Asking the Way – Directions and Misdirections in Arts in Health

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Where Are We?

Arts in health is at a fork in the road. The hard-paved route, The Empirical Highway, leads to probable damnation by way of austerity culture, a narrowing definition of accredited practice, and evidence calls that are signalled through a medical model of health. Those who venture on this path will find their creativity randomised, controlled and trialled. The other route, which I term The Lantern Road, tracks its progress through reflective practice, has lit beacons of new traditions in participatory health promotion, and affirms relationship-based working as the way to a sustainable vision of community-based arts in health supported by inter-disciplinary research.

As the World Health Organisation declared in 2008 "Evidence is only one part of what swings policy decisions – political will and institutional capacity are important too. But more than simply academic exercises, research is needed to generate new understanding in practical, accessible ways, recognising the added value of globally expanded knowledge networks and communities"[i]. In this article, I want to reflect on some recent experiences and observations in my work portfolio that suggest where that 'new understanding' might be found. En route I hope to reveal both the inherent tensions and resilience of arts in health at a difficult juncture brought on by the search for evidence of benefit, funding pressures and the downbeat organisational re-structure of public services.

The Lantern Road

Lantern parades have been a connecting thread of imagery throughout my twenty-five years of involvement in arts and health projects. The lantern parade is an occasion to view a community in another light. Sometimes it is a one-off event, but in many cases it becomes an annual celebration that generates narratives and traditions, leading to wider programmes of work that connect arts, health education and community development. Lantern imagery provokes wonder and engagement in community arts worldwide, and offers opportunities to explore the impact of participatory arts on community health and individual well-being[ii].

Earlier this year I and Mary Robson, my artist colleague in the Centre for Medical Humanities (CMH) at Durham, organised a colloquium in the university on the subject of lanterns because we wanted the phenomenon of community lantern parades to be better theorised in an inter-disciplinary context that could support future collaborations. Our purpose in this two-day conversation was to engender opportunities for academics, community participants and arts and health practitioners

to meet and work up outlines for further work and research. It aimed to be a congenial exploration of the meaning, value and purpose of lantern-making.

I feel the event got the results we had hoped for as together we came up with an inventory of ‘what works’ for community-based arts in health events, some philosophical underpinning of the lantern parade phenomenon, the framework for a research bid, and a few publications-in-waiting. For me, it was great to re-connect with several veteran lantern-makers who share a common point of origin in the Welfare State theatre company of the 1980s and to sense the genealogy of an extra-ordinary offshoot of community arts practice that now reaches worldwide. By also drawing in insights, possibly for the first time, from a wide range of academic disciplines along with the reflexive narratives of participants in these celebratory events, we became indeed a lantern parade ourselves in the course of the conversation.

The conversation was structured in three sessions; ‘Framework’ (how do successful lantern parades evolve?), ‘Covering’ (what is the philosophical reach of lantern-making activities?), and ‘Illumination’ (what might research discover that adds value to these events?). In the first session, we organised our responses to a guiding question of “what are the key ingredients of annual community-based lantern parades?” into seven clusters that I now venture might be headed as follows: creating congenial space, having a motivating aesthetic, ensuring inclusivity, making new traditions, keeping attention to health and safety (in a wider sense of mutual caring), providing quality conditions for shared celebration, and enabling transformations of people and places.

For the second session CMH Director Professor Martyn Evans gave us a rumination on light and wonder that spurred us to see lantern events anew in respect of the metaphorical connections and actual relations they create, their unfolding phenomenology in both affect and materiality, and their provocation of wonder and well-being – all succinctly expressed by one participant as “the wow”. In the final session we laid a pathway of emergent themes and reflected on the research potential of these in discussions groups under the headings of ‘lantern stories’, ‘the elemental nature of light as both thing and event’ and ‘inter-relationships of art, community and social context’.

As part of this event, artist Gilly Rogers worked with Mary Robson and some local families on creating a cocoon lantern that encapsulated (exactly) the spirit of our conversation and revelations to come. Participants in the lantern parade conversations added their own delicate tissue-paper paper-cuts, and the completed lantern was gifted to Tilery Primary, a school that is our community partner in an annual lantern procession (now in its sixth year) for the housing estates that are in nearest proximity to Durham’s Queen’s campus in Stockton where both the Medical School and the Wolfson Health Research Institute are based. This year’s parade, however, was unavoidably postponed due to a major refurbishment of the school, so the cocoon was made to hold the aspirations of this now traditional event until its imago emerges in the next manifestation.

The cocoon became the focal point of a cancellation ceremony in the Tilery school grounds a few weeks later in order to commemorate this blip in the timeline and assure the children and their families that lanterns will continue to mark their social

well-being and the diversity of their community. The school's roll is drawn from local housing estates which have seen a significant increase in the last decade of refugees and asylum seekers. The head teacher estimates there are now over twenty languages spoken on the local estates, and the growing ethnic diversity is both reflected and addressed in the school. For the cancellation ceremony, attended by over 200 local people, the social integration messages celebrated in the annual event were expressed in back-lit paper-cuts made by the children to fill all the windows in the school, transforming it into one giant lantern.

Tilery's parade will return next winter, sustained by a communal will for the event and its integral health education programme, buoyed by an ongoing partnership with the university that works at a grassroots level of facilitating medical student placements on the estates, and boosted through the school's own ingenious fundraising from local businesses. The event has yet to secure support from statutory agencies, however, and local health promotion agencies' engagement with it has been minimal despite the school embedding the event in its 'social and emotional learning' programme. The magic of the event continues to manifest annually, and it resonates year-round in a collective consciousness, but the systemic infrastructure I expected to support it has not materialised – at least not in Stockton, one of the UK's most deprived areas with the worst health profile.

Entering a New Landscape

In a previous article for the ixia website in 2011[iii], I declared that "What I think is becoming clear is that the practice of arts in health needs to re-adjust conceptually and in delivery. The transfer of public health into local government is likely to demonstrate even more the development of health service delivery by hybrid professions and partnerships rather than by traditional specialists". Although I have not yet managed to galvanise such partnership support for the projects I am running, I find that claims for this sea-change in service delivery of health promotion through culture are borne out elsewhere. For example, NCVO's newly launched Cultural Commissioning Programme[iv] optimistically asserts that "nearly one year on, the move of public health into local authorities seems to be supporting use of arts and cultural programmes to deliver health and wellbeing outcomes. Driven by the need for a refreshed approach to tackling some of the underlying causes of ill-health, early indications suggest it is enabling collaborative working between public health and the arts and cultural sector to do exactly this". It cites glowing examples from Manchester, Liverpool and Doncaster. Elsewhere, Dudley in the West Midlands is focusing its 2013-14 public health report entirely around its arts and health activities – and the voluntary sector's social enterprise godfather the Bromley-by-Bow Centre is currently conducting major research into how entrepreneurship can steer future public health policy. I can chip in my own example too from Norfolk where I am currently evaluating a consortium of arts organisations piloting an arts and well-being programme for health and social care services.

So is it really so bright we have to wear shades? In truth, I have found it harder to see the light at the end of this transition tunnel, experiencing the phenomenon rather as the sight of a commissar with a torch bringing along another instalment of austerity in a nappy-bag. I would like to qualify the optimism abroad with an instance of a setback within the new healthcare arrangements. Last year I was invited to

mentor an arts in health residency in Gateshead with a seasoned community artist, Gilly Rogers, whose work spans public art commissions, installation art and participatory arts in health and education settings (including making the cocoon for Tilery). With Gateshead's reputation for public engagement in the arts, including an arts in health development programme going back twenty years, this seemed a residency full of promise to address and harness the changing health landscape within a local authority. With the restructuring of health services and the transfer of the public health function into local government the residency aimed to demonstrate the continuing importance of community-based arts in health work. It was to be an opportunity also to reflect on how effectively an artist can function within the new healthcare arrangements and what added value creative approaches bring to existing preventative healthcare services. One project in particular in Gilly's residency portfolio ambitiously crossed different tiers of healthcare and the statutory/voluntary axis – her 'Get Your Shed Together' project, which aimed to bring together older men and recovering addicts and successfully integrate them into a wider community of allotment gardeners.

The statutory services were initially resistant to Gilly's proposal to erect an artist-designed shed due to fears of vandalism, though the voluntary services readily embraced the idea. The alternative idea for a 'pop-up' shed emerged as an example of a funky portable shed, sentry box size, to stimulate interest in the project and be used as a promotional tool for men's health. Gilly identified that the difference with her project from the sheltered workplace initiatives elsewhere in the UK that have adapted the 'sheds' model from Australia was that it focused on the visual and social aspects of sheds and how people use them as opposed to just providing workshop space for men to be productive. Recent research by Lancaster University[v] found that whilst older men much preferred to be doing something useful and especially felt valued if they felt they were giving something to their community, it was the creativity and sociability of their enterprise that was most valued. This useful information helped frame Gilly's decisions on appropriate places and groups with whom to work, using the shed as a rallying point and symbol. The Warwick-Edinburgh well-being framework[vi] was introduced to measure the benefits of the project but was unsuccessfully applied due to the inconsistent participation from the group – a common problem in work with people with addictions. One participant from the 'Get Your Shed Together' project commented that he would never be able to give a consistent response due to his medication and his outlook changing from hour to hour. Others complained of having previously been offered so many choices of activity by over-eager agencies as to be de-motivated. Gilly's response to the problem was to make her sessions social occasions for voluntary work, enlivened with barbecue and high tea, so although attendances were inconsistent, the individual events were still opportunities to experience flourishing and a camaraderie.

Gilly's summary reflections in her residency journal were as follows, worth quoting at length as they capture the difficulties of working in an uncertain statutory/voluntary hybrid environment in which morale is weakened and compromised by institutional uncertainty:

> "The uncertain climate, with local government really struggling with cuts, de-motivational structures and job uncertainty has impacted on my work, but I can see that the project is invigorating workers who have become despondent

> because of lack of funding and disillusioned by the unstable job situation. New working relationships are still in the process of slowly developing, which has made it harder to establish connections. As an artist, sitting outside of organisational structures it has been difficult to challenge poor quality provision and it has taken a huge amount of passion, enthusiasm and perseverance to motivate people and get them involved and there has been little chance of match funding. The structures are very slow which I found frustrating, especially in the planning stages and I think I probably under estimated the time it takes to set up a meaningful project. My perception is that within the Council there still isn't a wide understanding of the benefits that arts in health can bring to mainstream services so it is still really important to be encouraging arts in health processes and demonstrating the importance of community- based arts in health work. I think that everyone who has been actively involved really understands and supports the project and recognises the potential to bring people together in a meaningful way but there is still some way to go before it becomes integrated into mainstream services and I am still working round issues and trying to establish a 'can-do' culture".

That 'can-do' culture is an important re-orientation of arts in health moving it away from the dominant hospital model of the last twenty years, concerned largely with commissioning art works for environmental or therapeutic enhancements, towards partnership working in community health in which the social determinants of health as identified in the reports of the Marmot review (WHO 2008[vii], 2013[viii]) may find alignment with an impetus in community arts to 'make special'. As Holden noted in a report to ixia in 2012[ix], "'Cultural well-being' is now mentioned in one of the National Planning Policy Framework's *'Core planning principles'*, where it sits alongside priorities for health and social well-being...an opportunity - and a responsibility - to take a lead in helping planners to understand what cultural well-being means, and what the implications are for the built environment and beyond".

Seeking Cultural Value in Cultural Well-being

'Cultural well-being' smacks of flaky coalition thinking, but on a good day. The lack of defin'ition prompts the call for an evidence base, thereby reducing arts in health practice to the inertia that has kept it out of serious policy consideration in the past. The inherent strengths in socially engaged arts have been disqualified for evidence-based health policy, perhaps because the deep immersion conveyed through the testimony of participants in creative activities to improve health is undervalued by the proponents of evidence-based policy whose evaluation criteria ignore the real gems embedded beyond the 'gold standard' of clinically proven benefit. The spatial domains of community-based arts in health and their potential for creating spaces for transformation have been overlooked in favour instead of attempting to identify instrumental therapeutic effects, despite community-based projects being more focussed on social than psychological processes. In evaluation studies to date, arts in health projects have frequently been required to demonstrate physiological and mental health benefits whilst neglecting the potential of the arts to help to shape people's world view, influencing their choices, autonomy and social engagement.

Much thanks, then, to the emergent thinking in medical humanities that is helping us validate phenomenological findings from the experience of illness and recovery and

reveal transformational effects in both individuals and communities. If this could be coupled with a search for longitudinal evidence through passionate practice in arts in health we may achieve an evidence base worthy of the inter-disciplinary effort required to amass it. Perhaps we should reflect more on the significance of artifacts like the cocoon and the shed than measuring health outcomes through an ill-fitting evaluation methodology.

The Arts Council's recent research report *The Value of Arts and Culture to People and Society*[x] offers a rapid review of instrumental impacts of arts engagement across a number of headings including 'health and wellbeing', but it tends to assess effects in isolation, overlooking how cross-cutting themes can evolve that are distinctive of the practice I have described above where arts in health may become bound up also with education, citizenship and inclusion. Furthermore, it notes that although some research "confirms that beauty has an impact on wellbeing, it raises questions about the direct impact that public arts interventions with a perceived quality of beauty can have on wellbeing". It fails, however, to differentiate between public art that is only viewed and participatory art that expresses a collective creativity that is conscious of quality and empowerment – possessing the 'wow factor' I refer to earlier. The nature and degree of engagement surely has some bearing on the perceived beauty of the artefact or activity? The Arts Council report appears limited and flawed in its assessment of the evidence base in the arts in health field[xi], but it at least acknowledges that better understanding through longitudinal study of the experiential or intrinsic aspects of arts engagement is vital to addressing the evidence gaps that arise by focussing primarily on instrumental impacts.

My end point is this; what has been previously enacted as 'arts in hospitals' in the golden age of capital redevelopment in the public sector should in these stringent times be re-configured as 'arts for emotional spaces', and be sensitively pursued in a more public domain that supports a co-existence of personal and communal rites of passage. Whether the work is in clinical or social settings, these spaces "for the built environment and beyond" can be creative spaces that support our transition to wellness or resilience or…adaptation (where a concept drawn from evolution infuses public health). That way we can shape and express together a different and purposeful aesthetic within healthcare.

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[i] World Health Organisation (2008). *Closing The Gap in a Generation: health equity through action on the social determinants of health*. WHO; Geneva. p.33.

[ii] White M. and Robson M. (2011). Finding Sustainability: university-community collaborations focused on the development and research of arts in health. *Gateways: International Journal of Community Research and Engagement.* Vol 4: 48–64

[iii] White M. (2011). *Checking-up on Arts in Health.* ixia website.

[iv] NCVO *Cultural Commissioning Programme - supporting arts and cultural organisations to engage in public sector commissioning.* Available at: www.ncvo.org.uk/practical.../public.../cultural-commissioning-programme (accessed 10 April 2014).

[v] Milligan C., Dowrick C., Payne S. et al. (2013). *Men's Sheds and Other Gendered Interventions for Older Men: improving health and wellbeing through social activity.* School of Public health research, Lancaster University

[vi] *The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)*
Available at: www.healthscotland.com/documents/1467.aspx (accessed 10 April 2014).

[vii] WHO (2008). op cit.

[viii] World Health Organisation (2013). Health Inequalities in the EU. European Commission; Luxembourg.

[ix] Holden J. (2012). Public Art, Cultural Well-being and the national Planning Policy (NPPF). ixia website.

[x] Arts Council. (2014). *The Value of Arts and Culture to People and Society*. Arts Council; London.

[xi] White M. *The Cultural Value of What Goes Around Comes Around*. Blog post of 28 March 2014 on Centre for Medical Humanities, Durham University website at www.dur.ac.uk/cmh (accessed 10 April 2014)