospitals NHS Trust to design an arts strategy and vision for the Trust and commissioned artists to produce works for the new St Helens Hospital, and to develop work in response to staff and patient needs.

They provided support to Derbyshire County Primary Care Trust. The Trust wanted to "embed creativity, culture and the arts in its service delivery".

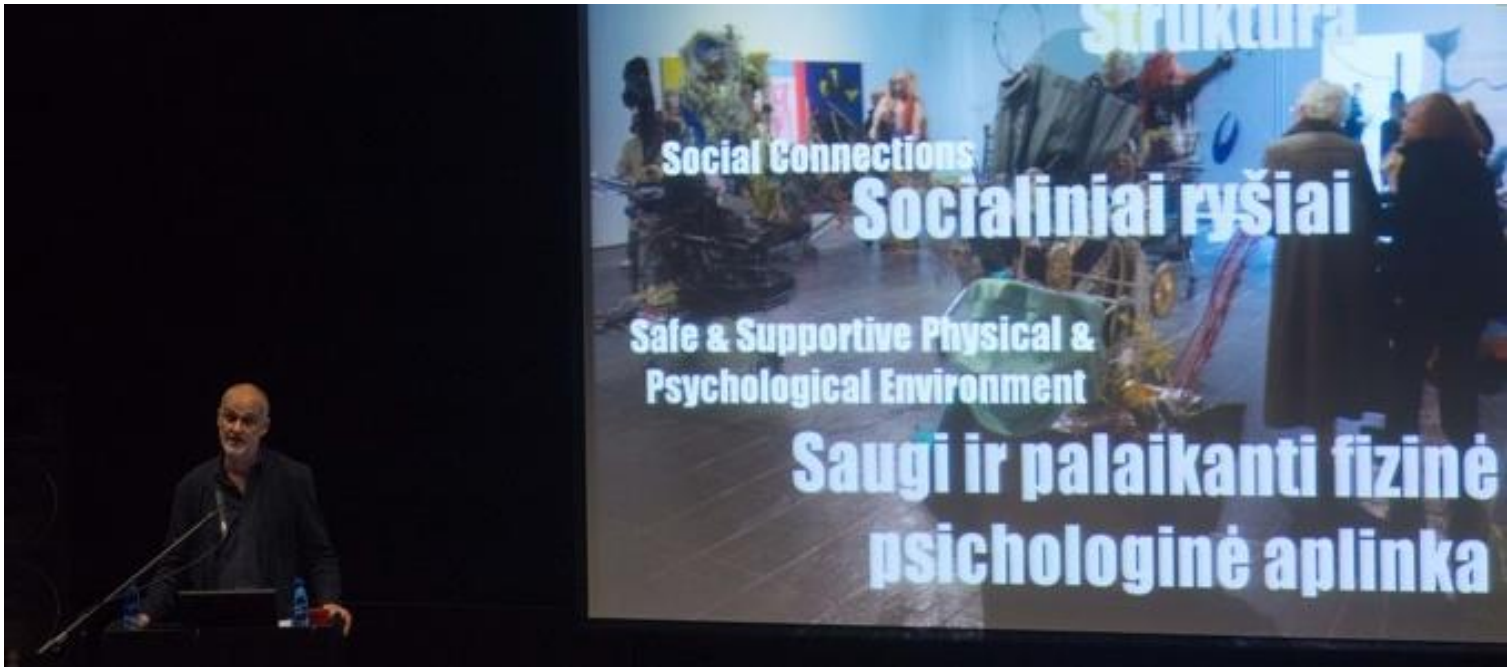
The key takeaways from the various projects and consultancies that Arts for Health Manchester have been involved in are that success and sustainability are driven by the health side of the equation, by the desire to embed arts into service delivery, and the anchor institution in the partnership is often an actual place/hospital.

The success of Arts for Health at MMU is a result of the strategic partnerships it has formed, embedding itself at the levels of policy and practice. Its relationship with Manchester Metropolitan University has allowed it to develop robust models of evaluation and produce an impressive body of practical and theoretical literature, as well as accredited courses and modules that enhance the professional status of practitioners and contribute to the development of shared language of arts/health.

These partnerships and structures allow the organisation to take radical and provocative positions. According to their Manifesto 2011:

> "So, when we're asked, what is this arts and health about, we must remember that our health and our well-being are bigger than narrow notions of sickness and disease. Our work is about our imagination and our voice, here on a street, there in the world. This isn't slavish instrumentalism, or impenetrable elitism. There is no formula, no commandments or little red book…It started out as arts, health and well-being, but its underpinned by so much more. And that's the thing: it's the politics of being alive, here and now. Our arts/health story can't ever be separated from the inequalities that underpin and undermine our world"

(Clive Parkinson of Arts for Health MMU presenting Dementia and Imagination project in Vinius)



ANALYSIS

The landscape of Arts and Health in the Midlands described in the previous section is complex (as it is across most of the country). It includes artists, art therapists, medical staff, participants and others; the work takes place across a continuum of settings from hospital to community care; it involves a range of practices and experiences along a continuum from process to product, participation to exposure; it exists in a complex policy environment that includes local authority arts and culture plans; local area development plans, the Arts Council, Slaintecare, Healthy Ireland, Creative Ireland and others. It is funded through a range of channels including local authority arts offices, the arts council, Tusla, Pobal, the ETB, Creative Ireland, the Department of Health, the HSE and others. The amounts involved are small and, by and large, project based and discretionary.

In addition, there is an asymmetrical relationship between the two principal cohorts – the artistic side and the medical side. Multiple respondents from the medical side identified the medical perception of arts projects as" fluffy" and as "hobby-based interventions" lacking a robustness of practice, a lack of clarity around purpose and outcome, and not addressing medical priorities. Acceptance of arts methodologies is dependent on individuals on the health side who "get it" – a phenomenon present in project reports going back to the early 2000s. This is a deep-seated cultural phenomenon, seemingly impervious to the growing body of research on arts and health.

There is an acknowledgement, made by nearly all respondents, of a change in the medical and care environments since the early 2000s, brought about by cutbacks in the HSE and reductions in the supply and availability of medical staff. Medical staff no longer have time to participate in, or understand the purpose of, an arts project. This resource issue is driving a disengagement from arts projects on the part of staff in healthcare settings. As a healthcare professional put it, after two years of work in an under-resourced environment staff "revert to clinical type"; or as a practicing artist described it, staff involvement has deteriorated to the point where "they think I'm someone doing some colouring with the patients"

There is an over-emphasis on "projects", driven in part by the way in which funding finds its way into the work. Funding in general is small and project driven – it is money to do a specific thing for a particular period of time. This project-based funding model does not contribute to sustainability.

The majority of projects are developed and driven by artists, motivated either by a passion for the work or the availability of small grants. The development phase of project ideas represents a significant volume of free labour, and the subsequent realisation of projects is dependent on personal relationships between artist and a care centre staff member who "gets it" and can champion the work within the care setting, and on occasion allocate some discretionary spend to a project at the end of a budget cycle. (It is worth noting that the fees paid to artists have not significantly increased since The Music in Healthcare projects in 2000 – 2004)

It is remarkable that so much vital work has been produced given the complexity and precarity of this landscape.

There are two fundamental challenges within this complex landscape: one is to do with “market design”, and the other - arguably more important – is to do with “purpose”.

Purpose

Local authorities, and in this instance, the respective arts offices, are not strictly speaking producers of work. Production and project delivery are based on an arms-length principal. In this instance Anam Beo, Helium Arts and Music Generation – as well as individual practitioners – are responsible for the development and delivery of specific projects. The local authorities support these projects in a range of ways including funding.

In general, there is a risk associated with all project-based funding models: purpose can become outsourced and diluted, and a common conceptual fallacy occurs. The fallacy in question being that we confuse the projects with the purpose. As Professor Clive Parkinson of Manchester Metropolitan University Arts for Health project (and others) pointed out in interviews, the projects exist *because* of the purpose. Projects come and go; it is the purpose that needs to be embedded across the system.

Therefore, in order to build a collaborative strategy that will deliver a sustainable model for the development of Arts/Health practice across the midlands the existing partners need to commit to a high-level shared purpose, expressed through a shared policy or MOU.

Applying the principles of Theory of Change, we can ask who is the target group? If we identify the target group as everybody – staff, patient, carers and family – on the healthcare journey, then the purpose becomes very clear. For example, we can state that the purpose of our work in Arts/Health is

> *to ensure that every person in a health care situation – staff, patient, carers and family - can enjoy the wellbeing and sense of self that is intrinsic to artistic practice and engagement at every step of their healthcare journey, and can experience the same cultural rights as the rest of the community*

An expression of purpose along these lines makes the work rights-based and cuts through the Gordian Knot of policy and practice. Whatever the patient requires (art therapy[7], art making, or a string quartet) is valid, and the idea of the healthcare setting becomes a continuum from home to community to hospital or other care setting and back again. It requires that Art and artist are embedded in the Healthcare journey, and the work – to use the Slaintecare phrase – follows the patient and is continuous and ongoing.

Commitment to a common purpose by the partners is an essential first foundation to the development of a sustainable model.

Market Design

The phrase "market design" is used here partially as a metaphor, and partly in response to the idea that new business models are needed. From the perspective of business model analysis, we have to ask the question, is the market functioning effectively? A dysfunctional market will make every business model seem dysfunctional. Sometimes the road needs fixing, not the car.

The research indicates that there is wealth of resources in the midlands in terms of talent, experience, knowledge and passion; a considerable number of excellent projects have occurred over the years, characterised by small budgets, low pay, limited duration and no sustainability of practice. While some of the partners – most notably Helium Arts and Music Generation – have developed robust organisational models, the better part of Helium's work occurs outside the Midlands, and Music Generation's primary purpose is not Arts/Health. Despite these robust organisational models the artists (and arts therapists) interviewed all spoke about poor and arbitrary payment levels, small project budgets, large volumes of "invisible" and unpaid creative and emotional labour, poor working conditions, lack of sustainability, professional development, and emotional supports in what is a highly charged emotional context.

The working challenges expressed by the artists is not unexpected, and unfortunately reflects the ongoing precarity of artists in all disciplines and contexts. However, in this specific context the experiences described by the respondents can be understood as a function of insufficient market demand: there is no anchor customer, and consequently there is a severe market failure. The market failure needs to be corrected if any business model is to function effectively.

If we accept that the purpose of the work is

> *to ensure that every person in a health care situation – staff, patient, carers and family - can enjoy the wellbeing and sense of self that is intrinsic to artistic practice and engagement at every step of their healthcare journey, and can experience the same cultural rights as the rest of the community*

[7] It must be noted that art therapy occupies a liminal place in arts/health in Ireland. The practice is not supported by the Arts Council or recognised by the HSE.

then it follows that Arts/ Health practices provide value to Health Care settings and providers. Managed effectively, arts/health practices can speed people through the healthcare journey by honouring the whole person, preventing the medicalisation of people, and creating human environments for staff and carers. It promotes wellbeing and has measurable medical outcomes and can reduce "the length of stay and…prevent admission altogether" and lower operational costs. It follows that the key customer is the healthcare provider. In terms of a collaborative action across the three counties the principal provider, and therefore the "anchor customer" is the HSE, Dublin Mid Leinster, and by extension the Department of Health and related agencies.

Repositioning the HSE and the Dept of Health as the key customer in the Arts/ Health Business Model in the Midlands is the second foundation for the recommendations that follow.

(Alison Morgan's Visibility Billboard digital image Irish Wheelchair Association, A Reconnect project with Julie Spollen and Rowena Keaveny. An Anam Beo project)

RECOMMENDATIONS

With these two foundations in mind (Purpose and Market Design) the recommendations can be grouped in four pillars:

- Purpose
- Partnership
- Policy
- People

Purpose

1. Develop a joint statement of purpose with the partners. Keep it simple (see above).
2. Identify and invite "champions" to form a development team tasked with realising the stated purpose. This will include the existing partners, and individuals from the HSE Dublin Mid Leinster, Creative Ireland, TUSLA, Athlone IT School of Nursing, ETB etc.
3. Move to have the Statement of Purpose approved at Local Council Level, as it is in keeping with legislation, is ambitious and is supported by national policy.
4. Propose to Councils for the appointment of an "Arts/Health Director Midlands" to deliver on this purpose. This co-ordinator to be funded jointly by the three local authorities and the arts council for three years.
5. Develop a joint communication/media strategy around this Statement of Purpose: this will allow the promotion and celebration of work to date, and the positioning of the partners as leaders in the Arts/Health sector.

Partnership

1. A formal invitation to partnership must be made to the HSE Dublin Mid Leinster. (At some point later this year the Arts Council will publish its new MOU with the HSE, committing them both to working closely together. This is a unique opportunity to pilot what "working closely together" could look like).
2. Partnership proposals should also be extended to TUSLA, ETB, Healthy Ireland (others?)
3. An MOU needs to be agreed and signed by all partners. Keep it simple. However, it must include:
    - the principal of joint funding.
    - embedded artist/co-ordinators in each county (working out of each regional hospital[8]),

[8] Regional Hospitals in Portlaoise, Tullamore and Mullingar

- development of joint training and networking events (for artists and medical staff), promotion of activities,
- the development of joint research projects and sharing of information and learnings.

4. Appoint embedded artists/arts co-ordinator in each regional hospital. These appointments to be funded over three years jointly by the HSE and Arts Council. There are other funding possibilities here, but commitment from principal partners is key.
5. Arts Officers to request appointment to relevant committees and sub-committees (e.g. Healthy Ireland).

People

1. Establish an Arts, Health and Wellbeing in the Midlands Network. This can have multiple functions:
    a. connect colleagues delivering arts and health work in the Midlands across the full range of art form practice in health, arts and other community settings
    b. act as a platform and promotional tool for projects and individuals
    c. Act as an archive for projects
2. Work with partners (e.g. Helium, Anan Beo, Music Generation, HSE, ETB etc.) to establish a funding/pricing model that acknowledges and establishes:
    a. The professional status of artists (including within the HSE)
    b. A payment structure that incorporates qualifications, experience, development time, associated expenses, and opportunity costs
3. Work with the Waterford Healing Arts Trust to provide additional supports for artists through advice clinics, networking, training and mentoring .
4. Work with Athlone IT School of Nursing to
    a. develop and deliver modules and programmes on the theory, delivery, and impact of Arts/Health programmes
    b. develop and deliver CPD programmes on Arts/Health practice for people working as artists and medical staff.
    c. Develop relevant action research projects
    d. Develop an evaluation practice and methodology that can be deployed across all work.

Policy

A key theme emerging from publications and interviews throughout this research is "policy". As one international respondent put it "All significant development happens at the policy level", and as a local respondent put it "if it's not in policy then it doesn't have a budget line".

The domestic policy environment is already crowded, and there is always the risk that any new policy will be lost in the existing policy environment, and criticised for taking up time and resources.

Therefore, the approach to policy should be agile, responsive, clear and practical. The opportunity here is to develop a shared policy between all the partners (Local Authorities, HSE, Dept of Health, Arts Council, Creative Ireland, ETB, TUSLA etc.).

The policy can be built on the statement of purpose and the MOU's (rather than the other way around) and can reflect the actions outlined in these recommendations. The policy should be a clear framework that incorporates all partners and enables collaboration and partnership, assigns clear funding responsibilities, and brings together the Health and Culture agendas by working toward a creatively active nation.

As a strategic tool, it is necessary for all partners to sign off on the policy. However, this is not a necessary first step. It is more effective, in change management terms, to view the formulation and publication of policy as the last step in the change process, validating and embedding the actions that have occurred in the previous steps.

A Note on Delivery Partners

Anan Beo, Helium Arts and Music Generation can be understood as "delivery partners", in that they develop and deliver arts/health projects in specific settings. All three organisations contain a wealth of experience that can support the implementation of the ideas set out here. Music Generation and Helium Arts have developed robust partnership and funding models that can be copied and adapted, and Anam Beo, operating as an artists' collective, has built up a robust practice and a reputation for quality in terms of both process and outcome. However, Anam Beo's funding model is not working and needs to be addressed, Helium does relatively little work in the region, and their plans for a Creative Health Hub in Westmeath needs investment, and Music Generation's mission is not primarily to engage with a health agenda.

If the goal is a sustainable model of arts/health provision across the midlands then the role of these organisations within the wider purpose needs to be worked on in terms of what they want to contribute, and what they need to make the contribution.

CASE STUDY II - UNIVERSITY HOSPITAL CARDIFF AND VALVE

The University Hospital Cardiff and Vale manages an Arts Programme with a delivery team, directly employed by the Hospital, of five people including a gallery co-ordinator, two project managers and a communications manager.

One of the project manager roles is funded by the Arts Council of Wales, with the balance of Arts Programme budget provided by The Cardiff & Vale Health Charity, including a project budget of £80,000 per annum. (c. €92,000).

The Gallery Co-ordinator manages the Hearth Gallery situated in the University Hospital Llandough. Exhibitions in the Gallery change every 4-6 weeks, and present work by emerging and established artists, and a variety of community groups and charities, as well as work produced through various projects.

The arts team also delivers work in music, creative writing, dance and movement, and animation.

University Hospital Cardiff considers itself to be an “arts space”. This perspective has allowed the arts team to turn corridors into exhibitions spaces, commission live music programmes for very ill children and babies, as well as performances for adults in the Critical Care Unit to ease anxiety and soften their experience of the clinical environment, deliver children’s drama in their hydrotherapy pool, weekly dance, movement and mindfulness sessions to improve post-operative patients' health and wellbeing in the Breast Centre, musical and singing workshops for people living with Dementia, Dance and movement sessions in the Stroke Rehabilitation Centre, develop a sculpture garden to highlight the connections between nature, art and health, and much more.

The Hospital boasts an art gallery that is used by patients, staff and visitors, and exhibits (and sells) work by commissioned artists, staff and patients. They think of the hospital itself as one point on the healthcare journey and they develop arts projects with local schools and community groups. Arts events are designed with staff, patients and the wider community in mind. As Alex Staples, Arts Project Manager at UH Cardiff put it, “...how we think about health and do healthcare are essentially expressions of culture, so it makes sense to think about hospitals and care homes as cultural buildings”

All of this work is delivered through partnerships with professional artists and art therapists directly, and through organisational partnerships with Welsh National Opera, The Forget Me Not Chorus, Rubicon Dance, Hijinx and Oily Carte Theatre Companies, Painting in Hospitals and others.

Strategic Focus

The Arts strategy is clearly focused on the health and well-being of the wider community, with a vision to

> "… improve health and wellbeing for patients, staff, visitors and local communities within Cardiff and The Vale of Glamorgan through access to the arts."

It is important to note that this is a hospital statement of purpose, as opposed to an artist statement of purpose. The hospital also states that

> “Despite the current financial pressures on health care providers, we know that embedding the arts into our care environments is essential and our focus on this will continue to grow and evolve over the coming years”.

Strategic Objectives

The strategic objectives at Cardiff and Vale UH cover quality of project delivery, upskilling staff, the healthcare environment, health and wellbeing outside a hospital environment and measurement and evaluation. In terms of strategically addressing a complex system to drive change it's a best in class approach and worth quoting in full:

1. To improve experiences through the delivery of high-quality arts activity projects, with a focus on access by all as an aspiration.
2. To support staff to gain the knowledge and skills to deliver useful and successful arts projects, including improving access to existing arts resources, providing opportunities for staff to develop their arts-based skills and increasing staff knowledge of best practice examples of Arts in Health & Wellbeing activities.
3. To use participatory arts projects and creative approaches to send positive messages to service users and staff and to promote Health and Wellbeing
4. To enhance the healing environment, including inpatient, outpatient, public and outside spaces
5. To measure the impact of the arts on the quality and effect on outcomes of care for our patients
6. To foster effective partnerships across disciplines and agencies, and with service users, carers, communities and volunteers in support of arts in health
7. To explore the impact of social prescribing on the wellbeing of people and a reduction of their dependence upon public service with Cardiff and the Vale of Glamorgan.

According to the arts team at Cardiff and Vale, much of their work is possible because of the MOU between NHS Wales and Arts Council Wales. This is also an example of agreements and planning at a regional and local as opposed to a national level.

Their success also reinforces the Arts for Health at MMU point, that the key success factors include the desire to embed arts into service delivery, and the role of a hospital as the anchor institution. The Arts/Health project team have their desks on the same floor as senior management and in the same room as the hospital communications and PR. This simple organisational fact is enormously important, giving them direct access to strategic decision makers and PR support, as well as lending status, professionalism and credibility to their work.

)

(Nurses in the hospital Gallery

PRACTICE AND PROVISION

Context

The research recognised all activity in both community and formal care settings, so long as the providers and/or participants believed that the arts activity had a positive impact on the health and wellbeing of the participants. What we are concerned with is the extent, type and intent of the activity, and not with evaluating the quality of what is taking place. Quality is a contentious issue and can change depending on who is measuring it and through what lens. Evaluating the quality of the projects was therefore outside the scope and remit of this project.

With that said there is no question but that there is a long tradition of excellent arts/health practice, and a skilled and passionate cohort of artists currently working in a healthcare context. This is attested to by the comments made in the course of the interviews by respondents from the healthcare and policy spheres, and by the participant and project evaluation reports available.

This tradition dates back to the ground breaking work of Music Network on Music in Healthcare, (2001 - 2004), and the foundation in 2005 of Anam Beo as the arts, health and wellbeing programme in the Offaly Arts Office. Then in 2010 Helium Arts, the National Children's Arts and Health Charity was established in Westmeath. Although Music Generation has no direct remit in arts/health, it has worked over the years delivering projects for young people in care situations and special needs schools, but its principle purpose is "...to create **inspiring experiences** for children and young people through **music"**. Given the ethos of Slaintecare, and the principals of the Social Determinants of Health, Music Generation's work clearly impacts on health and wellbeing, and is justifiably considered part of the arts/health eco-system.

These three organisations, along with the respective arts offices, can be considered as the main delivery vehicles. There are significant organisational differences between them.

Helium Arts

Helium Arts operates on a highly effective social enterprise model and received the Good Governance Award in 2019. It has a full-time staff, a robust funding model with multiple sources of funding and funding partners and works with artists on a contract basis to design and deliver projects. It has a clear strategic purpose and operates an effective "Theory of Change model". It also has a youth advisory group, essential for any organisation that purports to work with young people.

Helium is a *National* organisation and so works with local authorities and healthcare partners across the country. It is adept at building robust local partnerships to support and deliver its projects. Currently it is rolling out its "Creative Health Hubs" model in Cork and Limerick.

> "In each Creative Health Hub location, Helium's artist will deliver a continuous programme of activity connecting between hospitals, community and public settings...Through our "arts on prescription" approach, we will meet children in hospital who will then be referred to our workshop series in community & public settings".

From an organisational and delivery perspective this is state of the art, and this model and the knowledge that goes with it, is one of the major assets in the region.

Music Generation

Music Generation is a national organisation with regional "offices". Again, organisationally, it is a model of best practice, representing an effective structure of partnership and co-operation at a national level. It is co-funded by U2, The Ireland Funds, the Department of Education and Skills and Local Music Education Partnerships. The partnerships are composed of local experts, individuals and organisations that "champion and guide the development of the Music Generation programme in their area". The partnerships are led by the relevant Local Authority or Education and Training Board.

Music Generation's work in general contributes to the health and wellbeing of young people, and as such makes a significant contribution to arts/health practice in terms of prevention and in terms of the work conducted in Special Schools.

If Helium Arts is an example of an effective social enterprise, then Music Generation illustrates best practice in organisation and delivery at a national level, built on robust partnerships and funding commitments at both national and local level.

Anam Beo

Anam Beo has a rich catalogue of successful projects and promotes a values-based process approach to the work. They have delivered work in Birr Community Nursing Unit, Riada House Day Care Centre, Tullamore, Clara Day Care Centre, Ofalia House, Edenderry, The Irish Wheelchair Association, Ballinagar, Birr Care Centre, The Attic Therapy Centre in Tullamore, and provided workshops to The National Learning Network, The Renal Unit at Tullamore Hospital, Carthage House Muchlagh and Clochan house in Tullamore.

Anam Beo is essentially an artists' collective designing and delivering projects that promote

> *"creative art inclusion through the delivery of comprehensive arts projects in care settings. As an arts organisation we encourage creativity and empowerment through a meaningful engagement in the arts".*

The quality of their work is widely acknowledged:

> "We have heard and read the many heart-warming testimonials and uplifting moments from patients and staff that have been in that creative space with Anam Beo artists....the significance of its quiet yet powerful impact...the innovation, dedication and warmth that the Anam Beo artists have brought to their work for ten years. It is a story that needs to be heard more and their artwork reflects beautifully on the ongoing journey that is our personal and creative wellbeing[9].

Anam Beo was developed in 2005 by Offaly County Council and the Dublin Mid Leinster HSE as a programme managed out of the Arts Office, following the evaluation and recommendations of an Artist in Residence programme in 2004 with artist Tom Meskell. Some years later Anam Beo was moved out of the arts office and established as an independent company in 2010.

Unlike Helium Arts and Music Generation, Anam Beo is fundamentally an artists' collective, and its ambitions and focus are to do with the quality of the art and the engagement and not with corporate development.

Since 2010 its annual funding has never exceeded €40,000 and has averaged out at €28,777. Unusually the largest funder is the HSE contributing 43% of funding in 2019, followed by the local authority contributing 32%. Annual funding has been trending downward since 2010, with total 2019 funding being 75% of the 2010 high. As a final note, 48% of the funding is absorbed by governance and administration costs.

These numbers tell us that the artists involved are investing an unacceptable amount of unpaid time, energy and talent into maintaining this programme. Like Music Generation and Helium Arts, Anam Beo is an invaluable regional asset in terms of knowledge, skill and talent; unlike Music Generation and Helium Arts, Anam Beo is an arts/health program, not an organisation. It needs to be embedded in another organisation (a local arts centre, local authority or HSE centre) that will take responsibility for the administration of the programme, remove the governance burden, and return the 48% of the funding to the people and the work they do.

The expertise and approach of Anam Beo are core assets in the Midland's arts and health landscape, but it is fundamentally a project office and not an independent organisation. Not all artists want to be cultural entrepreneurs, some just want to deliver great work.

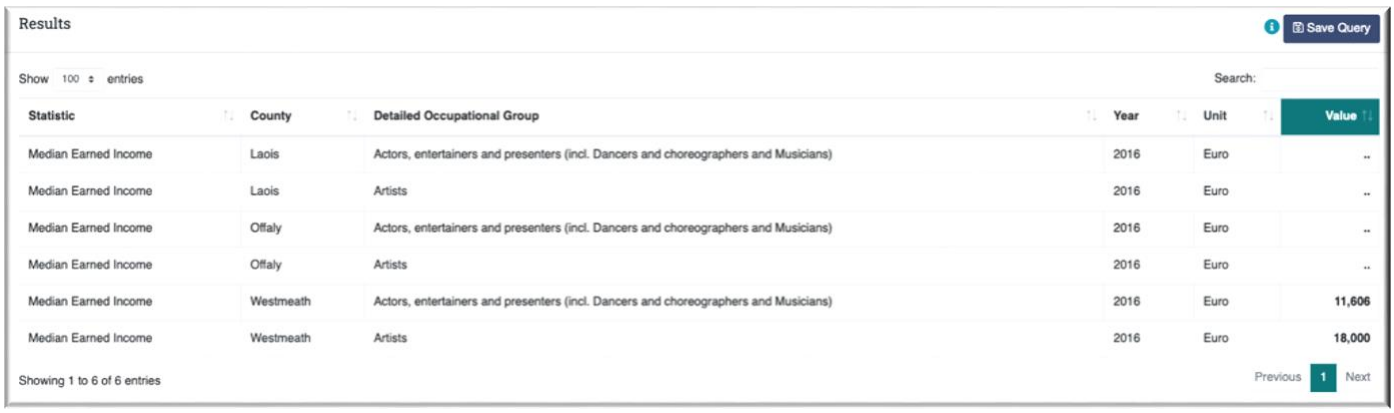
[9] Sinead O'Reilly Arts Officer, Offaly County Council

THE ECONOMIC LANDSCAPE

The extraordinary achievement of the arts/health sector in the midlands must be measured against the economic situation as well as the policy situation.

In 2019 the average local authority spend across the country on Arts Programmes was 1.5% of total local authority budget in any given county, or €15.82 per head of population. The equivalent numbers in the three midland counties were Westmeath €12.50 (1.44%), Offaly €6.64 (0.86%), and Laois at €15.14 (1.8%), all below the national average[10].

The 2016 census reports median income for artists and performers in the three midland counties as follows



Results

Save Query

Show 100 entries

Search:

Statistic	County	Detailed Occupational Group	Year	Unit	Value
Median Earned Income	Laois	Actors, entertainers and presenters (incl. Dancers and choreographers and Musicians)	2016	Euro	..
Median Earned Income	Laois	Artists	2016	Euro	..
Median Earned Income	Offaly	Actors, entertainers and presenters (incl. Dancers and choreographers and Musicians)	2016	Euro	..
Median Earned Income	Offaly	Artists	2016	Euro	..
Median Earned Income	Westmeath	Actors, entertainers and presenters (incl. Dancers and choreographers and Musicians)	2016	Euro	11,606
Median Earned Income	Westmeath	Artists	2016	Euro	18,000

Showing 1 to 6 of 6 entries

Previous 1 Next

(https://data.cso.ie/table/IIA13)

There are issues with the way artists and performers report themselves, and issues with the way the census tries to capture cultural sector data, but even with these caveats in mind it is clear that artist earnings in Laois and Offaly are well below the national average, while earnings in Westmeath are close to the national averages (€13,488 and €11,930 respectively. CSO).

The Arts Council acknowledges that funding is low in the midlands, for example only 0.2% of total arts council spend makes its way to Offaly. This is not the result of an Arts Council decision: the council responds to the applications it receives, and if their funding in the midlands is low this is in part a function of the number and size of applications it receives. It is possible that the zero reported median income in Laois and Offaly indicates that a very small number of artists are living in those areas and this would go some way toward explaining the low number of arts council applications. Another possible

[10] These figures are derived from data on Local Authority budgets available on localauthorityfinances.com A project of The Whitaker Institute at NUI Galway

interpretation is that, given the low-income levels, people quite simply have neither the capacity nor the motivation to make applications. As one interview respondent put it, referring to their experience in one of the local authority areas

> *"It has only taken 20 years of actively fighting for a creative hub to come to fruition. Which required a lot of politics, ambition and steadfastness...I believe that is where the energy and focus has been. The basic infrastructure and top down buy in. Of the last 20 years I estimate there were 5 years where there was no active arts officer, and where the role had to be championed for reinstatement by the artists community itself as the position was nearly lost on one occasion completely"*

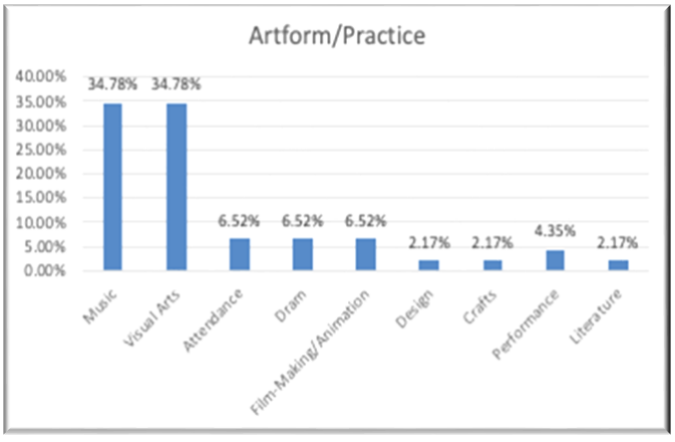
It should be noted that Arts Offices across the country are under-resourced in terms of staff and budgets, and consequently spend a considerable part of their time and resources behaving like their clients and applying for funding. The issue of the under-resourcing of the arts offices occurred throughout the interviews, with respondents acknowledging both their desire to support the work and the resource constraints the arts officers are working under. As stated previously , the levels of resourcing to Arts Offices is itself a function of the way in which local authorities fund their budgets.

Against this landscape the achievements in arts/health of the last 20 years are beyond remarkable and the assets developed in terms of skills, expertise, organizational knowledge, and networks are considerable. It is also apparent that there is no coherent structure for the sustainable development of the sector at this time, that funding levels are low and dependent on competitive application processes, that there is either a shortage of artists in at least two of the counties, or an extremely high level of poverty within the artists' community. Given that the majority of arts/health projects are developed and driven by artists this is a major challenge.

PROJECT STRUCTURE

Artforms

As we can see Visual Art and Music are the most common art forms accounting for 70% between them. This is in keeping with the international research and with the nationwide trends. [11]



The questionnaire captured a number of subtleties around practice, with respondents qualifying their choices, describing their practice as "socially engaged" or as "collaborative" or with interests in "public creative equitable spaces for societal health".

[11] A similar pattern of preferred artform is found both in the WHO (2019)report, and The Arts and Health Co-ordinators report (2019)

The emphasis was on collaboration, process and participation throughout, whether that meant "working with groups to bring out their sounds….build a connection with their past, their self" or simply trying "... to get them to re-engage and a big part of that is art - not art therapy".

The level of experience varied considerably. 44% of the respondents identified the number of arts/health projects they had been involved with, and this ranged from one project to "over fifteen".

Spontaneous and Informal

There is a wide range of work happening on the ground, reinforcing the observation in the literature that much of the work happens at a "grass roots level". In many cases the work discussed and held up as exemplary did not fit any specific definition of art/health.

For example alongside the conversations on projects that were clearly arts/health, there was a wonderful informality about much of the work discussed : "in 2014 we got a group together…. of special needs young people up to the age of 12...but our other work includes people from 16 to 70! Just people from the local community", or "we started with adult colouring books" or "so we decided to provide a crochet class and a ukulele class" or "then there were people from the men's sheds who came in and did music with us" or "nothing formal happens but pockets of activity...where young people did up the room for us" or "I returned to work as a Nurse in a nursing home. Retrained and then began to bring in the guitar, didn't matter what songs. Began doing concerts"

There is a spontaneity and a passion that generates work that may not easily fit definitions or descriptions of what arts/health should be, but rings true to Clive Parkinson's comments that the work is about "…our imagination and our voice, here on a street, there in the world. This isn't slavish instrumentalism, or impenetrable elitism. There is no formula, no commandments or little red book…"

Some projects present themselves as something other than arts/health for funding purposes, others maintain that they are therapy but by any definition they are arts/health, and still others won't use the words therapy or arts because people "wouldn't come if they thought that's what was going on".

The projects these comments refer to were spoken of with great passion and commitment by the respondents, but do they qualify under existing definitions of arts/health? Do they belong with the remarkable body of work produced by Anam Beo and Helium Arts in particular, or with the work done by Music Generation or the partnership between Laois Arts Office and IMMA that will "...facilitate a training programme around understanding cognitive challenges, share knowledge and resources, develop local artists and collections, and provide access to the IMMA collection".

The answer is dependent on the purpose of the definition, on who the definition serves and what it is protecting.

However, what this range of activity demonstrates is a widespread intuitive understanding of value and potential, and a real appetite and opportunity for increased acknowledgement, support, development and training.

Social Prescribing

The practice of social prescribing is growing. It's currently in its fourth year in Offaly - and running 52 projects in total. The core idea is to help people reconnect through community support - volunteering, joining a library, or taking a course. Increasingly the practice is starting its own arts programmes, as it can cannot find relevant existing programmes to refer people to.

Healthcare Staff and the "Gatekeeper"

In terms of the development of projects within traditional healthcare settings, all of the respondents identified the role of the "Gate-keeper" as a key success factor. In this context the Gatekeeper is an individual within the health setting who "gets it", who is predisposed to the idea of arts/health because they are artistic themselves, or they have an artist in the family, or they are familiar with the theory and practice. Whatever the source of the pre-knowledge, their role is essential to the success of the project. They champion the project to their line managers and fellow staff, they make time and space available, the manage the logistics of bringing the participants and artists together, and sometimes they have a discretionary spend available at the end of a budget cycle. Their role is both vital and informal, and projects can be disrupted, decline, or end if Gatekeepers are transferred, promoted or retire.

> ***"I'm arty and crafty myself, - so I understand the value and role of peer support - their ability to have conversations, break the isolation, and encourage each other"***
>
> ***"I finally approached the director of nursing and said I have to do something"***

Healthcare staff are under increasing pressure. The HSE is underfunded and under-resourced and this is formally acknowledged in the Slaintecare report, and affirmed by all respondents in the course of this research. The increasing pressure on healthcare staff means that the power of the Gatekeeper is declining. Put quite simply staff no longer have the time to invest in non-clinical activities.

> **"I've become just another person who comes in to give people stuff to colour in. I'm a professional artist but the staff don't see that, the staff don't know and don't have the art appreciation. I'm just another person they have to deal with";**

Ironically, the healthcare respondents acknowledge the value of the human centred, human focused quality of arts/health work, while acknowledging that the pressure they were under means that the time is not there for it.

"this kind of thing is not regular - it depends on staff available".

As one senior respondent from the health sphere put it

> "While the idea of being person /patient centred is a policy position there is still a piece of work to be done on the cost effectiveness of such an approach"

"some days this is not even an arts practice but an intervention",

Several HealthCare respondents were part of workplace staff choirs in their hospitals, and they spoke passionately about the physical and mental benefits of this to the staff. They also referred to the organisational impact, "it's much easier to deal with a problem or get something done after you've spent an hour singing beside a colleague".

LOCATIONS AND CARE SETTINGS

The HSE identified the following Health Care sites and offices across the midlands:

HSE	General/Acute Hospitals:	Midlands Regional Hospital Portlaoise	Portlaoise
HSE	General/Acute Hospitals:	Midlands Regional Hospital Tullamore	Tullamore
HSE	General/Acute Hospitals:	Midland Regional Hospital Mullingar	Mullingar
HSE	Mental Health Hospitals:	St. Fintan's Hospital	Portlaoise
HSE	Mental Health Hospitals:	St. Loman's Hospital	Mullingar
HSE	Hospitals for Elderly Care:	St. Vincent's Hospital	Athlone
HSE	Hospitals for Elderly Care:	St. Vincent's Hospital	Mountmellick
HSE	Hospitals for Elderly Care:	Birr Community Nursing Unit	Birr
HSE	Disability and Care Facilities for Laois, Offaly and Westmeath	Health Centre,	Tullamore.
HSE	Disability and Care Facilities for Laois, Offaly and Westmeath	Area Office,	Tullamore.
HSE	Disability and Care Facilities for Laois, Offaly and Westmeath	Midlands Louth Meath Community Healthcare Organisation	

The respondents worked on projects from 2009 to 2020, and the following locations were specifically identified:

Project Location	No. of Projects
Abbeyleix	1
Athlone	2
Balycumber	1
Banaher	1
Birr	5
Edenderry	3
Ennistymon	1
Longford	2
Mountmellick	2
Mullingar	3
Portlaoise	6
Tullamore	9
	36

There were references to 36 projects, and specific references to twenty-three separate places at these locations where projects were located.

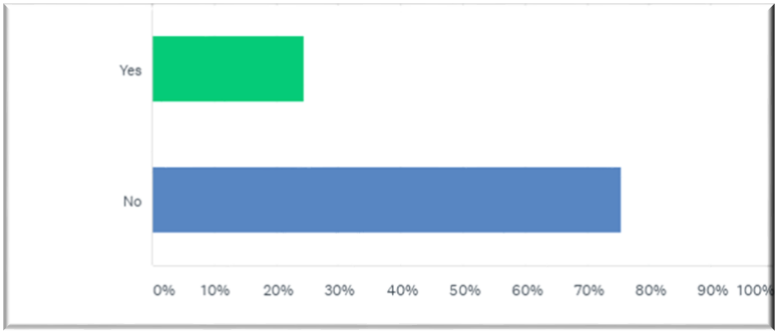
The settings were a mixture of formal and community settings. And predominantly care homes at the "formal" end of the spectrum, but as the settings moved deeper into the community the focus widens to deal with young people and mental health, and issues of inequality and access become more apparent.

The following health care contexts were identified by respondents:

- Children with diabetes
- Children with special needs
- Elderly patients, some with dementia, some psychological issues
- long stay care residents - including dementia
- Mental Health
- Adult Mental Health
- Residential care settings, community care setting and community centre

As we can see the work is focused on older people, children in healthcare, and mental health.

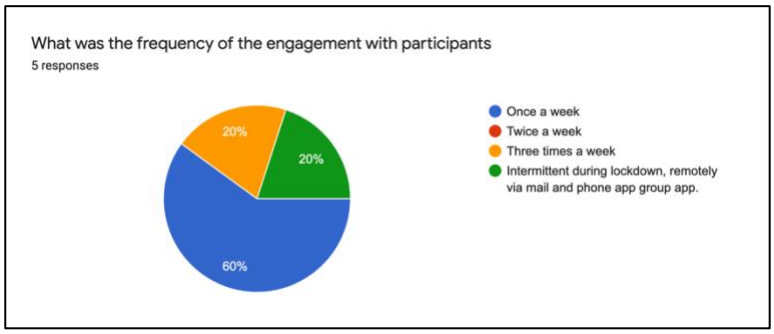
24% of the HSE respondents were aware of an arts health project delivered by a professional artist in their place of work over the last six years



DURATION, LENGTH AND PARTICIPATION

The projects discussed in the course of the research ranged in duration from four weeks to two years, with “eight to ten weeks” being the most commonly reported project duration.

60% of projects had a once a week engagement



The most common length of a session is 1 hour, and the longest recorded session was three hours.

The number of participants at each session ranges from 8 to 27.

What determines the structure?

The questions of project duration and frequency of engagement are interesting. It would be incorrect to assume from the data collected that this is how arts/health is “done”, or that one two-hour session for eight weeks represents some kind of best practice.

In effect this structure is shaped by available resources, by the project nature of the funding, and by the informal quality of the relationships between the arts and health spheres.

For arts practitioners the project structure described above is perceived as inherently problematic and not necessarily conducive to quality work: “Very hard to work in 6-week blocks, I know it's determined by financial constraints - very frustrating and limiting”.

The project structure also misses the fact that “this is community-based work, it looks to the long term of the patient, the community development aspect of it”. The structure raises the question: is it sufficient - and ethical - to “give” people a short-term opportunity to discover a fundamental aspect of their personality, and then have no follow through?

> “You’ve spent three years opening up the patients to this work and then what? Is it better or worse?”

As the Arts Project Manager at University Hospital Cardiff puts it "there also needs to be an informed pathway - leading from care experience to a community experience and support"

The short-term nature of the project model and the funding approach that drives it are also viewed with scepticism;

The dominance of the short-term project model is a function of discretionary funding and low prioritisation within the system. Indeed, it seems that the majority of funding from all available sources is competitive or discretionary and project based. Consequently, the majority of the work struggles to get past the level of an activity. In order to move beyond this, to build a sustainable and valuable Arts/Health sector the work needs to exist "….at a policy level with a budget line so it goes beyond any one person in the role". This need for a policy commitment to the work was expressed by respondents from all stakeholder groups".

"The projects as they currently are can't sustain but can get profile"

"The whole thing can become a PR exercise as opposed to a sincere, rights-based practice. Make it happen and give me a story".

PROJECT BUDGETS AND PARTNERS

22% of the respondents were aware of the total project budget for the last project they worked on.

The project budgets discussed ranged from €3000 for a four month long project, to €8000 for a project spread over two years.

Given the average durations set out in the previous sections it can be argued that these budgets are predicated on an unacknowledged investment of time, talent, and skill on the part of the artists.

There are a range of agencies and organisations involved in funding Arts/Health projects across the midlands – either directly or indirectly - including but not only:

Laois VEC	Laois Partnership	Laois Leader Programme
Longford Westmeath Mental Health Occupational Therapy Services	Mullingar Mental Health Association	Mullingar Mental Health Association
Mental Health Ireland	HSE	Irish Wheelchair Association
Acquired Brain Injury Ireland	Offaly Local Development	Diabetes Ireland
Creative Ireland	Alzheimer's Society of Ireland	Nursing Homes Ireland
Ballycumber Active Age Groups	Alone	Age and Opportunity

Birr Mental Health	Community Foundation of Ireland	ETB
Pobal	TUSLA	

Funding is primarily project focused, and rarely exceeds the €10,000 level. In the case of one particular the funding was under €1500 for a project that ran throughout the year, and had remained at that level for five consecutive years.

Although the individual spend is not significant (in terms of both size and potential impact), this is a significant list in terms of the potential cumulative investment budget. However, as one practitioner phrased it "So many different partners but no meaningful relationship".

Bringing these stakeholders into alignment around a shared purpose and policy is a strategic priority.

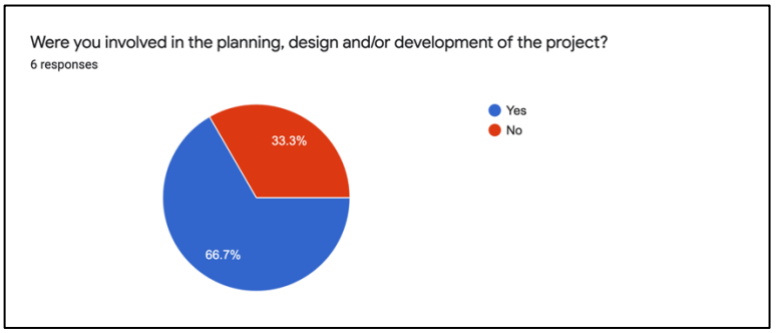
PAY SCALES

How to value artistic labour

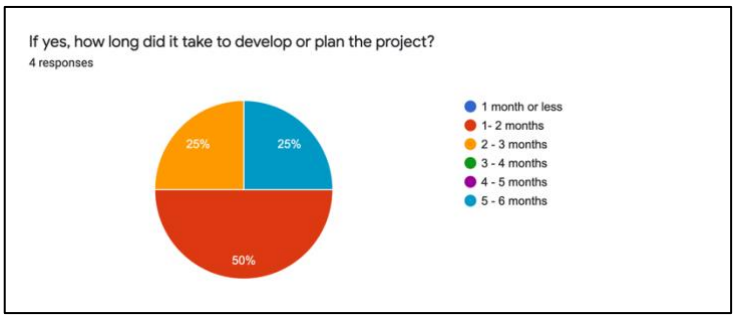
There is an issue surrounding rates of pay and unpaid creative labour throughout the arts and culture sector, specifically around the areas of research and development, so the following is not unique to people working in arts/health.

Official policies on the fair and equitable remuneration and contracting of artists exist (Paying the Artist, 2020). However, these policies have no legal status and no influence outside of the arts context. What constitutes fair and equitable remuneration is not immediately apparent to non-arts funders. Is the artist being paid for their engagement time, or their talent, or the expected results, or for the original idea, or the development of the idea, the hidden and emotional labour or the expertise, or a combination of all of these? And how do we value each of these elements?

66.7% of respondents were involved in the development and planning of projects, and 75% of the projects took 1 to 3 months to develop.



The time spent thinking about, planning and developing a project during this 1 - 3-month period is seldom if ever acknowledged or paid.



Only 33% of total artists surveyed (via questionnaire and survey) gave details on their payments. The reported payments range from €1800 (+ expenses) to €2500. 15% of the respondents

If we look at the higher payment, of €2500 fee, we see that is was for a 10-month project, with a weekly engagement, giving a rate of €62.50 per hour of engagement before tax, with no preparation or reflection time, no development time, travel or materials etc.

€62.50 is at the very high end of the pay scale.

Few of the respondents had any clear sense of how rates of pay are set. In general rates appear to be set against the anticipated size of a potential grant, and not against actual work done.

Depending on who the principal funder is in a project then rates are tied to, for example, ETB part time teacher rates, or in one instance to Care Assistant rates in the HSE. These rates tend to assume that the payment is only required for the period of contact work (i.e. one or two hours), and ignore development time, prep and reflection time, travel time and emotional time - the fact that it is almost impossible to go from one session directly into another. In other words, the necessary emotional down time and travel time is a cost borne entirely by the artist, as is the cost of emotional drain and recovery.

> "There was a period when every time I turned up somebody had died. We have relationships with these people. It takes its toll. But where do I go with that? Where do I take it?"

The following comment is unsurprising given the rates of pay:

> "I turn up week after week for this, and I have done for a number of years. I don't understand why this isn't a job"

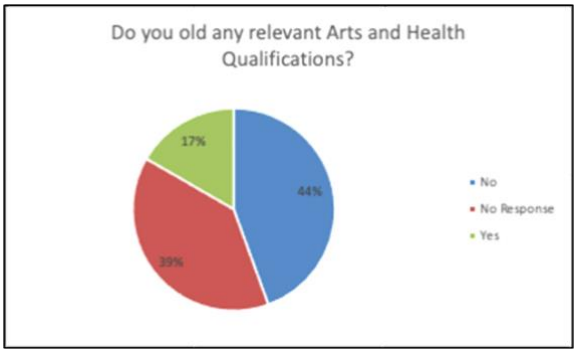
"an increased timeframe not little bursts – a year, six months minimum. A rate of pay that reflects the professionalism and preparation. Network of people (collaborative approach) like in Kildare. It needs to be visible"

Valuing artistic and cultural labour is an economic conundrum with a long history. However, we can say that a payment model based on hours of engagement only, with an hourly rate of €62.50, with no guaranteed travel, materials and related expenses, and no adjustments allowed for development time, experience and/or expertise does not contribute to the idea of equality and partnership associated with principles of "arts and health". It also contributes to the challenges associated with power and status in the development of the work

QUALIFICATIONS, TRAINING, AND SHARED LANGUAGE

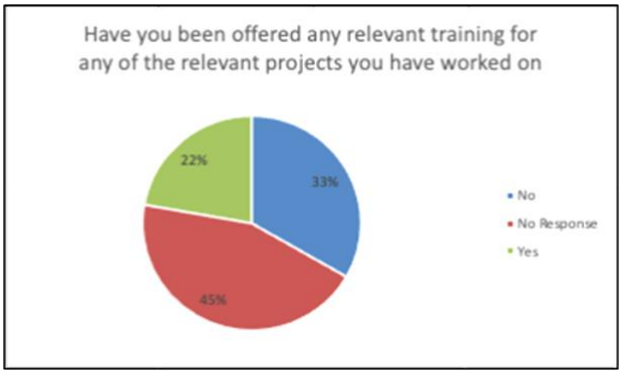
17% of the artists who responded reported relevant arts health

qualifications, including qualifications that ranged from "...a clinical nurse manager in mental health, hold a BA hons in fine art and design and an MA in Socially engaged practice" to "arts and health care facilitator course".



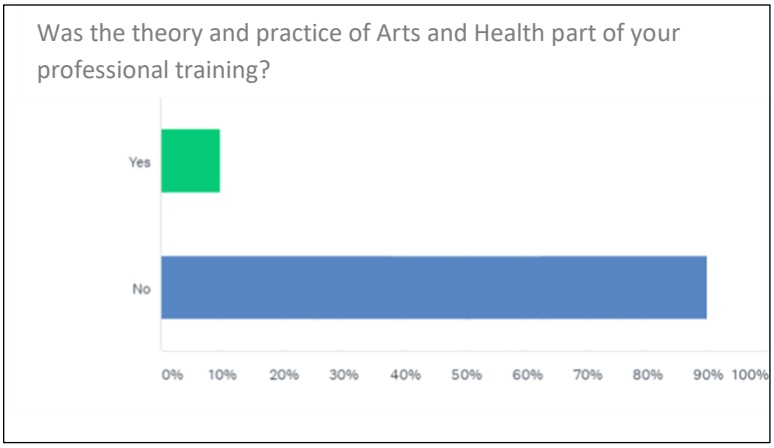
39% had "No Response" to the question on training, that is they chose neither yes nor no. We can only speculate as to the reason for this.

The respondents were also asked if they had been offered training. 22% said yes, and 45% had no response. Again, we can only speculate as to the reason.



The kinds of training offered included "Training around trauma awareness", "worked with an arts group that provide training for working with children", "with create one year - a one day event" and "Working with groups, vulnerable and older adults".

90% of HSE respondents had received no training in Arts and Health.



When we look at these statistics on training side by side we understand why so much of the work depends on "Gatekeepers", the 10% of people in the health setting with a prior knowledge, experience or predisposition to arts or specifically arts/health practice.

There is another interesting interpretation: these statistics when considered side by side suggest the absence of a shared language between the arts and health spheres. A language gap if you will.

On either side of this language gap are groups of highly qualified, professional people. As with all such groups there are issues of status and power associated with qualifications, skills and practice.

In the absence of a shared language of skill and professionalism, expressed through a shared qualification, partnership is inherently problematic, and this is true in any context. As one interview respondent pointed out:

> "I'm taken seriously because of my clinical background. I turn up at the meetings and I know the language to use".

There are a number of practitioners who hold qualifications in both the arts and health spheres and speak about how that allows them to negotiate the work with ease. Likewise, there are qualified Arts Therapists working in this space but for them their practice is not officially recognised by the HSE, despite the fact that sports therapy is. These artists have pursued two independent courses of study (i.e. a medical or nursing qualification and an arts degree, or an arts degree and post grad in arts therapy). However For the majority of artists and front line staff engaged in arts/health projects there is clearly no official, shared professional language, and no place where that language can be developed other than in practice.

Why is this important? Because in the absence of policy the majority of projects are dependent on the discretion of individuals within the health sphere who have a personal interest in, experience or understanding of arts practice.

> "The healthcare side is person dependent, who is actually interested either through deep understanding or just likes it a bit. But they are not coming with resources".

Every interview respondent from the health sphere with experience of arts/health projects spoke of their personal interest or background in or understanding of arts practice.

> "A lot of my colleagues read, and we paint - we may be health practitioners, but we have interests. You just don't hear much about it".

However, as one HSE respondent put it,

> "you can't develop a sustainable sector on personal pre-disposition and discretionary funding", and another "There is no real sense of these things being valuable outside of a personal understanding or empathy"

The absence of a shared language speaks to a need for shared training. Speaking about the training of nurses one respondent pointed out that

> "...as part of the general teaching of nurses and informed by Gestalt Theory underlying programmes... the 'benefits' of arts as part of whole person care and development are taught, but not the competencies to actually implement such programmes themselves. The knowledge is considered the competency. So, arts in health is taught purely theoretically with no practical application element".

However, this theoretical training comes under pressure in the actual workplace

> "Given the pressure the core staff are under now in terms of rapidly contracting resources, student nurses will revert to clinical type within three years. Which means that even though they have the knowledge competencies and the "whole person" ethos, they revert to viewing the person as a patient to be cured and moved through the system"

This "absence of a shared language" creates imbalances in the arts/health relationships, and narrows the conversation, so that artists, care and medical staff don't get to talk about how the practice impacts *everybody* involved in the project.

> ***"In an arts project the staff get to interact in a different way, important to even the playing field"***
>
> ***"There will be a few people who will be open to it but 98% wont - you can't make people like this kind of thing"***

One of the ways to develop a shared language is through real research partnerships between practitioners and academic institutions. Public policy is calling out for evidence and so the opportunity exists to work in partnership with academia - specifically in this instance the School of Nursing at Athlone IT - to develop robust action research projects that explore areas of relevance to all the partners.

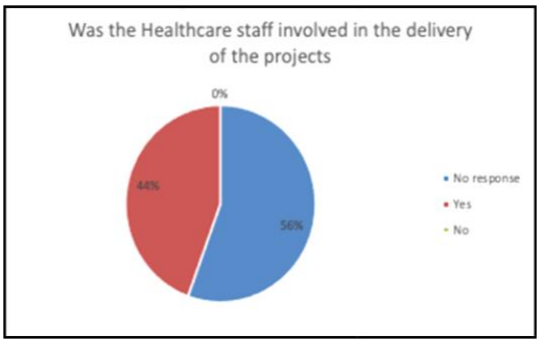
STAFF INVOLVMENT

The term Arts and Health (as opposed to arts "in" or "for" health) is said to represent the idea of partnership between the arts and health practitioners.

One of the indicators of partnership is the extent of health care staff involvement in projects, measured by the extent of their involvement in the design phase, the delivery phase, and in the design and delivery of evaluation methods.

The survey asked the question "was the healthcare team involved in the delivery of the sessions".

None of the respondents selected no, but the majority (56%) gave no response to the question. Again, we can only speculate as to why.



Responses collected in the interviews point toward a definite decline in involvement from health care staff over recent years. Healthcare Respondents cite reductions in staffing levels and other cutbacks, resulting in staff being too "busy" (the negative result of productivity gains in a human context) and focused on purely clinical tasks. This squeeze on time and resources was mentioned and acknowledged by the artists interviewed.

As mentioned in the previous section, this decline in participation by the staff will become a significant obstacle if it is not addressed. In the absence of a shared professional language (as expressed through a professional qualification), the time and emotional pressure resulting from a contraction in time and resources will prevent the development of informal languages and understandings and could create hostility.

> ***"... it seems to have returned to a medical model. Staff pressure is huge, and they have no time to engage"***
>
> ***"I've held sessions in corridors, where people are wheeled out to me".***

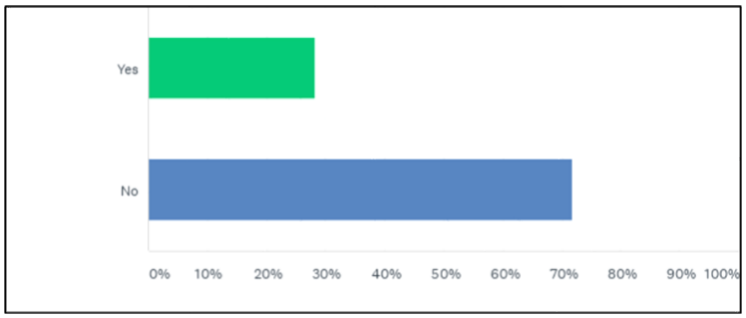
The international evidence[12] mentions the impact of arts programmes on staff morale and retention, and several respondents mentioned the organisational impact of staff choirs they were involved with. There is, of course, a risk in

[12] See Appendix 1

acknowledging these organisational positives in that arts programme could be instrumentalised as a cover for underinvestment (the entertainment will continue until morale improves). Arts/Health practice cannot fill the gaps created by under-investment in health, indeed such underinvestment can only have a negative impact on the practice and provision of arts/health. The strategic challenge is how do we ensure that arts/health practice and provision in incorporated into future investment in health?

HSE staff in the midlands were asked “Do you personally engage in an arts/creative practice in the workplace”

Almost 30% of the respondents answered yes. This can be interpreted in a number of ways, but all of them are positive. At the very least we can argue that almost a third of staff are receptive to the values of arts practice.



When asked what art they were actively engaged with they said:

- Currently working with secondary school in area with a group of our clients to promote communication between different age groups this is in the form of letters art photos music
- Painting / Sculpture / Choir
- Choir
- Visual Psychotherapy
- Arts in Care Programme with Offaly CoCo and Bealtaine
- Arts group for residents
- Choir; also on the board of local arts and health charity
- I am in a workplace choir and I also assist Activities Co-ordinators in some Day Care settings by doing Reminiscence based on songs in Irish and English
- Creativity group and art projects with service users
- Painting - the patients are assisted by a local volunteer artists
- workplace choir
- art group- collage and scrapbooking on inpatient unit
- Workplace choir

It is interesting to note the dominance of music and visual arts here, and it's also interesting to note the familiarity with the language, and the use of “volunteer” artists.

These respondents also identified the following resources within their place of work.

ANSWER CHOICES	RESPONSES	
An Art Room	26.92%	7
A dedicated Gallery Space	15.38%	4
A Visual Art Collection (paintings or sculptures) on display throughout the building	73.08%	19
A Music Room/Performance Space	23.08%	6
Total Respondents: 26		

What do these statistics and responses tell us about the nature and extent of staff engagement with arts/health? We can see that in the midlands, among our respondents, there appears to be a significant visual art presence on permanent exhibition; just under 30% of the staff have some direct personal understanding of the values of art through their own practice, but only 10% have received any formal training or education in practice of arts/health in the workplace.

EVALUATION AND "MAKING THE CASE"

Evaluation is intimately connected to quality and is essential in "making the case". A phrase usually used in the context of proving the value to the health sphere or to the funders.

Evaluation involves a necessary definition of quality and an understanding of the different components that together constitute our understanding of quality. We experience quality when the things we expect to happen actually happen.

Consequently, quality can be understood as the measurement of the gap between what we do and what we had hoped to do. The smaller the gap the higher the quality. (The measurement of the gap is part of the evaluation process).

Consequently, our perception of quality is tied to the definition of the work and our understanding of the purpose of the work. If a partner in collaboration has a different definition or purpose then their experience of quality will be different from ours.

There is a tendency in arts/health to measure the work (is the art good?) and the responses of the participants - they enjoyed it, they looked forward to it, it made them feel "better", or as one of our respondents put it "People come out of themselves and there's a camaraderie and a confidence - it's just FUN!" This rediscovery of self and of social interaction and community is commented on by artists, participants, and healthcare staff.

There are risks if these elements – albeit vital – become the only metrics of evaluation. The principle risk being, can we prove that the "art' or the presence of the artist is the cause of the outcome?

This is a real concern in underfunded and understaffed context, in which any acknowledgement of the patient as a person will have a positive effect. The following comments from participants, artist and healthcare staff illustrate the problem

> "These people (participants) have no connections, and this has a very positive impact. They say to you "it passes the afternoon" rather than sitting there for an afternoon. It's different, it's new and it breaks the boredom"

or

> "Very different story in residential care. That's great! For them just to do anything but sit and look out the window!"

or

> "Something to do during the day"

The question that sits behind these comments is, what's having the impact? The art or the fact that someone turned up and paid attention to them, listened to them, and for a brief moment engaged with them as people and not as patients ? And of course if an arts/health project has a limited duration and engagement how much "impact" can it actually have if it is the only thing that people can "look forward to?".

The short-term project nature of the work, as outlined in the previous section, is identified as one of the most significant constraints on quality, as the comments on the right illustrate.

However, the respondents also addressed the conditions within which the work takes place and the implications of those conditions for the quality of the work, and this brings us back to the questions of underfunding and staff shortages.

"Inconsistency around the projects, delivering them is just too difficult, and they should be a lot longer - 3 to 5-year projects to get traction and impact"

"It was very inconsistent, so I moved on",

"I don't do it anymore - it brings joy but it's fleeting, it's not consistent".

The pressure on staff in healthcare settings has increased following the austerity budgets post financial crash, accelerating an already underlying trend. The situation is neatly summarised in this comment:

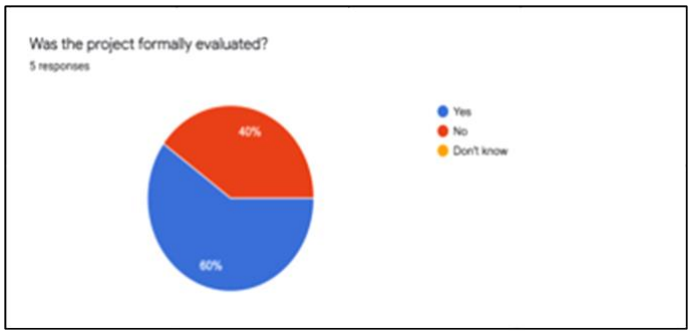
> "People lose energy and get demoralised - culture changes after restructuring. Training is required and staff need to have and make the time. It needs to be perceived as essential, urgent and critical, but the nature of the roles in health staff have changed"

The challenges around quality identified by the respondents are systemic and cultural as opposed to deliberate, and driven by underfunding (in both arts and health) and staff shortages. They reflect also the challenges around status and equality of professionalism between the spheres of art and health, as well as a general practice of outsourcing and "partnership" when it comes to provision of public services.

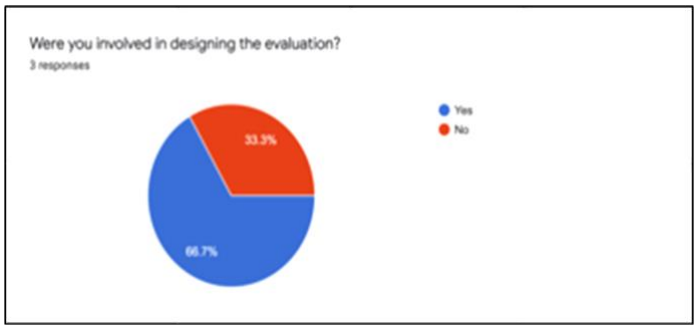
The general experience on the ground is captured in the comment that "People are trying to do this off their own bat - doing great work".

THE PRACTICE OF EVALUATION

60% of the respondents stated that the projects they worked on were formally evaluated.



66.7% of respondents stated that they were involved in the design of the evaluation.



This is important because it is best practice for all parties, artist, participant, and healthcare worker, to be involved in the evaluation; and because collaboration on evaluation will develop a common language and understanding.

The evaluation practices were variously described as follows:

- The project was evaluated by our Youth Support worker... who collated the evidence into a booklet
- I can't remember the whole process, but it involved the clinical nurse specialist and myself.
- Informal evaluation with feedback in final group session
- Feedback after the final session on participants' experience of the group- did it impact their roles, routines, engagement in arts. We normally do an arts questionnaire also but just did not get to do it this year.
- Not yet, maybe in the new year as staff down now to 1 instead of 4.

In terms of what stage in the process the evaluation took place 66% of responses said evaluation happened at the end and 33% said throughout. Overall, these responses on evaluation do not indicate an overly robust evaluation practice.

There is also an almost moral resistance to the idea of evaluation:

> "What are we evaluating - People come from all around the county. They get to know each other, develop a wider circle of friends"

or

> "There was no evaluation - if their eyes lit up that was the evaluation!"

And the more pragmatic understanding expressed as:

> "The main aim of the programme is to get them out of their rooms"

or

> "Try to get them to re-engage and a big part of that is art - not art therapy. So many of them would have some interest in the art".

Interestingly, despite the tension around the practice of evaluation, there was a surprising level of agreement between artists and frontline staff on the impact and value of the work:

> "Then they light up like Christmas trees! It's life happening, allowing people to come alive again"

> "The reward was seeing the impact on participants and musicians, getting the musicians more invested in their music, and then the moments of magic communicating musically with a patient".

> "The impact of this work has been described by the participants/parents/carers as being "so good; amazing; pleasant, relaxed, inclusive. Amazing transformation of the young people".

> "The project allows people to find a cohort"

> "These people (participants) have no connections, and this has a very positive impact. They say to you "it passes the afternoon" rather than just sitting there for an afternoon. It's different, its new and it breaks the boredom"

"The service users say they can relax - they have great trust in (the artist)"

There is a general agreement that the work is good, and a general agreement around what is good about it. However, the indicators mentioned above are all tied to personal responses to social engagement and we have to ask is this the core purpose of the work? What if the purpose of the work was to reduce the length of stay and where possible prevent admission? How would we measure and evaluate that?

> ***"There is no systematic evaluation practiced, and there is no time for formal evaluations. There are other adults in the room (SNAs etc.) but all that means is that support is relying entirely on what's happening in the moment. Data is not being captured over time"***

Part of the challenge with evaluation is that it is seldom factored into the budget in any meaningful way, and real effective evaluation needs full involvement from design through to delivery and analysis from a health staff that is under increasing pressure.

Alongside these challenges there is a tension in the conversation around evaluation, because it is always the art that is required to prove itself. The very idea of asking the healthcare staff to demonstrate the value of *not* an having arts/health programme is considered absurd. This is a cultural as opposed to a rational response.

> ***"The work was evaluated but feedback based, no budget for the evaluation. They like it but we need more case studies. There was no pre-planned***

The "case" can only be made if robust evaluations are conducted, if all partners are engaged in the design of the evaluation, and if all partners are invested in the results of the evaluation.

> ***"There was no evaluation, (it was) suggested...but it was late in the process"***

This requires funding, academic support and - perhaps most importantly - acceptance of professional status between the partners. It is important to move beyond the assumption that "Evaluation, the evidence base, the need to prove the arts - it's just to get past the door!"

> ***"As regards evaluation the staff fill out the form at the end - but some people don't want to take the responsibility or the accountability - so sometimes the form is passed up the line, so the evaluation is flawed''***

According to a medical respondent:

"To me the benefits are obvious (I sing in a choir) in terms of social, intellectual, physical and spiritual. But the benefits need to be clear and included in the process moving forward"

CASE STUDY III - ARTS FOR HEALTH WEST CORK

The Arts for Health partnership programme in West Cork started work in 2005. It takes place in Community Hospitals in Castletownbere, Clonakilty, Dunmanway, Schull, Skibbereen, Bantry General Hospital Care of the Elderly Unit and Day Care Centres in Bantry, Castletownbere, Clonakilty, Dunmanway and Skibbereen Day Care Centres.

It is managed by Uileann West Cork Arts Centre and provides an arts programme for older people in healthcare settings.

The projects run all year round and are delivered by a team of professional artists from different disciplines.

From its inception in 2005 Arts for Health has understood the importance of partnership and collaboration, and the governing partnership was put in place at the very start of this undertaking. Arts for Health brought together **West Cork Arts Centre, Cork County Council, Cork Education & Training Board and HSE**. The HSE is represented through Cork South Community Work Department, Nursing Directors of Community Hospitals and Day Care Centres, Community Services, West Cork and was initiated with the Health Promotion Department.

The programme is delivered by a team of freelance artists contracted and managed by West Cork Arts Centre. These artists have established a close, professional working relationship with the staff and management of each care setting. The artists, each with distinctly different practices, have developed their professional expertise in working with older people and numerous individual and collaborative projects have been undertaken since it began in 2005.

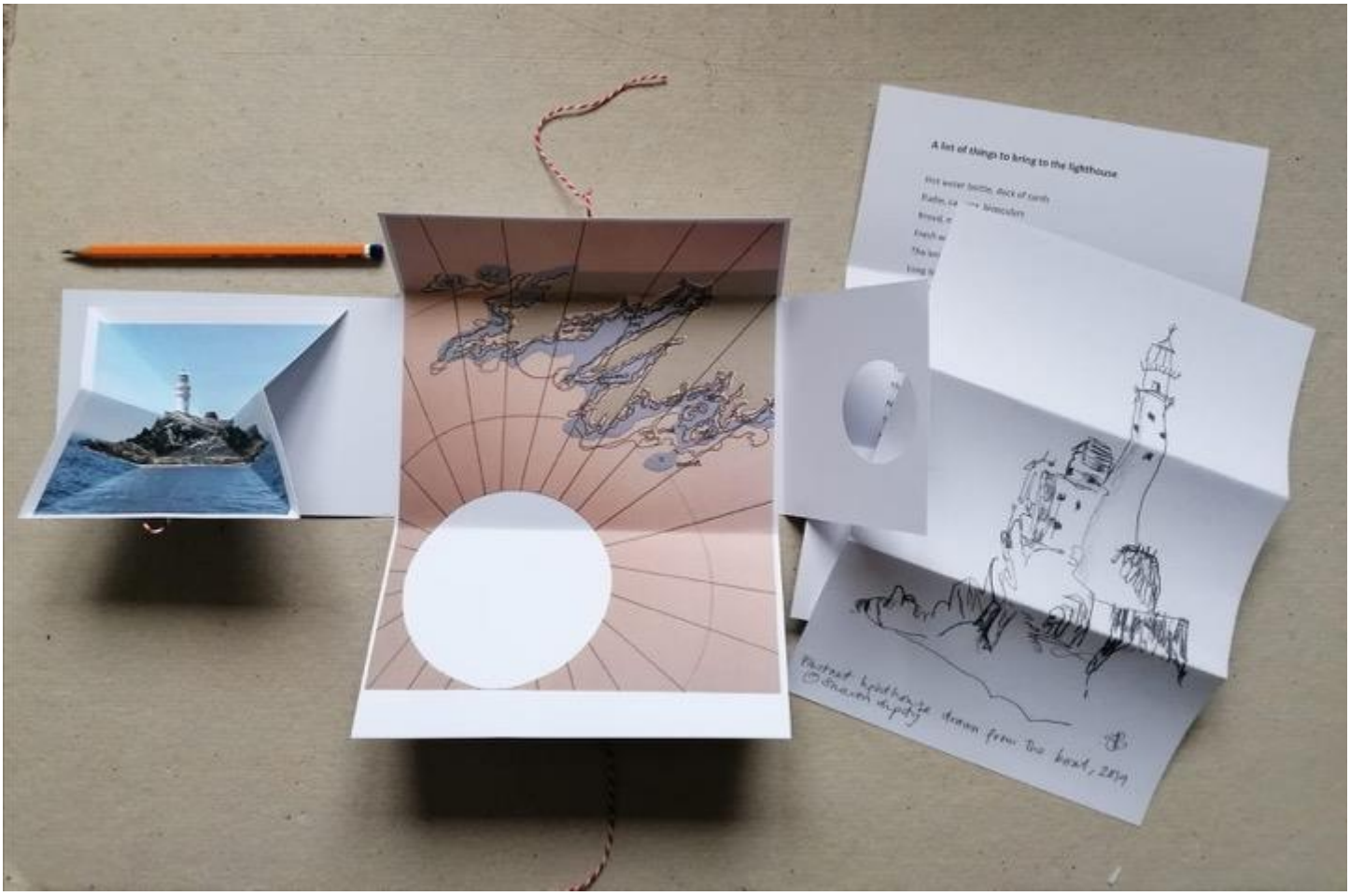
It is interesting to note, in terms of the ecosystem in Ireland, that the HSE made the first move led by a director of Nursing who “got it”.

The representatives from each of the partners all have spending powers within their respective organisations. This, combined with embedding the project within the Arts Centre, is an effective partnership model and a sustainable approach to arts and health provision, demonstrating a proactive way to make best use of locally embedded resources and expertise. The management structure and inter-agency partnership exists to implement, develop and promote the Arts for Health programme in line with the policy objectives of partner organisations.

Over 400 people from community hospitals and day care centres engage with the programme. Everyone in the healthcare setting is welcome to participate including staff, relatives and visitors.

The idea of ongoing learning for everybody involved is central to the work, and as learning needs are identified - for participants, artists, healthcare professionals, management and advisers. - appropriate solutions are put in place including peer to peer learning, mentoring, placements training days, conferences, accredited courses and network meetings.

Arts for Health West Cork is model of best practice in collaboration between multiple partners and project delivery. It is interesting that it reflects the experience and insights of Arts for Health at MMU, that that success and sustainability are driven by the health side of the equation and by the desire to embed arts into service delivery, and the anchor institution in the partnership is often an actual place/hospital. The development of Arts for Health West Cork also clearly illustrates the importance of the "Gatekeeper" in the development and sustainability of projects.



THE POLICY FRAMEWORK

All creative health work occurs within a policy framework. Artists, arts managers, and their healthcare partners in the midlands develop and deliver their programmes within a complex policy environment. It is policy that ultimately decides what kinds of activities are valuable, what will be supported and developed, what partnerships and collaborations are favoured, and what funding will be allocated in an ongoing and sustainable fashion.

A number of strands around policy emerged in the course of the conversations. The fundamental thrust of the comments is that without Policy there is no budget line and no mandate or permission. There is also the risk that other, related policies will instrumentalise arts/health for immediate or short-term gain.

The point was made repeatedly over the course of the pandemic the arts have proven their value in the care context and are now pushing an open door. There may be truth in this, but it comes with a caveat. As a senior policy maker commented, "that door won't be open forever and the money is short term".

Professor Clive Parkinson of Arts for Health at the University of Manchester played a key role in the development of arts/health practice in the UK over the last twenty years. He ascribes the success and growth in the sector to sustained lobbying and advocacy at the highest levels of government and the emergence of specific policies and memoranda of understanding.

The University Hospital Cardiff and Vale have attested to this point, stating that "Much of what we do is possible because of an MOU with the Welsh government"

The Arts Council and the HSE have worked hard since 2008 to develop a joint Arts and Health Policy, but this has been delayed by re-organisations within the HSE. At the time of writing an MOU has been agreed but not published.

The publication of the MOU is a vital development, as there needs to be a stronger mandate in the HSE, so that arts in terms of both practice and provision becomes normalised. The HSE also requires its own, internal policy on arts/health. As one senior respondent phrased it

> "Ultimately the HSE needs to have a budget line - cos the work on the ground is amazing - but people need policy. And ultimately the HSE need a budget line".

And another

> "An effective policy is a permission slip for the HSE, but we need to understand the extreme demands on the healthcare staff"

And

> "We need to get this at policy level with a budget line, so it goes beyond any one person in the role"

The arts/health work in the Midlands is influenced by Arts Council, Local Authority Community and development plans, and arts and culture plans, Creative Ireland, and The Department of Health primarily through Slainte Care and Healthy Ireland.

The question is whether the policy frameworks for health and arts overlap or speak to each other in any significant or actionable way at this present time. [13]

There is a risk that valuable work can be lost in a proliferation of policies. On the other hand, policies set priorities, perceptions and budget lines. If there is no specific policy for something, or if something is not specifically mentioned in policy then it will not be entertained or funded in an ongoing and sustainable way.

While this is true in general for organisations it is especially true in the realm of public goods and public value (Health, education, culture etc.). Indeed, we could argue that the proliferation of policies in the public goods arena (and the frequency of their production) can sow confusion, disrupt activity, reduce or dilute investment and prevent scale and sustainability. As one health respondent commented, the presence of Creative Ireland in the Healthcare space is driving a lot of activity, but that activity is being driven by the money, and will cease as soon as the Creative Ireland project ends.

[13] It is important to point out that the HSE, Arts Council and Creative Ireland have produced an MOU toward future co-operation. Although this MOU was not available/published at the time of writing, it signifies a major step forward. As a number of international respondents pointed out, the sustainable development of practice, provision, working conditions, and infrastructure for a sustainable Arts/Health sector is dependent on policy agreement and commitment between the principle partners at the highest level of government.

In short, the complexity of the policy environment is more than a simple bureaucratic irritation - policy informs budget allocations and action plans, and that which is not specifically mentioned in policy is in danger of becoming, or continuing to be, discretionary and marginal - nice to have but not essential. Consequently, the work that is developed and supported will be dependent on personal relationships and the preferences and prior knowledge of key gatekeeper figures such as Arts Officers or Directors of Nursing, or healthy Ireland Co-ordinators.

What follows is an analysis of relevant policies in both Arts and Health. The purpose is to tease out the current placement and understanding of Arts/Health within this complex web of policies in order to identify gaps, obstructions, potential development pathways and required actions.

('This is Me' 2022 Birr Community Nursing Unit book launch. An Anam Beo project0

THE HEALTH ACT

Healthcare in Ireland is shaped by the The Health Act 1970, recently revised and updated to November 2020 and incorporating a group of acts from 1947 to 2020. The language of the Act is concerned mostly with eligibility and costs, with who can and cannot access what care, and what charges will be levied. The Act makes no mention of healthcare or related rights despite Ireland being a signatory to the International Covenant on Economic, Social and Cultural Rights.[14] Article 12 of that Covenant states clearly that medical treatment in the event of sickness is a human right, and that everyone - regardless of insurance - has the right to enjoy " the highest attainable standard of physical and mental health"

The "highest attainable standard of physical and mental health" suggests a whole of person approach, which must include by definition supporting the cultural rights of people in a care system.

The absence of rights - other than patient rights - from the Health Act was pointed to by a number of respondents, identifying the absence as causal in the wider culture of Irish Healthcare, and it's favouring of the "Medical Model" of care.

All of this is concisely captured in the Slaintecare report which states "In Ireland, there are virtually no universal entitlements to healthcare, and the 1970 Health Act only sets out eligibility for some services. (op.cit. pg 15)"

SLAINTE CARE

The Department of Health website describes the Slainte Care strategy as transformative, promoting " a healthcare system where the majority of services are delivered in the community and access is based on need, not ability to pay". (This widens the definition of what is and is not a "healthcare setting" and opens the potential for a wider use of social and cultural prescribing).

The Slaintecare report (op. cit) received submissions form several arts organisations - including Helium Arts - and there are significant opportunities in the language of the original report. However, there are six references to "art" in the report, all in the appendices and all referring to the submissions made by relevant organisations. There are fifty-eight references to wellbeing, one reference to creativity ("Communication that facilitates information flows is critical, especially information hard to share, as is time for reflection and creativity, learning new capabilities and establishing new capacity within and between organisational units. This form of capacity-building needs proactive action"), and one reference to

sport: ("For older children, ages 11-17, being from a more affluent family is correlated with rating one's own health as good, having higher life satisfaction and self-confidence, being more engaged with hobbies, doing more sports and belonging to clubs, having higher fruit and vegetable consumption, eating breakfast regularly and being less likely to be the victim of bullying.")

The Slainte Care report is a revolutionary approach to healthcare provision in Ireland. It is focused on patient needs, acknowledges structural inequalities and pressures in the current system, focuses on the wider social determinants of health, and aspires to deliver a modern European model of healthcare delivery.

It does not specifically address or include arts practice or provision as key elements in Health prevention or management.

Slainte Care's radical approach opens up an opportunity for practice-based research into "examining...the operating assumptions on which health policy and health services are based" and a meaningful cost benefit analysis into Arts/Health practice.

This is an important opportunity and requirement as the cost benefit argument is perceived as "anecdote rich but data poor", (WHO 2019), however

> New evidence is emerging that demonstrates that these programs also have an economic benefit. Data show that such programs result in patients requiring shorter hospital stays, less medication, and having fewer complications—all of which translates to a reduction in healthcare costs. ... hoped that future analysis of the economic benefits of arts in healthcare programs will advance policy conversations about using the arts to simultaneously reduce health costs and raise the quality of care. (ibid. Pg 1)

> In addition, research shows that the arts can reduce patients' use of pain medication and length of stay in the hospital and improve compliance with recommended treatments—offering substantial savings in healthcare costs. (Arts in Healthcare, 2009 Pg. 2)

At the most basic level of staff morale and recruitment costs, the work by Staricof et al (2001, 2003) demonstrated that "an active arts program integrated into the healthcare environment was found to be a major consideration for healthcare staff when seeking employment or considering whether to remain in their current position. Arts programming can create a less stressful work environment for nurses and other healthcare professionals".

Slaintecare, with its emphasis on patient wellbeing, operational redesign etc opens the door to the arts to play a significant role in cost reduction, whole patient care and reimagining of the health care provision.

The report also acknowledges that

> "Primary care and general practice are also facing a manpower crisis. As we reorient our health services towards primary and social care in our community the recruitment and retention of existing general practice and primary care professionals will be essential if our new reformed health service is to have a solid foundation (Slaintecare, 2017pg 12).

There are two points to be made here: first the manpower crisis is being felt on the ground in the midlands by artists working in health settings. For those with experience pre and post financial crisis the difference is palpable. Specifically, the nursing staff have less time to engage with the projects on site, marginalising the work and reducing their awareness of its benefits, and adversely affecting the formal relationship between the artist and the care setting.

The second point is that the evidence needs to be presented that Arts in Health is as much about the health and well-being of the medical staff as it is about the patients, and that this perspective plays a major role in staff health and well-being and overall organisational morale, staff retention and development.

Slainte Care further commits to a model of integrated care, that is "... planned and provided so that **the patient is paramount** (ensuring appropriate care pathways and seamless transition backed-up by full patient record and information"

In essence, Slainte Care' s ambition is to create a national health service for the 21st century, and acknowledges that such a service needs "to deliver the 'triple aim' of health systems by improving care, improving health and reducing costs". (pg 18) where 'Healthcare (is) delivered at the lowest appropriate level of complexity through a health service that is well organised and managed to enable comprehensive care pathways that patients can easily access and service providers can easily deliver. This is a service in which communication and information support positive decision-making, governance and accountability; where patients' needs come first in driving safety, quality and the coordination of care.' pg. 19

Slainte Care provides arts in health practitioners with the key strategic questions: how does our work improve care, improve health and reduce costs? And how does our work contribute along "comprehensive care pathways".

HEALTHY IRELAND

The funding for Healthy Ireland is managed through POBAL, and the aim of the fund "is to support innovative, cross-sectoral, evidence-based projects and initiatives that support the implementation of key national policies in areas such as obesity, smoking, alcohol, physical activity and sexual health".

The funding strands are closed calls and are channelled through Local Community Development Committees and Children and Young People's Services Committees.

The programme of events is decided by the Healthy Ireland subcommittee in each local authority area and managed by the Healthy Ireland Co-ordinator.

Specifically, within the midlands area it was commented on that the presence of artists/arts managers at the public consultations was not significant and that it is necessary for the arts to have a representative on the sub-committee to advocate for arts projects.

The original Healthy Ireland document set out a vision of a healthy Ireland "...where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility"(A FRAMEWORK FOR IMPROVED HEALTH AND WELLBEING, 2013)

Healthy Ireland is designed "to bring about real, measurable change and is based on an acknowledgement of the social and personal determinants of health. Health and wellbeing are affected by all aspects of a person's life; economic status, education, housing, the physical environment in which people live and work. Health and wellbeing are also affected by policy decisions taken by Government, the individual choices people make about how they live, and the participation of people in their communities" (ibid)

It aims to achieve this change by building effective "cooperation and collaboration across Government, the health system and other relevant areas. It is about each individual sector helping to improve health and wellbeing, multiplying both our efforts and our results".(bid)

Healthy Ireland makes no specific mention of the arts or arts practice in this context. There are no mentions of art or artists throughout the report, 1 mention of creativity ("Healthy Ireland is designed to harness the energy, creativity and

expertise of everyone whose work promotes health and wellbeing, and encourages all sectors of society to get involved in making Ireland a healthier place to live, work and play), and 1 mention of Culture ("Healthy Ireland aims to support a working culture within the health service that prioritises cross-sectoral partnerships and collaborations".) and 5 mentions of sport. (ibid)

In keeping with the social determinants of health model it locates much of the responsibility for health and well-being in "the formal health sector", stating that a great deal of health and wellbeing is dependent on wider factors including "clean air and water, better housing, safer roads, safer food, safer workplaces, actions to address poverty and inequality"

As a policy document Healthy Ireland is built on economic justifications and a sense of economic urgency.

> Health comprises the second largest component of public expenditure in Ireland after social protection. From 2000 to 2009, the Irish public healthcare spend more than doubled in real terms to €15.5 billion per annum…. Chronic diseases and their risk factors are major drivers of healthcare costs, as well as associated economic losses. (ibid)

Even when the discourse spreads into the realm of the public good, the rationale remains strongly economic

> Health is a personal, social and economic good, and the health and wellbeing of individuals, and of the population as a whole, is Ireland's most valuable resource. A healthy population is essential to allow people to live their lives to their full potential, to create the right environment to sustain jobs, to help restore the economy and to look after the most vulnerable people in society.

The cost/benefit argument seems to be clearly understood, if overly instrumental

> Proven economic benefits flow from having a healthy society. Prevention at the population level results in better value, increased productivity and improved quality of life. Unless we change course, healthcare will become unaffordable for society and for the country. pg. 12

The implementation framework for Healthy Ireland is designed on a participation model, and calls for joint action between "Government Departments, local authorities and public bodies, businesses and employers, sports and voluntary groups, communities and families". (ibid)

The report expressly states that It is beyond the capability of any one Government Department or organisation to promote society wide health and wellbeing. This can only be done through society-wide involvement in and engagement with health and wellbeing promotion and improvement activities - from individuals making positive lifestyle choices and projects run by community and local groups, to policy and legislative changes at the highest level of government".

It is important to note that the Healthy Ireland list of partner organisations does not include the Department of Arts/Culture or the Arts Council, but it does include the County and City Managers Association and The Irish Sports Council.

The programme is built on a "Framework of Actions" that include

- Partnership and cross sectoral work
- Empowering People and Communities
- Health and Health Reform
- Research and Evidence
- Monitoring, Reporting and Evaluation

The programme also calls for a focus on research, to ensure that programmes and funding decisions are based on " robust evidence about the determinants of health and best practice approaches in addressing them" (ibid)

The Healthy Ireland framework offers a range of opportunities, specifically with its emphasis on Partnership and Cross sectoral work, Empowering People and Communities and Research and Evidence. Specifically, the requirement that **All public sector organisations and workplaces will...promote and protect the health and wellbeing of their workforce, their clients and the community they serve. These commitments will be detailed in corporate, strategic and/or business plans"** (ibid)

Healthy Ireland acknowledges that creating a healthy population is a complex problem that requires the development of relationships between "Partnerships – between Government Departments, across sectors or within the community – are essential to the full implementation of the Framework".(ibid)

CASE STUDY IV - KILDARE

The arts in health programme in Kildare is one of the longest running local authority arts and health programmes in the country. It was also one of the first to embed arts in health within a County Development plan.

The development of the programme can be traced back to the capital development programme at Naas General Hospital in 2003. The project manager for the development implemented the Per Cent for Art Scheme, and this supported a number of arts initiatives at the hospital including a public art commission and creative writing workshops.

The hospital established a voluntary multidisciplinary arts committee in 2004.

The following year Kildare County Council identified Arts in Health as a key area for development and committed the Council to "continue to identify, advocate for, influence and provide support for artists and agencies involved in art and health practice." It also identified the need to develop "inter agency" development of Arts/Health programmes, and this led to the establishment of the Kildare Arts in Health Steering Group in 2008. A key element of the plan was the appointment of an Arts in Health officer.

The steering group was essentially a partnership for the arts composed of artists and representatives from a variety of agencies in the health, disability and community sectors. It identified the need for networking between professionals within the arts and within healthcare to 'encourage information and experience exchange, and to promote high standards'.

The Arts Service of Kildare County Council committed to the ongoing facilitation of the Arts in Health Steering Group to

- Promote and support inter-agency collaboration and partnership for Arts in Health projects
- Provide opportunities for statutory bodies, voluntary agencies and artists to exchange information, experience or skills for mutual support and benefit
- Inform the development of a sustainable Arts in Health programme in County Kildare
- Training and support for artists as an integral part of Arts in Health projects
- Training programmes for healthcare staff to develop, support or facilitate sustainable arts programmes
- Training for both artists and healthcare staff which informs them of each other's practice, expertise and role
- Training for service users across art forms, including accreditation, where possible

Central to the development of Kildare's Arts in Health Programme is the anchor tenant partnership with Naas General Hospital. Although the HSE's budget contribution is anecdotally about 10% of the project, the ongoing relationship supports the development of practice and lends credibility to the programme.

There are two immediately relevant pieces of legislation; the Arts Act (2003) and the Local Government Act (2001).

The former establishes the Arts Council as an authority on the arts with a mandate to make the public aware and interested, and the Local Authorities are mandated to create a development plan for the arts within their jurisdictions but are under no statutory obligation to fund or otherwise resource that plan.

The Arts Act (2003) sets out the definition of the Arts as follows, '…any creative or interpretative expression (whether traditional or contemporary) in whatever form, and includes, in particular, visual arts, theatre, literature, music, dance, opera, film, circus and architecture, and includes any medium when used for those purposes;' and goes onto to define the role of the Arts Council as

> 9.1. (a) stimulate public interest in the arts,
>
> (b) promote knowledge, appreciation and practice of the arts,
>
> (c) assist in improving standards in the arts,4

The Arts Act mandates local authorities as follows

> "6. (1) A Local Authority shall, for the purposes of section 67 of the Act of 2001, prepare and implement plans for the development of the arts within its functional area and shall, in so doing, take account of policies of the Government in relation to the arts.
>
> (2) A Local Authority may provide such financial or other assistance as it considers appropriate to such persons or in respect of such activities, projects or undertakings, for the purposes of:
>
> (a) stimulating public interest in the arts,
>
> (b) promoting knowledge, appreciation and practice of the arts, or
>
> (c) improving standards in the arts, within its functional area[15].

[15] There are five other functions (d – h) related to its function as an advisory body to advise, assist, furnish advice or information to the Minister or to other public bodies

The Local Government Act mandates arts plans but does not mandate a spend. However - and this is vital - spending may occur if it benefits the community. The act does not enumerate those benefits or establish a method of measurement.

ÉIRE ILDÁNACH - THE NATIONAL FRAMEWORK CULTURE POLICY. CULTURE 2025

This - the first Culture Policy - underpins the work of Creative Ireland. Éire Ildánach (and Creative Ireland) have been instrumental in shifting the policy discourse from Arts to Culture, and driving the Creative Industries model across government thinking. The ramifications of this shift are still playing out, however in policy terms the arts now sit within a contemporary understanding of culture, absorbing professionalism and excellence in art form, creativity and participation for everybody, and reframing these within a cultural and creative industries model.

For our purposes here we should appreciate that Culture 2025 is a framework that "defines the scope and sets the direction for Government policy in the whole cultural field", including specific aspirations and commitments.

The core strategic aspiration of Éire Ildánach is "...to ensure a unified and coherent approach to cultural policy across government and to planning and provision across the cultural sector." (Echoing the aspiration in Slainte Care for HiAP (Health in All Policies))

Éire Ildánach is driven by three fundamental principles:

1. Recognising the value of culture and creativity to the individual and society
2. Supporting creative practice and cultural participation
3. Cherishing our cultural heritage

And shaped by eight "key values" including

- The value of arts, culture and heritage to our lives and our communities.
- The right of everyone to participate in the cultural and creative life of the nation.
- The value of creativity to individual and collective wellbeing.[16]

[16] the other five being: The intrinsic value of culture; The importance of the Irish language, our cultural heritage, folklore, games, music and the uniqueness of our Gaeltacht areas; The value of cultural diversity, informed by the many traditions and social backgrounds that constitute contemporary Ireland; The value of culture as a means of fostering a more sustainable future for Ireland, including through economic, environmental and social policy; The value of culture in presenting Ireland to the world

Interestingly, there is no specific mention of health or healthcare (just as we find no specific mentions of arts or creativity in Health Policy), but there is an emphasis on wellbeing and creativity.

CREATIVE IRELAND

Creative Ireland, originally conceived as the implementation vehicle for Culture 2025, is currently described as "... a five-year Programme which connects people, creativity and wellbeing".

In keeping with Culture 2025's ambition "...to ensure a unified and coherent approach to cultural policy across government and to planning and provision across the cultural sector" Creative Ireland functions as "...an all-of-government culture and wellbeing programme that inspires and transforms people, places and communities through creativity". Culture Ireland is adept at forging effective and practical partnerships at the highest levels of government.

Most importantly for our purposes Creative Ireland is "... committed to the vision that every person in Ireland should have the opportunity to realise their full creative potential".

Creative Ireland works closely with local authorities in the delivery of its programmes. Perhaps because of its size (it is a programme office within the Department) it is agile, fast-moving and responsive.

In 2020 Creative Ireland worked with an array of partners including Healthy Ireland, the HSE, Local Government Management Agency (LGMA), Libraries Ireland, and the Arts Council.

In their review of 2020 Creative Ireland have stated that

> Interventions based on arts, culture and creativity in community and healthcare settings have been shown to improve people's health, and to contribute to the prevention of a variety of mental and physical ill health as well as the management of a range of long-term conditions. Such interventions are often low-risk, highly cost-effective and can help staff in their work. There is an emerging awareness in Ireland that approaches based on arts, culture and creativity can make a significant contribution to addressing a number of the pressing issues faced by our health and social care systems. However, as with many issues straddling the intersection between very different professional sectors, the process of cultural change can be challenging. The all-of-Government Creative Ireland Programme is committed to supporting this process of change.

In terms of the Policy environment for Arts Health in the Midlands and nationally this is a vital development. Interestingly their initial partnership discussions with Healthy Ireland focused on creativity and mental health outcomes and concluded that "a particular focus on older people would yield early progress".

This led to the development of The Creativity in Older Age Scheme and partnerships with Age and Opportunity, the Irish Hospice Foundation, the Irish Longitudinal Study on Ageing (TILDA), Waterford Healing Arts Trust (WHAT), Irish Museum of Modern Art (IMMA), Mercer's Institute for Successful Ageing at St James's Hospital (MISA) and Sing Ireland, leading to creative initiatives into over 250 hospitals and residential care facilities.

Creative Ireland also operates the *Creative Health and Wellbeing* initiative. The initiative "seeks to ensure that diverse, well-informed and sustainable forms of creative interventions focused specifically on improving health and wellbeing are available and accessible in community and healthcare settings".

The focus of Creative Health and Wellbeing is on:

- **Ensuring recognition** of the health and wellbeing benefits and value from creative engagement;
- **Strengthening collaboration** between the sectors involved in arts, culture, creativity, social care and health; and
- **Developing positive health and wellbeing outcomes** by delivering well-informed and sustainable creative interventions.

Creative Ireland's commitment to collaboration and culture as an all of government concern make it an essential partner in the development of collaborative partnerships. Brokering these kinds of partnership is what Creative does extremely well.

THE ARTS COUNCIL: MAKING GREAT ART WORK

The Arts Council's strategic plan is built on two core priorities: 'The Artist' and 'Public Engagement'. These priorities are supported by the pillars of 'Investment Strategy' (to invest public money effectively to realize the Council's priorities); 'Spatial and Demographic Planning' (to benefit people across Ireland) and 'Developing Capacity'.

Within the framework of Making Great Art Work the Council issues specific sector policies, including an Arts in Health Strategy in 2010. A new Arts in Health strategy is expected in the near future.

The strategy sets out a definition of Arts and Health as "...a range of practices occurring primarily in healthcare settings, which bring together the skills and priorities of both arts and health professionals. Good Arts and Health Practice is characterised by clear artistic vision, goals and outcomes. Alongside these it aims to promote health and wellbeing by improving quality of life in healthcare settings"

The strategy identifies a range of sites ("hospitals, residential units, day-care centres, primary care centres, and community settings as well as...arts venues") and points out that arts and health involves "health service users of all ages and abilities, their carers, visitors and healthcare staff".

The strategy also makes the vital point that Health venues are important access points to the arts for a very large part of the population, as every member of the population uses or visits a health venue at least once a year.

The strategy draws a number of key distinctions between Arts and Health and Arts Therapy and Arts and Health and Arts and Disability. In the former case the distinction is around intent: the primary goal of arts and health is the experience and production of art, whereas the key goal of art therapy is clinical. In the latter case the distinction is that arts and health

incorporates both artistic and health aims, whereas arts and disability is “focused exclusively on the engagement and involvement of people with disabilities in the arts”

The strategy allows for the crossover of Arts and Health with “any number of other arts practices such as: community-based arts; arts and medical humanities; and arts and science”.

Following on from these definitions the Arts Council strategy is built on three pillars

- The Promotion of Arts and Health at National Level
- Resources and Supports
- Partnerships

The strategy also lists six underlying values, which are worth repeating here:

1. Long term strategic partnerships and planning
2. Integration into the healthcare environment
3. Monitoring and Evaluation
4. Engagement with professional artists and in high quality arts experiences
5. Inclusive participant centred approaches
6. Documentation and dissemination

Again we see the importance of partnership and long term strategic planning and – echoing the learnings from Arts for Health at MMU – the need to integrate work into the healthcare environment.

LOCAL AUTHORITY PLANS

Rather than provide a detailed summary and analysis of each individual plan, this section will identify key themes, similarities and relevant actions.

Of the plans analysed for this section there is one specific reference to arts and health practice and provision. The Offaly Arts Strategy, Inspire Imagine Involve (www.offaly.ie, 2018) explicitly mentions Arts and Health, specifically in relation to Annam Beo, listing their work as one of the strengths in the SWOT analysis

> Anam Beo for their delivery of excellent in context arts in healthcare settings

And stating that they will

> Support Offaly's Arts, Health, and Wellbeing organisation, Anam Beo, reach its full potential for the delivery of high-quality arts engagement programmes in healthcare and other community settings (op.cit.)

Apart from that very specific mention of arts/health practice and provision the arts strategies and cultural strategies of the three partners display key common themes.

- An ambition for arts and culture to be seen as integral to quality of life.
- A desire for excellence in arts practice
- Developing Capacity
- Working in Partnership

The Local Community and Development plans tend to be more specific in terms of both arts and Health, with a greater emphasis on health. In general, these plans have much in common with the following themes emerging

- Job Creation
- Integrated development
- Vibrant, sustainable, inclusive communities
- Protection of the vulnerable
- Quality of life (wellbeing)
- Physical and Mental Health
- Poverty
- Age Friendly Communities

All Local Development plans mention Healthy Ireland and Age Friendly Ireland.

It is worth noting at this point that Athlone Institute of Technology is specifically mentioned in Westmeath's local development plan, with the ambition being that

> AIT will be a technological university distinguished by outstanding learner experience, international focus, distinctive regional contribution and high-quality impact of its staff, teaching, **applied research** and innovation. (p24)

POLICY CONCLUSION

The policy environment in the midlands is complex. What emerges from all of these plans is that different policies reflect different organisational priorities and positions

> "With regards to the existing arts council policy in Arts and Health the council are driven by the need to "Validate the professional Artist" and this can lead to a lack of necessary equivalence between excellent product and excellent process. At the heart of Arts and Health practice is people, and we need to appreciate and understand the transformative potential of art".

> "Healthy Ireland is amazing, but it's a case of ads speaking change versus cultural change - one is slow, and the Government want a quick win".

There are many opportunities within this policy environment in terms of support for long term strategic partnerships that deliver on mental health, wellbeing, patient centred interventions, research partnerships and more. The challenge is bringing the priorities of the different policies together into a single policy, a single statement of purpose that is focused on the people on the "healthcare journey", and is ambitious, supported by multiple agencies, and focused on long term sustainability.

Without a shared policy focus the work will always be project based, short term and underfunded, constantly responding to indirectly related priorities.

> "In developing this work in a sustainable fashion, we need to think in terms of longevity and sustainability - not just following the short-term money".

CONCLUSION

There is no question that there are artists and organisations across the midlands capable of delivering quality arts/health projects. The challenge is how to strategically manage the complexity of the environment in order to maximise the available resources to deliver a sustainable art in health care programme that benefits all people in health care settings at all points of the health care journey.

As one respondent put it, lock down has “opened a lot of people’s eyes about the value of arts practice in the context of health and wellbeing, and at this stage artists should be pushing an open door”. While this may be the case, but once we pass through that door many respondents made the point that it is vital that we take a “seat at the table” and make our voice heard.

(Pauline Stronge's Billboard image with other 'Still Lives, Still Alive' group Photographic Arttist Veronica Nicholson May 2022. An Anam Beo project)

APPENDIX I

> "There is an expanding body of evidence to support the contention that the arts have an important contribution to make to health and well-being. Currently the evidence is unevenly distributed across the field, is of variable quality and is sometimes inaccessible" (NHS 2018)
>
> "The review found evidence from a wide variety of studies using diverse methodologies. Overall, the findings demonstrated that the arts can potentially impact both mental and physical health. Results from the review clustered under two broad themes: prevention and promotion, and management and treatment." (WHO op.cit.)

There two quotes illustrate a challenge in talking about Arts/Health: what we see may depend on where we are looking from. For the NHS the evidence is still "unevenly distributed ...of variable quality and ...sometimes inaccessible", but for the World Health Organisation the findings demonstrate "that the arts can potentially impact both mental and physical health". Both sound a note of caution, and both are treating the evidence from their own particular perspective. This is an observation and not a criticism.

The quality of arts/health research has grown considerably over the last 25 years. The World Health Organisation's comprehensive review identified almost 4000 pieces of published research in English and Russian alone (ibid).

It is beyond the scope of this report to evaluate such an extensive body of research, and so this review is primarily a meta review, relying on existing literature reviews conducted over the years.

The key finding from the review is that the research literature, and especially the reviews of that literature that have been conducted over the last twenty-five years have different remits, were undertaken for different purposes, and from different perspectives. Some of the reviews are focused on building a compelling case for arts/health from the perspective of the artist; others come from a more medical and scientific perspective and tend to be cautious in their conclusions, raising issues around research models and evaluation practices, and calling for more research; others come from a policy perspective - such as the recent WHO report - and can be described as instrumental, concerned with the potential role of the arts as an input into policy delivery, and accepting that while more research is required sufficient evidence exists.

The role of the social determinants of health is common across all the reviews considered here, to varying degrees. This ranges from the argument that the effectiveness of arts/health projects or arts therapy depends on other external factors in the care setting, to the idea that the effectiveness of arts on a person's health and well-being is tied to socio-economic factors.

What emerges from all these reviews is that art is part of a complex system of health and well-being. The model of that complex system varies depending on whether you view it from the arts, medical, or policy perspective. Consequently, understanding and appreciating its role in that system can prove challenging for all potential partners.

What is Arts in/and/for Health?

Dr, Hilary Moss, who has over 20 years' experience in Ireland's arts/health sector as artist, academic, project manager and researcher writes that "...the activities encompassed by arts/health range from "receptive involvement" (e.g. reading, listening to music) to active participation (e.g. performance, painting, and dancing)" (Moss, 2016). When we consider what qualifies as art/health we can see that its practice ranges from simple environmental enhancement (exhibitions, design) to actual clinical interventions (such as singing in acute wards to reduce blood pressure, heart rate and related stress and anxiety), to supporting staff wellbeing and morale through workplace choirs, creative writing and other projects.

Arts/Health also includes arts therapies, community arts work both therapeutic and educational, arts in end of life care, the medical humanities and arts in medical education and narrative medicine (Moss, 2016, citing Brener 2003,Dileo & Bradt, 2009).

The Arts Council of Ireland's *Arts and Health Policy and Strategy* identifies two distinct strands of practice, or "groups of Arts and Health practitioners" (Moss, op.cit.), namely artists and arts therapists. The council differentiates these practices, saying "There is a clear distinction between arts and health practice, where a key goal is the experience and production of art, and the arts therapies, where the primary goal is clinical" (Arts and Health Policy and Strategy, n.d.).

A new Arts Council Arts and Health Policy is pending, and it will be interesting to see if this key differentiation will change. As it stands it can be argued that this differentiation is primarily a policy difference (the arts council is rightly concerned with protecting the professional status and power of arts and artists, whereas therapists are concerned with clinical objectives and are therefore not really artists). The question we can ask here is what happens when the primary goal is the health and wellbeing of the participant, as opposed to protecting the relative power and status of the partners? The issue of the blurred line between art as art and art as therapy was raised in the course of the interviews, and it seems that the distinction is not always clear.

This is an important question because it is a common theme in the research that health, wellbeing, and quality of life are reliant upon interconnections between physical, psychological, and social functioning (Thomson, Ander, Menon, Lanceley, & Chatterjee, 2012, quoted by Moss, 2016). Given these complex interconnections it is not always clear what is causal and what is correlated, what is practice dependent and what is relationship dependent - is it the art, the therapy, the person, or the fact that the patient has something to do that is related to their identity as a person (and not a patient) that drives the health outcome? Or is the outcome dependent on a constantly changing interaction between these and other factors?

From the medical perspective it seems that there are questions over the relative absence of research that can clearly identify cause and effect relationships. (NHS op.cit.)

There has been a proliferation of national agencies in the arts/health space over the last 25 years (Waterford Healing Arts Trust, Arts for Health at Manchester Metropolitan University, The Australian Centre for Arts and Health, Arts in Health Australia, National Organisation for Arts in Health to name a few) operating mostly as advocacy, networking and resource organisations. However, the majority of arts/health projects are developed by artists without payment for the development phase, and dependent for delivery on key staff (usually Directors of Nursing) within specific healthcare settings who "get it" (that is they are predisposed for personal reasons to arts/health practice). As the NHS review (ibid) put it "...a lot of arts in health work happens at grass roots levels, in community-based programmes that address both the clinical and social determinants of health".

There is an element of euphemism in the phrase "grass roots level", as it describes a situation where project development is unpaid, project duration is short (six weeks to three months), projects are stand alone with no built-in sustainability or scalability. There are additional problems with evaluation and credibility of the work under these conditions, which feeds the criticism that research findings lack credibility. If work is short-term, underfunded and not embedded in healthcare culture and practice it is hardly surprising that research surrounding the work is considered to be anecdotal and not conclusive.

Art Forms/Practices settings

Arts/health practice covers a wide range of forms including visual arts, performing arts, technology, creative writing, horticulture, video arts, and film. It can also be defined by the healthcare contexts in which it takes place, "from community health to educational settings to hospitals to drug rehabilitation centres to care homes". (Moss op.cit.)

Arts/health demonstrates benefits in a wide range of healthcare settings including hospitals, nursing homes, community centres, hospices, and other locations within the community, and "creative arts therapies" have been applied in "...a broad range of physical and mental health issues including post-traumatic stress disorder, autism, chronic illnesses, dementia, neurological disorders, brain injuries and physical disabilities to improve patients' well-being and quality of life"(NHS op.cit.)

Staricoff (2007) identified music as the most popular art form, or at the very least the most researched, and this remains true today (WHO op.cit. NHS op.cit.). Music is followed by visual art, dance (particularly as an intervention with patients with Parkinson's and other movement related issues) and drama. This hierarchy of art form is supported by the recently published *Mapping Arts and Health Activity in Ireland* in 2019 (Farina, 2021)

The WHO report (2019), citing work by Davies et.al (2012) propose that in the context of health research, engagement with the arts consists of five broad categories:

- performing arts (e.g. activities in the genre of music, dance, theatre, singing and film);
- visual arts, design and craft (e.g. crafts, design, painting, photography, sculpture and textiles);
- literature (e.g. writing, reading and attending literary festivals);
- culture (e.g. going to museums, galleries, art exhibitions, concerts, the theatre, community events, cultural festivals and fairs);
- online, digital and electronic arts (e.g. animations, filmmaking and computer graphics).

The NHS (2018) identifies four primary art forms as visual art, music, dance and movement, and expressive writing, claiming that these are "the most common ways people engage with the arts in health".

Under these headings' art/health can include travelling around a town enjoying architecture, attending concerts, galleries, museums or libraries as well as making or producing something.

> "The act of creation, and our appreciation of it, provides an individual experience that can have positive effects on our physical and mental health and well-being...Participatory arts and crafts activities in community and healthcare settings provide opportunities for people to engage with each other and their own creativity, directly improving their sense of well-being. The arts can reduce stress and increase social engagement as well as provide opportunities for self-expression".

This statement captures the complexity of the arts/health model: is the causal element simply the social engagement? Is it just "being occupied"? Is it social interaction? These are important questions, as one of the most common comments made by nursing staff and participants in qualitative evaluations is some variation of "it gives them (us) something to look forward to". Implicit in this comment is the possibility that for patients in care (whatever the setting) there is very little to "look forward to"; Clive Parkinson of Arts for Health at Manchester Metropolitan University suggested in interview that how illness is treated within the care system results in a loss of self, and of identity. Another interview respondent put it this way "...the healthcare system, regardless of how nice the people are, engages with you through what you can't do; it engages with your illness or your disability. The artists engage with you in terms of what you can do, in terms of your ability. That's why we look forward to it"

It is interesting to note that alongside this acknowledgement of benefits within a wide range of contexts, the tension between the two world views of arts and health remains. For example, the WHO confidently state that

> "...arts interventions can help improve health and well-being, contribute to the prevention of a variety of mental and physical illnesses and support in the treatment or management of a range of acute and chronic conditions arising across the life-course. As such, arts interventions are often low risk, highly cost effective, integrated and holistic treatment options for complex health challenges to which there are no current solutions" (Intersectoral action: the arts, health and well-being, 2019).

Staricoffs comprehensive review of the literature from 1990 to 2004 (op.cit.) states that "arts interventions" can lead to improved communication skills, giving patients new ways of expressing themselves, improving self-esteem and stimulating creativity. (It is interesting that art is described as a sedative when used in clinical settings – "…users become more calm, attentive and collaborative…diminishing the need for medication and physical restraint")

However, the NHS review from 2018 strikes a note of caution, in keeping with its position of specialisation

> "we need to consider whether some art-based programmes are more effective than others; whether the impacts can be tied to other important variables and preconditions; and whether health benefits are sustained over the long term" (NHS op.cit.).

These positions are not mutually exclusive or antagonistic - although they can be experienced as such. The WHO statement is driven by policy requirements and is instrumental in tone - arts/health is value for money, matches our policy position on holistic care, and can fill some gaps so let's just get on with it. It is very easy to see how a clinical perspective would view this approach as inadequately scientific, and a potential threat to status, practice and expertise. It is important to acknowledge that the relationship between arts practitioners (and therapists), medical professionals, and policy makers is informed by issues of status, power, and professionalism. Acknowledging, addressing and resolving these issues will be as important as any research evidence in creating sustainable models of practice and delivery.

Target Groups

There can be a tendency to think of arts/health as participatory arts projects delivered in healthcare settings to improve patient wellbeing.

> "The role of community arts and cultural consumption (for example, attending galleries and concerts as part of health and well-being) has also received some attention in the literature. It is notable that arts and health literature is predominantly focused on the participative arts (for example, engaging in arts activities such as painting or singing in a choir while in hospital or attending a health centre) as opposed to receptive arts (for example, listening to music, reading a book, watching a film). (Moss op.cit.)

Research and practice are pointing toward a role for the arts in the care and well-being of patients, staff, carers and family and friends. In practical terms what this is producing is a way of thinking about healthcare settings - what and where they are - and reimagining them as arts/cultural venues. For example, The University Hospital Cardiff boasts an art gallery that is used by patients, staff and visitors, and exhibits (and sells) work by commissioned artists, staff and patients. They think of the hospital itself as one point on the healthcare journey and they develop arts projects with local schools and community groups. Arts events are designed with staff, patients and the wider community in mind. As Alex Staples, Arts Project Manager at UH Cardiff put it, "...how we think about health and do healthcare are essentially expressions of culture, so it makes sense to think about hospitals and care homes as cultural buildings"

The WHO report (op.cit.) cites twenty-eight pieces of research exploring the role of the arts in improving the quality of clinical, personal and communications skills among healthcare professionals. The research links surgical skills to prior musical ability, art appreciation to visual diagnostic skills, aural training to recognition of abnormal bowel, heart and lung sounds, reading and creative writing to empathetic imagination supporting effective communication, design of hospital work spaces to the reduction of errors, the use of visual art in hospital spaces to ease anxiety for both staff and patients, and more.

However, mental health, older adults, and paediatrics remain the predominant areas where the arts are reported, qualitatively, to have benefits for clients' wellbeing.

Determinants of Health

The World Health Organization defines the social determinants of health (SDH) as the "conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (World Health Organisation, 2020)

The WHO lists the following as examples of social determinants

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development

- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality.

The WHO also state that the SDH may account for "...between 30-55% of health outcomes. In addition, estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector". (www.who.int, n.d.)

The Commission on Social Determinants of Health (*Closing the Gap in a Generation*. World Health Organisation, 2008.), identified that the health inequalities between, and the social gradient within, countries were a result of the uneven distribution of power, income, goods and services, including access to healthcare, education, good-quality employment, homes and communities.

As the Pan American Health Organisation put it

> "...conditions can be very different for various population subgroups and can lead to disparities in health outcomes. The experience of such conditions may simply be unavoidably different, in which case they are considered inequalities, or they may in fact be unnecessary and avoidable, in which case they are considered inequities and therefore appropriate targets for policies designed to increase equity." (www3.paho.org, n.d.)

This model of social determinants presents significant opportunities for arts/health practitioners. Specifically, we need to ask where we can, and should, best apply arts/health initiatives in the social determinant ecosystem. Does the work belong in traditional health care settings or does it belong in a wider community setting? Are there multiple "intervention points"?

The UK All-Party Parliamentary Group on Arts, Health and Wellbeing report aimed to bridge the gap between "strategies tackling the social determinants of health and an acknowledgement of the role the arts can play" (Creative Health: The Arts for Health and Wellbeing, 2017). It stated that evidence was found of a "beneficial relationship between arts engagement, health and wellbeing across the life course". Again, whether this relationship is causal or correlated is unclear in the report. Is health/wellbeing improving *because* of the arts engagement or is the engagement fruitful because of the nature of, and increase in, social activity around the engagement?

The Centre for Arts and Humanities in Health and Medicine at the University of Durham produced a comprehensive literature review in 2013. It expressed reservations around the paucity of research into the causal mechanisms, but it does state that, "The link between art and health is now recognised to be **a social process** requiring new and fundamental research." (Emphasis. added).

The Acheson report (1998), *Inequalities in Health*, cited by the Durham review, saw that solutions to key public health problems, including mental health, require interventions that take into account wider determinants of health that impact on people's experience of well-being. It identified the strongest determinants of health as literacy, sanitation and income. The report makes the point that employment, housing, leisure, friendship should become the central concern of health service providers rather than a secondary gain from efficiently implemented care programmes.

The Durham review emphasises social determinants and adaptation: the idea that physical and mental health are shaped by our ability to adapt to conditions and changes in our environment. It argues that an increasing number of life's processes and difficulties - birth, death, sexuality, ageing, unhappiness, tiredness, loneliness, perceived imperfections in our bodies - are being medicalized, diverting people from what may be much better ways to adjust to these problems. It quotes an editorial in the British Medical journal (2002) that says "…if health is about adaptation, understanding and acceptance, then the arts may be more potent than anything that medicine has to offer."

Overall the report makes a case for the primacy of user-led activity rather than therapist intervention, and reports that a commonly perceived benefit by participants is that arts activity is non-medicalised and non-judgmental. A common strength of community-based approaches to arts/health projects is the building of informal social support networks, which can go hand in hand with a semi-formal mentoring approach to stimulate creative activity.

Victoria Health (Australia) in 1999 sets out the key determinants of mental health and wellbeing as:

- social inclusion,
- valuing diversity
- economic participation.

VicHealth's framework was built on "…an emerging evidence base which indicates that communities with high rates of participation by individuals in community activities have better health outcomes than those with low levels of civic engagement". The report suggests that this emerging evidence base suggests that the arts - and community arts in particular - play a role in enhancing social connection, social capital, community building, personal skills and social development". The development of valuable "social capital" as both process and product of arts/health projects is also identified in the WHO report (op.cit.)

The Connection Between Art, Healing and Public Health (Stuckley and Nobel 2010), argues that art and health have been "…at the centre (sic) of human interest from the beginning of recorded history", and yet people still struggle with "…the 'fundamentals' of art and health and their meaning in society". The authors go on to propose that mental or physical "ill health" is an expression of environmental factors. Again, we have to wonder what the role of arts/health is in a complex

model of health and wellbeing? Should the work focus on social determinants (prevention), or on the management of illness resulting from the determinants? This question is only partly rhetorical: obviously the answer from an artist perspective is a personal choice, but from a policy perspective the answer goes to the heart of policy decisions and resource allocations.

Values

We can think about values in terms of simplistic cost/benefit models and in terms of usefulness, impact and patient outcomes.

In terms of utility the WHO report (op. cit.) identifies three themes that emerge from their comprehensive literature review

- There is a substantial body of evidence on the health benefits of the arts that lends "...credibility to the assertion that the overall evidence base shows a robust impact of the arts on both mental and physical health".
- The arts can provide a holistic lens to view conditions that are often treated primarily as physical; such a holistic approach gives a parity of esteem to mental health, and "...towards situating health problems within their social and community context". This is in keeping with current trends in health theory and practice.
- The evidence demonstrates both the efficacy of arts interventions and the economic benefits, "with some arts interventions showing equivalent or greater cost–effectiveness to possible health interventions".

The report states that arts practice and participation methodologies have a measurable impact in terms of both direct clinical outcomes and indirect psychological and wellbeing outcomes throughout the life course and across a wide range of illness and settings.

> "The report finds evidence of the contribution of the arts to the promotion of good health and the prevention of a range of mental and physical health conditions, as well as the treatment or management of acute and chronic conditions arising across the life-course. The arts can be cost-effective solutions since they can frequently draw on existing assets or resources, although more research is needed into the health economics of this field.
>
> The report also finds that the arts may help in providing multisectoral, holistic and integrated people-centred care, addressing complex challenges for which there are no current healthcare solutions. As such, the arts could help countries reach the integrated targets of key global frameworks, such as the 2030 Agenda for Sustainable Development and the Thirteenth WHO General Programme of Work, 2019–2023, which aim to increase human capital, reduce inequity and promote multisectoral action for health and well-being".

In common with the other reviews cited here, the authors state that, "…there is evidence that engagement with artistic activities…can enhance one's moods, emotions, and other psychological states…" and that "Engagement with creative activities has the potential to contribute toward reducing stress and depression…" It is interesting to note the tentative quality of these comments: "…there is evidence…", "…has the potential…", and the avoidance of conclusive statements that speaks to the power relationship between health and arts, and the cultural superiority of rational models of knowledge. The authors make the point that much of the thinking in this area has been philosophical, built on anecdotal discussions about the benefits of art to healing, with little discussion of specific outcomes. The idea of "specific outcomes", which dogs the medical/scientific evaluations of the research, avoids the complex phenomenon of the accidental outcome, and the possibility of confusion of cause and agent in evaluation models. The art may well be the agent of health improvements, but the cause could be the behaviours, ethics and values of the facilitators, the emotional impact of new friendships and connections etc.

The Authors reviewed a wide range of projects in different contexts, with different participant groups and different art form practices. They concluded as they started by stating that there are clear "indications" (nothing conclusive) that artistic engagement has significantly positive effects on health, that despite methodological and other limitations, the studies "…appear to indicate that creative engagement can decrease anxiety, stress, and mood disturbances", but that there are significant limitations to the studies they reviewed.

The Durham review (op.cit.) made the case that solutions to public health problems, including mental health, require strategies that take into account wider social determinants of health and well-being. The report identifies the values or outcomes of arts/health strategies as:

- improvements in self-esteem and well-being reported by participants
- the formation of "social capital"
- people with enduring or severe mental health problems found that arts practice supported the ability to make their own choices, take control of their lives and maintain their mental health.
- Patients who worked with artists had fewer readmissions to hospital than those who did not

It follows that if arts/health interventions reduce readmission rates and increase a sense of personal control then there are associated cost savings over time. The proposal is usually that these savings should be redirected to fund arts/health projects. The same argument was proposed by economist Pier Luigi Sacco in his paper Culture 3.0.

There is other evidence on the economic value of arts/health interventions. For example the Creativity and Aging Study (Cohen, 2006) compared medication use and doctor visits between individuals who participated in a chorale group and a control group. He calculated annual savings of $172.91 per year per participant.

Memorial Health Care in Tallahassee introduced an art programmed during the preparation period for paediatric CT scans. The initiative "saved $567 per procedure, put three hours of nursing time back on the floors, reduced the medications needed by the young patients, cut down on overnight stays, and boasted a 98% procedure success rate for a test that is very difficult for kids (Walworth, 2005)". With at least four million CT scans performed annually on children alone, the potential cost savings for this single procedure exceeds $2.25 billion (Wood, 2008).

This value outcome of people developing self-management skills and taking charge of their own life is explored in detail in *The Transformative Potential of the Arts in Mental Health Recovery – An Irish Research Project (*Sapouna and Pamer, *2014).* The authors suggest that there is a growing body of evidence on the benefits of the arts for people experiencing emotional distress. The arts stimulate creative skills and self-esteem, confidence, improved self-expression and communication between service users, staff/service providers and family, leading to a sense of empowerment, and a clearer self-image. Essentially, so the argument goes, the arts facilitate people to take greater control of their lives and their recovery. The authors cite nine research and evaluation projects from 2007 -2011 that claim that arts support participants to "explore and understand feelings, develop alternative coping strategies…feel more hopeful and better able to cope with distress …can lead to a reduction of stigma and social exclusion for people experiencing distress and their families."

It is stated that the personal outcomes identified in these nine projects were achieved "through an expansion of social networks and the associated decrease in isolation, and the opportunity to develop a "new identity" as an artist or creative person, as opposed to a depressed person or a user of health or other social services". Note that there are two distinct things occurring – meeting people and making stuff.

This increase in social networks – and the decrease in isolation – creates opportunities to "give and receive mutual support, collaborate with others, develop a sense of belonging within the wider community (Secker et al., 2007; Spandler et al., 2007) and to connect with further opportunities within the community (Hui & Stickley, 2010)".

The authors sound some notes of caution, interestingly the concern that "If the arts become a "commodity" of mental health systems primarily focused on medication, containment and coercion (Stickley, 2012a), their creative contribution may be compromised", and most strikingly that collaborations between arts and mental health services "...is not just a technical measure but requires a cultural shift in the way we understand, respond to and engage with human distress. The arts in mental health care provide opportunities to see people in distress beyond their diagnosis and can facilitate such a shift towards embracing creativity of expression, nurturing strengths and facilitating service-user care choices, both inside and outside mental health structures". However, the question of whether the art is "agent" or "cause" is not explored.

Identifying the evidence-base for art-based practices and their potential benefit for mental health recovery (Van Lith, Schofield and Fenner, 2012) focuses on recovery from diagnosed and clearly categorized mental illness. It concludes that

arts practices are "…of high benefit to psychological and social recovery particularly in the areas of self-discovery, self-expression, relationships and social identity".

The authors talk about "the journey of recovery" and list as the elements of this journey "…renewing hope and commitment, redefining self, incorporating illness, being involved in meaningful activities, overcoming stigma, assuming control, becoming empowered and exercising citizenship, managing symptoms, and being supported by others". They argue that arts based interventions are effective because they offer "…a person-centred and recovery-oriented approach that embraces emotional, social and spiritual needs alongside the clinical …can enhance overall general health through strengthening self-esteem and self-worth, contribute to a feeling of being valued, facilitate development of interpersonal relationships, and widen social networks".

The report concludes with the claim that the existing research indicates that art-based practices are of high benefit to psychological and social recovery "…particularly in the areas of self-discovery, self-expression, relationships and social identity. These findings…indicate that art-based practices may play a substantial role".

Prevention and Promotion

The WHO report (op.cit.) identifies two points - Prevention and Promotion, and Management and Treatment on the healthcare journey where arts/health is deemed to be effective and lists the values in each area:

Within Prevention and promotion the arts can:

- affect the social determinants of health (e.g. developing social cohesion and reducing social inequalities and inequities);
- support child development (e.g. enhancing mother–infant bonding and supporting speech and language acquisition);
- encourage health-promoting behaviours (e.g. through promoting healthy living or encouraging engagement with health care);
- help to prevent ill health (including enhancing well-being and reducing the impact of trauma or the risk of cognitive decline); and
- support caregiving (including enhancing our understanding of health and improving clinical skills).

Within Management and treatment the arts can:

- help people experiencing mental illness at all stages of the life-course (e.g. by supporting recovery from perinatal mental illness and after trauma and abuse);

- support care for people with acute conditions (e.g. by improving the experience of and outcomes in care for hospital inpatients and individuals in intensive care);
- support people with neurological disorders (including autism, cerebral palsy, stroke, degenerative neurological disorders and dementias);
- assist in the treatment of noncommunicable diseases (including cancer, lung disease, diabetes and cardiovascular diseases); and
- support end-of-life care (including palliative care and bereavement).

The NHS (2018) have a slightly more cautious but still wide-ranging conclusion:

- Art enhances the psychosocial treatment of cancer, including decreased symptoms of distress, decreased levels of fatigue, improved quality of life and perceptions of body image, reduction of pain perception, and general physical and psychological health
- Research with children with cancer indicates that engaging in drawing and painting is an effective method for dealing with pain and other symptoms of illness and treatment
- Research on art therapy with children with asthma indicates that it reduces anxiety, improves feelings of quality of life, and improves self-confidence
- Evidence indicates that art stimulates cognitive function in older adults who have dementia or related disorders, and may reduce depression in those with Parkinson's disease
- Engagement with arts and crafts may reduce anxiety and stress reactions as measured by cortisol
- Art reduces acute stress symptoms in paediatric trauma patients; and
- Arts and culture can be used directly to improve clinical outcomes.

It identifies four key areas in which the values of arts/health can be felt namely

Patient Care:

- supports physical, mental, and emotional recovery, and can return a sense of control to the patient, reducing stress and loneliness and providing opportunities for self-expression.
- relieves anxiety and decreases the perception of pain leading to reduction in the use of pain medication;
- can reduce length of hospital stays, and improve compliance with treatment regimes, offering substantial savings in healthcare costs.

Healthcare Environments:

- can create safer, stimulating, supportive and functional environments in healthcare settings, reducing patient and caregiver stress, improving health outcomes, enhancing patient safety and overall quality of care, and reducing costs.
- can improve staff morale, job satisfaction and staff retention

Caring for Caregivers:

- can be focused on caregivers as they process what are profound and complex emotional experiences. (The report also noted that caregivers taking part in projects with patients "challenged the caregivers' perceptions of what the patient was capable of).
- can improve diagnostic and communication skills with medical staff and students and can be used to improve communication of key messages.

Community Well-being:

- can be a communication tool, supporting the community by promoting prevention and wellness activities, improving knowledge, increasing self-esteem and developing "...more effective coping mechanisms".

Policy

What are the policy implications of the research? Or what aspects of the research speak directly to policy makers.

*The Transformative Potential of the Arts in Mental Health Recovery – An Irish Research Project (*Sapouna and Pamer, *2014)*, provided a concise summary of the relationship between arts and mental health at a national policy level:

> "The integration of arts into Irish mental health services is one element of a broader attempt to embrace creativity as part of recovery-informed, person-centred practice. A Vision for Change (Department of Health and Children 2006), the Irish National Mental Health Strategy, identified the need for mental health services to adopt a recovery perspective and considered it a core principle to ". . .inform every aspect of service delivery" (ibid.).

They state that the medical understanding of "recovery" has undergone a shift from a clinical understanding as an absence of symptoms or a recovery to normality, to a process of "recovering what was lost", including citizenship, rights, meaningful roles, responsibilities, decisions, potential and support (Bracken & Thomas, 2005; Crowe & Taylor, 2006; Mental Health Commission, 2008). This is an argument given a radical voice in Clive Parkinson's *Recoverist Manifesto*

If we think of recovery in this way (a recovery of what was lost) then a very fundamental power shift occurs in the relationship between the individual and the service provider. The individual takes charge of their own life, they become "…the central driver of their own life, a life of their own choosing, in a community in which they are citizens with equal rights to all other citizens (Ryan, Ramon, & Greacean, 2012)". As the authors put it, this shift poses a challenge to the dominant medical approach to mental health by putting "individual choices, social inclusion, citizenship and human rights to the centre of practice. As Roberts and Wolfson (2004) argue, this "…redefinition of recovery as a process of personal discovery, of how to live (and to live well) with enduring symptoms and vulnerabilities opens the possibility of recovery to all" (Sapouna and Pamer, *2014*).

This concept of the individual taking charge of their own life has radical implications for how we think about healthcare, implications that are evident in the thinking behind Slaintecare and Healthy Ireland. Within this "recoverist" paradigm we need to consider the role of arts/health practice. At the most basic level is art one of the tools of recovery or is it part of that which needs to be recovered? And what implications does the answer have for policy?

The WHO report proposes a policy framework, supported by their summary of the available research that aims to address the "lack of consistency in policy development, encourage sharing of good practice between nations, and support the development of long-lasting national policy and delivery frameworks".

> "Since the beginning of the 21st century, there has been a major increase in research into the effects of the arts on health and well-being. This has occurred alongside developments in practice and policy activities in different Member States across the WHO European Region and further afield. However, because of a lack of awareness of the evidence underpinning these activities, there has been little consistency in policy development across different Member States in the Region."

The rise of Arts/Health is timely from the WHO's perspective, as all of the "goals, priorities and approaches" of WHO policies since the early 2000s are supported by arts/health practices:

> "...increasing the cultural capital within societies and potentially helping to promote resilience, equity, health and well-being across the life-course. Finally, because they operate simultaneously on the individual and social, as well as physical and mental, levels, arts-based health interventions are uniquely placed to address the full complexity of the challenges that being healthy and well are increasingly recognized to present".

The WHO proposes the following policy actions "...aimed both at the culture as well as the social care and health sectors":

- Acknowledging the growing evidence base for the role of the arts in improving health and well-being.
    - Support the implementation of arts interventions for which there is a strong evidence base. This could include the use of recorded music for patients prior to surgery, arts amongst dementia patients, and community arts programmed for mental health.

- Share with other countries knowledge and practice from effective interventions and case studies that have used the arts to promote health, improve health behaviours, or address health inequalities and inequities.
- Support research in the arts and health, particularly focused on policy relevant areas such as studies scaling up interventions to larger populations, or exploring the feasibility, acceptability and suitability of new arts interventions.

- Recognising the added health value of engagement with the arts.
  - Ensure that culturally diverse forms of art are available and accessible to a range of different groups across the life-course, especially those from disadvantaged minorities.
  - Encourage arts and cultural organisations to make health and well-being an integral and strategic part of their work.
  - Actively promote public awareness of the potential benefits of arts engagement for health.
  - Develop interventions that encourage arts engagement to support healthy lifestyles.
- Noting the cross-sectoral nature of the arts and health field.
  - Strengthen structures and mechanisms for collaboration between the culture, social care and health sectors, such as introducing programmes that are co-financed by both arts, health and social care budgets.
  - Develop stronger lines of referral from health and social care to community arts programmes, for instance, through the use of social prescribing schemes.
  - Support the inclusion of the arts and humanities within the training of healthcare professionals.

Alongside the Summary Report the WHO published *Intersectoral action: the arts, health and well-being* In September 2019 the WHO. stating that:

> "..the 2020 policy framework has been adopted by **all** Member States of the WHO European Region to address Europe's great social and health challenges, **calling upon the health sector to reach out to and work with all the various sectors and parties in the continuing work of improving people's health and well-being**" (emp added pg. 2).

Referring to the WHO Health Evidence Network synthesis report 67 it states that the potential impact of arts/health interventions is not being fully realized, because "opportunities for collaboration between the arts and health sectors are not being properly developed", arguing that

> "Stronger pathways between the arts, health and social care can provide creative solutions to help to achieve the Health 2020 targets and the Sustainable Development Goals. Further, more collaboration between sectors can also enrich cultural capital by ensuring that everyone has equitable access to the arts in community and health-care settings across the Region" (pg. 3)

The paper makes the following recommendations for effective synergistic collaborations between the two sectors:

- supporting the design and implementation of high-quality arts interventions;
- promoting public awareness of the benefits for health of engaging in the arts;
- identifying and removing barriers to accessing the arts, including among older adults, people with mental ill health, people of lower socioeconomic status, members of ethnic and other minorities, people with a health condition or disability and people living in geographically isolated areas;
- facilitating the development of partnerships and partner-working between the health, social care and arts sectors;
- developing training, resources and guidelines that will support collaboration between the arts and health sectors; and
- incorporating evidence on the health benefits of the arts into relevant policy documents. (pg. 6)

It is a commonplace of arts/health that the burden of proof and investment (both time and money) lies on the arts side of the equation, so it is very significant that this paper asks the question *What can health do to make a difference to the arts?* , and proposes that the Health partners in the arts/health equation need to:

- Explore opportunities for co-commissioning programmes that benefit both the arts and the health sector.
- Provide clinical insight into the impact of arts programmes within health by collaborating on programme evaluations.
- Incorporate the arts into the training of health professionals, both for the well-being and skills development of personnel and to raise awareness of the value of the arts within health.
- Provide training and development opportunities to support the development of artists, including building knowledge and skills on working with specific health populations.

The paper then identifies four challenges in the development of the Arts/Health relationship and proposes responses to those challenges.

Challenges	Responses
Designing effective arts and health interventions to address complex health problems for	Engage with artists and arts organisations on health-care committees, steering groups and task forces to identify opportunities for collaboration. Collaborate across arts sectors and health sectors to design, test and deliver arts interventions

which there are incomplete solutions	to address complex health challenges. Ensure that arts organizations have the capacity and training to deliver such interventions
Developing strong pathways between the arts, health and social care	Undertake joint work across sectors to identify opportunities for referring individuals to arts activities and promoting arts engagement, especially where health and social care resources are scarce. Identify and address barriers to partnership working across sectors
Measuring how providing arts programmes affects population health	Improve the monitoring and surveillance of patterns of arts engagement, include measures of arts engagement within cohort studies and relevant routinely collected data and routinely analyse population-level data on implications for health
Ensuring free or affordable provision of arts resources and equal access to these resources to help improve equity in health	Support the work of arts sectors internationally in funding arts and cultural institutions and organizations. Develop policies and strategies that support organizations in reaching diverse audiences across communities, schools and health-care settings

The All-Party Parliamentary Group on Arts, Health and Wellbeing in the UK conducted an inquiry into practice and research in the arts in health and social care from 2015 - 2017, with a view to making recommendations to improve policy and practice. In their report 'Creative Health: The Arts for Health and Well-being' ('Creative Health') published in July 2017, the group makes 10 recommendations on realising the potential of arts in health. These recommendations include:

- That leaders within the arts, health and social care sectors establish a strategic centre, on a national level, to support the advance of good practice, promote collaboration, co-ordinate and disseminate research and inform policy
- That the education of clinicians, public health specialists and other health and care professionals includes accredited modules on the evidence base and practical use of the arts for health and well-being outcomes; and
- That the National Institute for Health and Care Excellence (NICE) regularly examines evidence as to the efficacy of the arts in benefiting health, and, where the evidence justifies it, includes in its guidance the use of the arts in healthcare.

The report also addressed the cost/benefit question and produced the following numbers

- £1 spent on early care and education amounts to a saving of up to £13 in future costs
- 79% of people in deprived areas of London live more healthily after engaging with the arts, 77% engage in more physical activity, and 82% enjoy greater well-being
- An arts-on-prescription project shows a 37% drop in GP consultation rates and a 27% reduction in hospital admissions, representing a saving of £216 per patient. This amounts to a social return on investment of between £4 and £11 for every £1 invested in arts on prescription;
- Music therapy reduces agitation and the need for medication in 67% of people with dementia; and
- Creative Health calls for a change in policy thinking around arts and health:

> "The arts can make an invaluable contribution to a healthy and health creating society. They offer a potential resource that **should be embraced in health and social care systems** which are under great pressure and in need of fresh thinking and cost-effective methods. Policy should work towards creative activity being part of all our lives". (emp added)

Evaluation and Research

Without dismissing the strength of the findings and recommendations of the WHO report, there are ongoing issues and concerns around quality of evaluation and research.

Promoting Mental Health & Wellbeing through Community & Cultural Development was published by the Globalism Institute of RMIT University in 2002. (Vic Health) It described the research it reviewed as "unconvincing to those outside the field" because of over-reliance on selective case studies, anecdotes, and small sample sizes, lack of baseline data collection that could be used for comparative purposes, and the lack of long-term studies making it difficult if not impossible to generalise. "**Much of the existing research is based on anecdotal accounts of success stories and the views of arts program organisers. The consensus that has emerged needs to be tested with more rigorous research into the views and experiences of participants and audiences".**

The report cites the work of Jermyn (2001) who claimed that "…there is a huge amount of empirical evidence which shows the difference the arts make to individuals and communities. And yet there has been little serious evaluation; precisely because these social impacts are often long term and difficult to quantify". Jermyn makes a valuable point, stating that there is "…a fundamental contradiction that afflicts the literature on health and community arts. The evidence for the health benefits of community arts is, according to researchers in this field, at the same time both overwhelming and difficult to pinpoint, undeniable and yet impossible to prove".

Staricoff's remarkable *Arts in Health* (Arts Council England 2007) reviewed the medical literature on the arts and health published between 1990 and 2004 with the aim of strengthening "…existing anecdotal and qualitative information demonstrating the impact that the arts can have on health" (Dr Rosalia Lelchuk Staricoff, 2007, p 4). This report made the by now customary observation about "…considerable anecdotal evidence" of increased patient wellbeing and self-esteem, but "…relatively little hard evidence about costs and benefits". It is important to point out this has changed considerably since 2007, and a growing body of work is being produced exploring the economics of arts/health.

In 2013 Schofield and Fenner (op.cit.) drew evidence from studies published in English between 1987 and 2011. The report claims – again - that the evidence is inconclusive. It states that "…incorporation of art-based approaches into mental health services has been impeded by claims of an insufficient evidence-base and ongoing debates about the most suitable research practices"

In 2018 the NHS review of the literature stated that

> "The lack of robust evaluation around the effectiveness of the arts on a person's well-being is partly because it is extremely difficult to record the positive benefits of the intervention in any meaningful or usable way.".

This is a more traditional conclusion than that reached by the WHO report, in that it agrees that evidence exists to support the idea that arts have a contribution to make to health, but that the evidence has still not reached a critical mass. It calls - as many reports and pieces of research - for more and better evidence, and for "high-quality evaluation of existing projects and initiatives, which would allow for robust comparative analysis. Equally, there is a need for appropriate longitudinal research into the relationship between arts engagement and health and well-being".

It argues that because so much of the data is qualitative, gathered from semi-structured interviews or self-reporting questionnaires, it is difficult to translate this into measurable, representative conclusions "which would be required to inform policy development on a national level". There is also an ongoing need for longitudinal research and monitoring to evaluate the sustainability of arts and health interventions and the relationship between intermediate and strategic outcomes.

Without doubt the summary of research literature conducted by the WHO is comprehensive and compelling. What then is the point of acknowledging the reservations dating back to the start of the century? We need to remember that the WHO report is just over a year old. It will take time for its conclusions and recommendations to work its way through the culture. On the other hand, the reservations expressed in the earlier work are already part of conventional wisdom in arts/health and will continue to inform thinking in this area, as is evidenced in the interviews conducted for this report.

Emerging Themes

There are several themes that emerge from this meta review:

- The effort to prove the usefulness of the arts/health offering is ongoing, despite the growing body of evidence that the arts have an important contribution to make to health and well-being. This is despite a general sense of agreement that arts in health is a "good thing", and the emergence of various high-level partnerships and agreements. For many projects and practitioners on the ground the level of scepticism around the offering appears to be high and culturally embedded, and investment is minimal
- Projects are initiated and driven by individuals with a passion for the work. This individual may be an artist, or it may be an individual within a healthcare setting
- In general projects are too short lived, creating a self-fulfilling prophecy around their perceived usefulness
- There is a hierarchy of professionalism: essentially the health side of the equation is perceived as being higher, having more realistic and measurable outcomes etc., than the artist side. Again, this is culturally embedded
- Arts in Health project partnerships tend to be built on personal and informal relationships
- Project budgets are low and, in many cases, unrealistic
- Artist pay does not reflect the time commitment or the professionalism
- Long term, equal partnerships are essential for quality outcomes and evaluation, but this is constrained by budget.
- Greater focus needs to be placed on high quality evaluation of projects and initiatives
- There is a need for appropriate longitudinal research

It is important to note that these themes have emerged from the *international* academic literature (and literature reviews), and that they are reflected in the interviews with practitioners and experts across the midlands.

Conclusion

Why are we in a situation where on the one hand compelling evidence exists that arts have significant impacts on health and wellbeing outcomes, but on the other that evidence is not convincing, and investment into arts health practice is marked by low levels of investment and a significant amount of personal investment on the part of the artists? How do we reconcile these tensions?

A possible answer lies in the observation that the research, and the evaluations of the research come from different positions and have different remits. We can propose that there are three overarching positions that inform the research and the evaluation of it: the Medical, the Policy, and the Artistic.

Within the complex system of socially determined health and wellbeing, and the provision of healthcare within that system there are dynamics of status, power and professionalism at play. If a sustainable, thriving model of arts/health practice and provision is to be developed then those dynamics must be acknowledged and openly discussed.

('No.7' By Archive Artist Jackie Lynch. An Anam Beo project)

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