

**Arts and Health
Programme for Nuneaton
2010-2011**

**Report of Evaluation of the
Pilot Programme
on behalf of
Warwickshire County
Council
April 2011**



**Cultural
Consortium**

**NOTTINGHAM
TRENT UNIVERSITY**



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1. Executive Summary:

- 1.1 This report is an evaluation of the Pilot Phase of the Nuneaton Arts in Health programme, January to March 2011. It took place in 4 venues across the town for people with mental health or long-term physical health issues who were generally referred by the health or social care teams at each venue.
- 1.2 The 4 venues were at: (1) a health centre, (2) a clinic service for people with mental health difficulties, (3) a health & well-being (H&WB) centre, and (4) a District General Hospital (DGH). There were 56 participants over the life of the Pilots.
- 1.3 Methods of evaluation employed were qualitative - namely interviews with session participants, artists, link coordinators and service providers, plus diaries kept by the artists – and quantitative, through a comparative longitudinal case study methodology by administering validated questionnaire scales over the 12 weeks. This triangulated approach offered insights into the same phenomenon through data collection from a range of sources.
- 1.4 This evaluation is one of the most detailed analyses of the impacts of creative activities on people with long-term mental and physical issues who currently rely on the National Health Service for on-going support, because it has analysed the results session by session, addressed a group that is regarded as large (in comparison to other studies), and has taken a longitudinal focus into the sustainability of the project.
- 1.5 There was a statistically significant decrease in mental ill-health symptoms among the whole sample when comparing at weeks 1 and 12. A significant increase was also found with mental health-related quality of life levels in the sample within the same period.
- 1.6 The decline in mental health symptoms and respective improvement in mental health-related quality of life continued over all sessions in the 12 weeks. This supports the case that the creative process itself is engaging participants over a substantial period and that they do not lose interest easily.
- 1.7 As expected, symptoms of physical health remained stable throughout the period.
- 1.8 There was a correlation between the quality of the creative process (i.e., what people achieved) and improvements in mental health. Participants engaged on a consistent basis, showed evidence of thinking about related projects, with some participants engaged in related activities in between

each session. It was evident that almost all participants were highly engaged and wanted to come back on a regular basis to continue their work.

- 1.9 Health managers who referred participants to the Pilot projects all wanted to see this programme continue in the future.
- 1.10 In the context of NHS reorganisation, this type of project can offer a cost-effective alternative to conventional treatments that can achieve results. Further evaluation of the drop-in phase, using appropriate methodology, will continue. It would be helpful if this phase could include an analysis of Social Return on Investment (SORI) to evaluate the comparative cost of the programme.

2. Introduction

2.1 Rationale

The evaluation has been based on the need to address the lack of an evidence base into whether participatory arts workshops, which use a range of different art forms, can offer benefits for people with ongoing health problems.

The main aim of this work was to evaluate the provision of an Arts and Health Programme designed for residents in north Warwickshire who have chronic health problems. The evaluation has had the objective to monitor the health, well being and quality of life among people who took part in participatory arts sessions during a 12-week pilot period within one of four pilot study sites.

2.2 Evaluation Methods

A mixed-method design approach was used. The processes and outcomes involved with the participatory arts sessions were also evaluated by using qualitative data collection techniques, namely interviews with: session participants, artists, link coordinators and service providers. Qualitative data from diaries kept by the artists were also analysed and used to supplement the quantitative data and the interview data. For the quantitative part of the study, a comparative, longitudinal case study methodology was employed by administering validated questionnaire scales.

A total of 56 people took part in the Programme. At some point during the Programme, 48 of these participants had completed at least one evaluation questionnaire about their health and well-being. For the evaluation, 20 stakeholders were interviewed; these stakeholders were people involved in the process of this Programme, either as a participant or as the providers of the Programme or as a service provider where one of the pilot sites was based. Diary data provided by the link coordinators after each of the sessions were also analysed.

The arts and health Programme started in January 2011 and finished in March 2011, after a period of 12 weeks.

2.3 Main Findings, in Summary

Salient findings from questionnaire data included a statistically significant decrease in mental ill-health symptoms among the whole sample when comparing at weeks 1 and 12. A significant increase was also found with the mental health-related quality of life levels in the sample within the same period. Physical health-related quality of life did not differ significantly over this time, which was anticipated, since the activities in the Programme were not necessarily meant to boost physical health but were rather more likely to foster good mental health among participants. Well-being in the form of being engaged in a state of 'flow', in which one is being fully challenged, did not differ significantly over the pilot Programme period and neither did scores on a standardised measure of well-being related to satisfaction with one's life. Well-being, in the form of positive and negative mood states measured before and after each of the 12 sessions, was generally good. Across the whole duration of the pilot Programme, there were consistently higher levels of positive mood states

when compared with negative mood states before, or after, any of the sessions. When comparing the change in negative or positive mood states before and after each session, the change was most pronounced after the first session; negative mood states were reduced markedly at the end of the first session, while increases in positive mood states were a feature of most of the sessions.

Qualitative data uncovered a range of themes including one that focused on the positive impacts that the Programme had had on participants. The non-judgemental, supportive atmosphere was appreciated by participants, particularly in being able to progress at their own pace. Participants saw the Programme as “a healer” and one in which they could focus on the joys in being creative; some of them appeared to be ‘drawn’ to attend, even if they were not feeling well, as it appeared that the Programme helped some participants to cope with their ongoing health problems. The interpersonal dynamics, in being supported by the Escape staff and by fellow participants, were particularly appreciated by the interviewed participants. One theme that arose out of the interviews was that of the Programme having an unclear identity to some participants and service providers. Another theme was the perceptions of lack of support by service providers to the Programme, although this was not always the case and there was evidence of strong support from some service providers who were able to envisage the benefits that the Programme could provide. Other themes that were uncovered from interview and diary data included: the inclusive philosophy of the pilot sessions and the challenges involved; difficulties experienced with the evaluation process; and the ability to maintain enthusiasm and interest with the shift to the drop-in sessions.

3. Background

3.1 Current Research into the impact of Arts and Health

There is a substantial body of evidence to support the role that the arts can have in promoting and maintaining satisfactory levels of health and well being. A working party set up by Harry Cayton, National Director for Patient and the Public, has found that “*Arts and health initiatives are delivering real and measurable benefits across a wide range of priority areas for health, and can enable the Department [of Health] and NHS to contribute to key wider Government initiatives*” (Cayton, 2007; p.3). This working party also found evidence of a wide range of good practice exemplars to show the role that arts can have on health, with the arts being defined as “literature and writing, theatre and drama, dance, music, visual arts which include crafts, new media, architecture, design, moving image, and combined arts” (Cayton, 2007; p.5). Arts Council England (2007) also concluded, with their own report of the evidence, that participation in the arts can have an impact on key social determinants of health and illness such as the development of social capital, improvement in living environments and developing better levels of education.

A wealth of research (e.g. Staricoff, 2004) has shown that arts can have beneficial effects on health and well being, and on health care delivery. However, there are issues that still need to be addressed concerning the efficacy and utility of the arts for promoting health and preventing ill-health. Many of the studies have focused exclusively or primarily on music when making claims for the evidence base on the impact of the arts on clinical outcomes. There is very little available research into the impact that interventions with *multiple* art forms can have on health and well being; this Arts and Health Programme is aimed at addressing this gap in the literature by examining the impact of a participatory arts project with the utilisation of a range of art forms across the life cycle of the Programme.

3.2 How this Study increases our understanding

A review of research into the arts and mental health by Walford (2010) has demonstrated that the arts has a pivotal role in promoting good mental health and in reducing symptoms of mental ill-health, especially in effecting a sense of social inclusion and community cohesion. However, the recent studies that Walford (2010) has reviewed have been relatively small-scale in size and have not used a mixed methods approach to understanding what makes arts participation have such an impact on health. For example, Walford (2010) refers to ‘larger scale’ studies such as by Eades and Ager (2008) and by Hacking *et al.* (2008), which involved analysis of only 59 and 61 participants respectively, albeit over two time points. Eades and Ager’s (2008) research of participants at the start and end of a 12-week community arts course did not capture session-by-session as to which sessions may have had an impact on health and well-being; likewise, they did not use validated questionnaires but instead used six, brief health-related questions to measure impact. By contrast, ***the evaluation of this Programme’s pilots has analysed health and well-being session-by-session*** and has employed standardised instruments to do so. Moreover, the pilot sites (and its evaluation) have involved delivery of participatory arts activities to groups that could be labelled as ‘large’ by Walford’s (2010) standards;

the focus of this Programme has been to create a sustainable Programme for a relatively longer period than those projects described in the literature, which appear to have a short-term nature instead. For the next stage of activities, the Programme will seek to welcome a wide range of people in the north Warwickshire region who may have a variety of health and social care needs, by establishing a site for ‘drop-in’ sessional Arts and Health activities for at least 6 months, with a view to making this Programme sustainable in the long-term.

Reviews of arts and health projects have also shown that there is a lack of good quality studies with the use of triangulation (i.e. gathering data on the phenomenon from a variety of perspectives or methods) to get an optimal understanding of an arts and health Programme. As a result, Walford (2010) has argued that there is dire need for projects to “*use triangulation of quantitative standardised outcome measures and qualitative analysis of interviews with participants to provide broad based and rigorous support for their activities*”. The pilot evaluation of this Programme has used multiple data collection methods so far, including: standardised outcome measures of well being, health and quality of life; analysis of face-to-face interviews; and collection of documentary data in the form of diaries that were kept by the artists.

3.3 What we understand by mental wellbeing

To measure health and well being of participants of the participatory arts sessions, it will be helpful to define what is meant by these concepts. Health and well-being is more than the absence of disease. According to the World Health Organization (2007), “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” It encapsulates a wide range of characteristics including physical, emotional, interpersonal states of being. To be healthy includes a person’s subjective well-being, which encompasses three main areas (Seligman, 2002):

- **Hedonic States** (e.g. focusing on a person’s emotional state at any given time);
- **States of Engagement** (e.g. the phenomenon of flow in which a person is fully challenged, driven by the joy of the activity itself, and the person’s sense of time passing is distorted so that time seems to speed up or slow down); Being fully engaged, and in a state of flow, has been found to occur in a range of activities including participation in the arts (e.g. Bakker, 2005);
- **Purpose/Meaning-Making** (e.g. deriving a sense of satisfaction for a life well-lived and a sense of meaning from each activity).

In the current pilot evaluation these states of well-being have been measured, along with assessments of mental ill-health symptom frequency and levels of quality of life. Quality of life (QoL) refers to “functioning and well-being in physical, mental and social dimensions of life” (Farivar, et al., 2007). For this Programme, the pilot evaluation measured the physical health and mental health dimensions of QoL.

3.4 The Nuneaton Context

In August 2010, Warwickshire County Council Arts Service had sought to fund an organisation to establish regular arts drop-in sessions in the north of the Warwickshire county (located in either Nuneaton & Bedworth borough or North Warwickshire borough), which will be targeted at health and wellbeing service users. The Arts and Health Programme was funded from this call for funding bids under Warwickshire County Council's 'Arts and Health' funding stream. The call for bids had required the following for the evaluation to *"capture: number of attendees, regularity of attendance (by individuals), impact on health and wellbeing outcomes for attendees in terms of mental health and well being, independence and access to health and support services. If possible both qualitative and quantitative evaluative tools should be employed, with a range of comparative input sought from service users, support staff and artists"* (Warwickshire County Council 2010, p.2).

Some of the communities within Warwickshire (particularly in the north of the region) are facing a number of challenges. Some parts of the region, such as the base for one of our pilot study sites, are undergoing considerable levels of neighbourhood regeneration but also face a number of challenging social and health care needs. The Joint Strategic Needs Analysis (JSNA) for Warwickshire has identified a range of health and social care needs relating to mental health and well being and living with long-term conditions (Warwickshire County Council & NHS Warwickshire, 2009). The six most deprived Super Output Areas are all in Nuneaton and Bedworth. As a result, the funding that Warwickshire County Council has given to conduct the current project is aimed at seeing how well an arts and health scheme can work in a geographical region that has levels of social deprivation and is in a state of regeneration and renewal.

3.5 The Intervention

3.5.1 The Team, Managing Delivery

Escape: Community Art in Action is an established participatory arts team, based in Stratford, Warwickshire. It works with people who have difficulties with health and well-being and has set up similar drop-in projects in the area, with support from health professionals, including creative projects around healthy eating. It has devised and delivered creative projects for people with mental health issues at Queens Road Wellbeing Centre in Nuneaton and Bedworth district, for older people at Bracebridge House and those with early onset Alzheimer's disease - both of these schemes in Atherstone, North Warwickshire.

Cultural Consortium Ltd is a cultural sector consultancy company based in Nottingham that has been in operation since 1996. It specialises in innovative research and development to show the benefits of non standard approaches, particularly with the third sector, and is at the forefront of implementing new business models to assist the third sector in working within a context of commissioning and other new ways of providing services.

Nottingham Trent University was used to provide expertise on the design, collection and analysis of data related to the Programme through Dr Glenn Williams of the Psychology Division.

3.5.2 How it was delivered

From January to March 2011, four pilot projects were held in sites within north Warwickshire for people dealing with ongoing physical and/or mental health issues.

The artists delivering the intervention were tasked with developing tailor-made participatory arts sessions providing a range of creative skills and media. These sessions would engage participants in a variety of interests and offer each individual with the opportunity to develop skills within their own capacity at the same time as challenging expectations of their abilities. The artists devised programs that allowed individual 'voyages of exploration' and creativity without any preconception of outcome. In addition, each artist was asked to develop collaborative opportunities for those participants willing to get involved and to prepare some work for exhibition at the end of the pilot. The objectives of the activities were to allow individuals to feel comfortable with the activities so they could find new ways of expressing themselves and discover new talents or to re-discover talents they already had. The skills offered through the pilots included print-making, a range of textile techniques, photography, creative writing, hand-made book-making, collage, painting and drawing and ceramics. The collaborative work developed during the pilots included a large textile hanging, a Ceramic wall feature and portfolio books of work by all participants.

At the end of the pilots, work from all four pilots was exhibited as an Arts Trail running through a number of central community spaces in the centre of Nuneaton. This Trail include the chosen venue for the Integrated 'Drop in' project that will follow these pilots involving an on going weekly session which has been planned for a minimum of 6 months. All the spaces used for the Trail are familiar to many of the pilot participants and frequented by the wider community in Nuneaton. It is hoped that this familiarity will encourage current participants to feel encouraged to make the move to the new venue and that they will be joined by other members of the community to develop a more integrated group.

Appendix 1 by Robin Wade, from *Escape*, provides a fuller account of the processes involved in running the Arts and Health Programme.

4. Evaluation Goals and Methodology

4.1 Objectives

For this evaluation of the Pilot Phase, the Objectives were:

- To assess, through the use of standardised and validated measures, the health, well being and quality of life upon entry into, and upon completion of, the pilot of the participatory arts Programme;
- To assess health, well being and quality of life at various stages during the pilot Programme;
- To evaluate the processes and products that emerge from these participatory arts events through using qualitative methods of data collection.

4.2 Participants in the Programme and the Evaluation

Inclusion criteria for being invited to take part in the Programme and the evaluation included: having an ongoing physical or mental health problem, having the capacity to give informed consent to take part, and the prospective participant should be aged 18 years or older. The four pilot sites were a health centre, a clinic for people with mental health difficulties, a H&WB centre, and a DGH.

4.2.1 Participation levels and their contribution to the evaluation

These were as follows:

- 7 participants at the health centre, with an average rate of attendance of 4 participants per session. Participants were generally rated as keen and fully engaged with only two exceptions in which the participant was rated as moderately engaged.
- 16 participants at the clinic, with an average rate of attendance of 6 participants per session. Participants were also rated overall as being keen and fully engaged in each of the sessions. There was one instance of a participant being rated moderately engaged in session 1 but that person was rated as being keen and fully engaged from session 2 onwards. Two participants were rated as being moderately engaged in sessions 5 and 7 and then did not attend from session 8 onwards. One participant attended only sessions 5 and 6 and was rated as being diffident over both sessions and then did not attend from session 7 onwards.
- 21 participants at the H&WB centre, with an average rate of attendance of 11 participants per session. Participants were generally rated as keen and fully engaged in the sessions, with only one or two exceptions in which they were moderately engaged.

- 12 participants at the DGH, with an average rate of attendance of 9 participants per session. Almost all participants were rated as being keen and fully engaged. One participant was rated as being diffident over two sessions and then did not attend from the third session onwards.

Evaluation questionnaire data were collected from 48 participants. One participant completed the pre-Programme questionnaire and the pre-session #1 questionnaire and then refused to complete any more questionnaires for the rest of the pilot Programme. Being asked to complete a questionnaire did not deter that participant from attending the bulk of the pilot sessions (9 out of 12) and that person still wrote a few words as feedback at the end of each session attended.

4.2.2 End of Pilot Phase Interviews

For the interviews, 18 interviews were conducted, with 20 people (i.e. 2 interviews with 2 people at a time), and used a semi-structured interview schedule. Interview topics did not adhere to asking questions in a set order but were rather adapted to meet the issues raised by the interviewees so that the interview had more of a conversation-like 'flow' to them. The interviewees were as follows:

- session participants, who were drawn from 3 pilot sites; it was recommended not to interview participants at one of the pilot sites because of the fragile mental states that many of the participants in that pilot site were experiencing on a regular basis.
- 6 Escape: Community Art in Action staff (link coordinators/artists/project coordinator)
- 4 service providers (i.e. staff based in the pilot sites)

The total durations of interview length were 231 minutes with Programme participants, 238 minutes with the Escape team and 91 minutes with the service providers.

4.3 Instruments for Data Collection

The evaluation employed standardised questionnaire scales that measured health, well being or quality of life. The following tools were used:

- **Hedonic states of well-being** were monitored with the Positive Affect Negative Affect Schedule (PANAS; Watson et al., 1988). Through this scale, participants were meant to assess the extent to which they have felt each of a list of 20 emotions. Respondents needed to rate the extent of the emotional experience from 1 ('Very slightly or not at all') to 5 ('Extremely'). The PANAS measured positive and negative mood (also known as 'affect') states at the beginning and end of each session. The possible scores that could be obtained for the Positive

Affect and Negative Affect scales ranged from 10 (i.e. very low levels of a positive or negative mood state) to 50 (i.e. very high levels).

- **States of engagement** were assessed with the short form of the Flow State Scale (FSS; Jackson et al., 2008). This scale comprised 9 items and analysed the extent to which an activity has enabled participants to get fully engrossed and engaged in the activities during each session. Responses were coded using a 5-point scale. The Minimum and Maximum possible scores that respondents could get from the FSS were 9 and 45 respectively, with higher scores denoting more intense flow experiences after the event.
- **Levels of purpose/meaning-making**, which could be affected by participation in the project, were analysed with the 5-item Life Satisfaction scale (Diener, et al., 1985). Responses were coded from 1 ('strongly disagree') to 7 ('strongly agree') and scores that respondents could obtain on this scale ranged from 5 to 35, with higher scores indicating greater satisfaction with one's life.
- **Fluctuations in mental health problems** were assessed with the 12-item version of the General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988), which has been used to detect the levels of non-psychotic psychiatric morbidity. Responses were coded with the Likert method, which meant that items were analysed using an ascending scale of psychiatric symptom levels from codes of '0' to '3). This meant that GHQ-12 scores could range from 0 to an extremely high level of likely psychiatric morbidity of 36.
- To assess **quality of life**, the Short Form-12 (SF-12; Ware, Kosinski & Keller, 1996) was used. A complex algorithm (see Ware, et al., 1996) was employed to calculate quality of standardised measures of quality of life for physical and mental health, with higher scores indicating better quality of life.

Table 1 gives an overview of types of data collected and stages of data collection.

Table 1: Stages of data collection and methods used

Stage of data collection	Measure							
	PANAS	FSS	GHQ-12	Life satisfaction scale	SF-12	Interviews with participants	Interviews with artists, link workers & service providers	Ratings of creative work produced
After being referred				×	×			
Before each session	×		×					
After each session	×	×						
End of pilot phase				×	×	×	×	To be done

Key: × = measurement taken;

PANAS = Positive Affect Negative Affect Schedule; FSS = Flow State Scale;

GHQ-12 = General Health Questionnaire; SF-12 = The Short Form-12 on quality of life

5. Conclusions

5.1. Quantitative data using the standardised measures

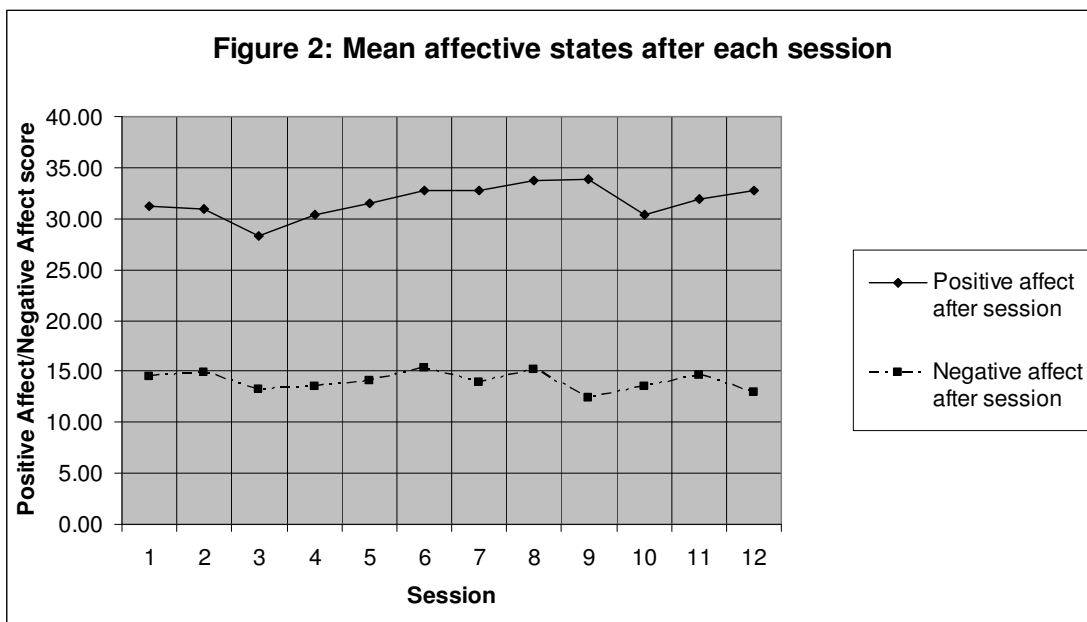
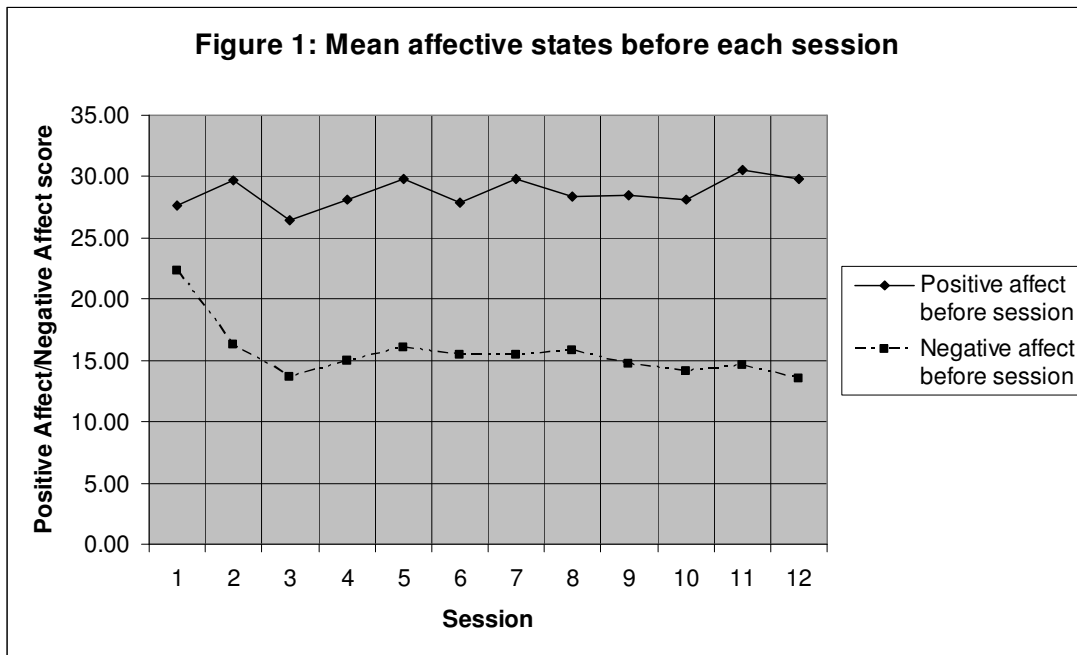
There were several assessments of the multi-faceted nature of well-being to capture its hedonic, engagement-focused, and purpose-linked forms. Hedonic states, namely positive and negative moods (or affective states) were measured before and after each session; flow – an indicator of engagement – was assessed after each session; life satisfaction (i.e. a purpose-linked form of well-being) was measured before the pilot Programme commenced and at the end of it. Mental ill-health was assessed at the start of each session by using the General Health Questionnaire to tap into the degree of psychiatric symptom experience over the week before the questionnaire was being completed. Quality of life was monitored at the beginning and end of the pilot Programme by using the SF-12.

5.1.1. Hedonic well-being – positive and negative affect

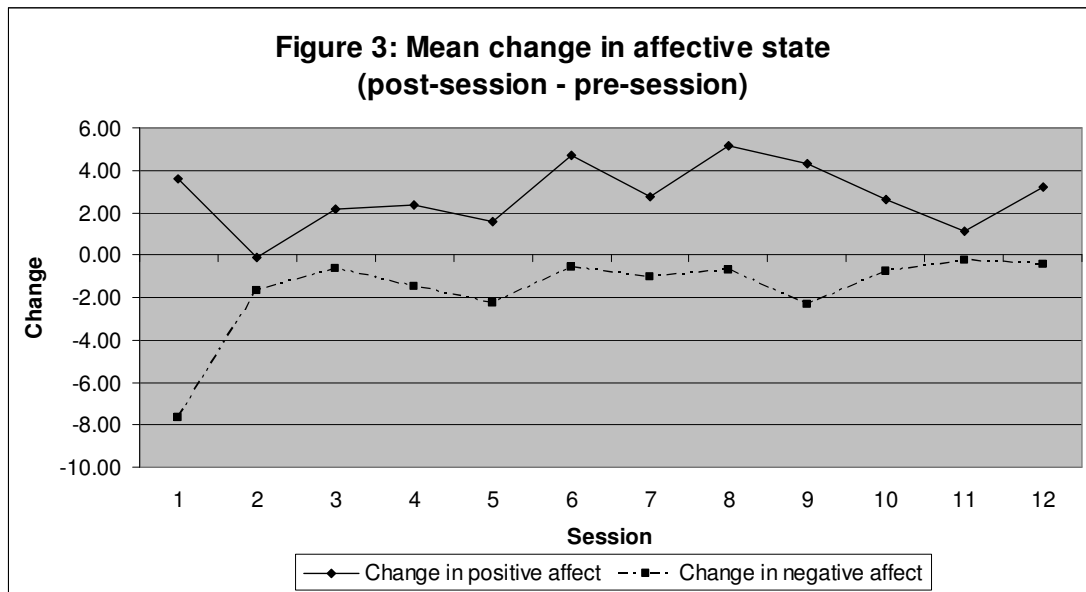
With positive affect levels before the sessions, this was on average, at its highest before session 11 (Mean = 30.55, SD = 12.34) and at its lowest before session 3 (Mean = 26.45, SD = 9.56). Negative affect was highest before session 1 (Mean = 22.35, SD = 9.80) and at its lowest before session 3 (Mean = 13.69, SD = 4.76).

After sessions, positive affect was highest after session 8 (Mean = 33.72, SD = 9.62) and lowest after session 3 (Mean = 28.24, SD = 10.29). Negative affect was highest after session 6 (Mean = 15.30, SD = 6.99) and lowest after session 9 (Mean = 12.38, SD = 3.26).

It is clear from the trends obtained on participants' levels of affect before, and after, sessions that there was a general trend for negative affect to decline after the first couple of sessions and for the negative affect levels to stay consistently stable after that initial decline. On the other hand, positive affect levels before the session had commenced were generally stable around the 27-30 mark, whereas after each session positive affect levels were consistently above the 30 mark, with only one exception. Figures 1 and 2 illustrate these overall patterns.



Most importantly, to examine the impact of the Programme on well-being, we examined the overall degree of change in positive affect and negative affect by subtracting the respective affect scores after a session from the affect scores before a session. Figure 3 below shows the Mean differences in affective state per session. As can be seen, the largest increase in positive affect occurred in session 8 with a Mean of a 5.17 (SD = 6.83) rise in positive affective states. Negative affect, conversely, did not increase at all after any of the sessions. The largest Mean decrease was after session 1 with a Mean reduction of -7.66 in Negative Affect (SD = 8.64).



5.1.2. Engagement levels of well-being – flow

Flow was measured after each session to check for any changes over time. As expertise and familiarity with the activities grew, it was expected that flow levels would also increase. Table 2 gives an overview of the Mean flow scores for the total sample over the 12 sessions. Mean flow states peaked at session 9, but generally the flow scores remained relatively consistent over the duration of the pilot project and did not fluctuate markedly. There was no significant difference between levels of flow reported after the 1st session when compared those after the 12th session, $t(17) = 1.83, p = .18$.

Table 2: Mean flow scores after each pilot session

Session	Mean (and standard deviation)
1	32.47 (4.96)
2	32.68 (6.29)
3	31.55 (7.15)
4	33.32 (5.21)
5	33.38 (5.08)
6	33.59 (5.51)
7	33.50 (5.22)
8	33.33 (5.36)
9	35.10 (5.37)
10	32.38 (6.61)
11	33.73 (6.87)
12	34.46 (6.16)

5.1.3. Well-being related to purpose/meaning-making – life satisfaction

The average life satisfaction score for the total sample was 18.05 (SD = 8.94) before participants commenced participation on the Programme which increased to a Mean of 20.55 (SD = 6.52). A related t-test found that, however, this increase was not statistically significant, $t(19) = -1.16, p = .26$.

5.1.4. Mental ill-health symptoms

As can be seen in Table 3, the extent of self-reported mental ill-health symptoms was of a moderate level at the start of the pilot Programme with a Mean score for the whole sample of 14.62 out of a possible 36. This average level of mental ill-health symptoms dropped to 10.86 in week 2 and later hit a low of 8.36 in week 11 before rising to an average of 9.21 in the final week. A related t-test showed that the difference in the reduction from week 1 to week 12 of GHQ-12 scores was statistically significant, $t(17) = 3.74, p = .002$.

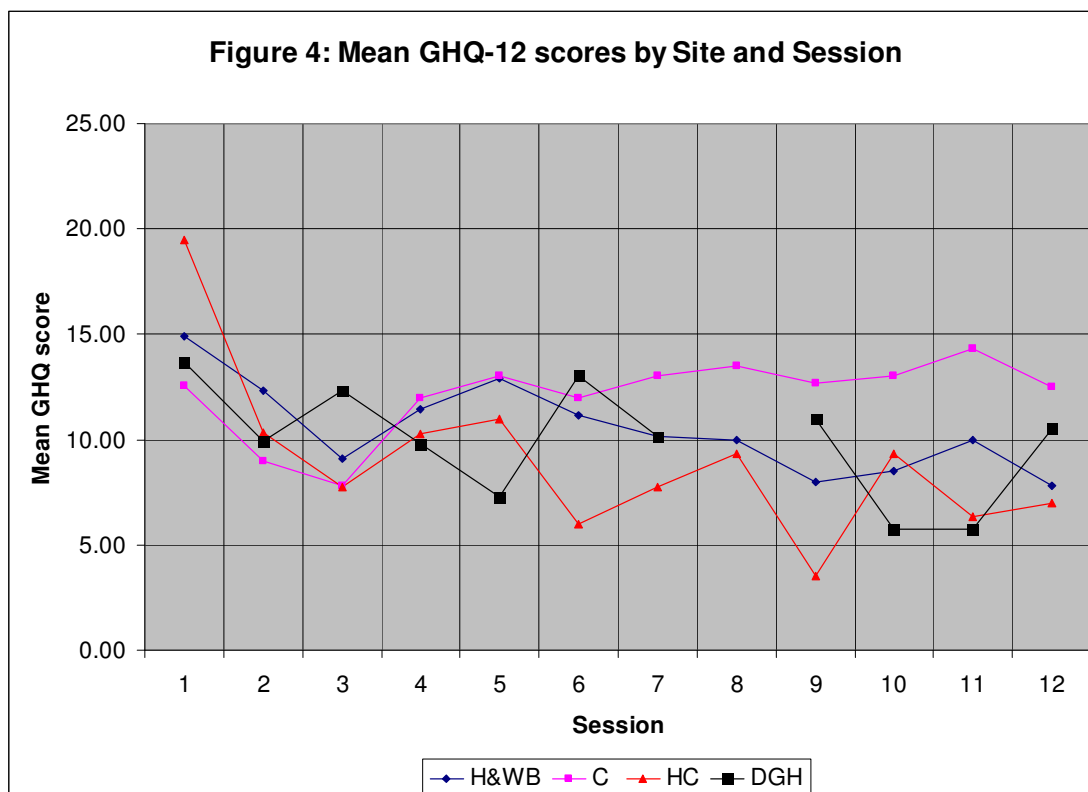
Table 3: Mean General Health Questionnaire (GHQ) scores for the total sample

Week	Mean (and standard deviation)
1	14.62 (6.61)
2	10.86 (4.56)
3	9.73 (5.79)
4	10.79 (4.89)
5	11.17 (4.89)
6	11.04 (7.08)
7	10.35 (4.86)
8	10.63 (6.92)
9	9.26 (6.39)
10	8.43 (3.72)
11	8.36 (5.99)
12	9.21 (6.25)

N.B. The GHQ measures levels of non-psychotic psychiatric morbidity – the higher the score, the poorer the mental health; likewise, the lower the score, the better the mental health.

Figure 4 shows the average GHQ-12 scores for each of the sites and before the start of each particular session. As can be seen in Figure 4, those at the health centre pilot had a drastic reduction in mental ill-health symptoms after session 1, whereas the clinic participants had an initial decline in mental ill-health symptoms after the initial 3 sessions but these symptoms then increased (on average) among this group and stayed consistently higher than the other pilot site groups. However, the clinic group did not, on average,

see an increase in mental ill-health symptoms beyond their initial levels at week 1.



Key: H&WB=Health & Well Being Centre; C=Clinic;
 HC=Health Centre; DGH=District General Hospital.
 N.B. There was no session 8 for the DGH group.

5.1.5. Quality of Life (QoL) for physical health and mental health

By using the SF-12, standardised scores were calculated for the QoL that participants reporting having for their physical and mental health. An Analysis of Variance was calculated to examine potential differences in these scores when comparing between the pilot sites and detecting any changes from week 1 to week 12. No significant differences were found between the sites in relation to QoL for mental health or physical health. Likewise, there was no significant difference in QoL for physical health when comparing these scores before and after the pilot Programme. However, a difference was found in overall QoL for mental health at the beginning of the pilot (Mean = 40.61, SD = 13.23) versus at the end of the pilot (Mean = 47.36, SD = 8.92); a mixed two-way Analysis of Variance showed this difference as statistically significant, $F(1, 17) = 5.53, p = .03$.

5.2. Findings from Qualitative Data Analyses

Thematic analysis (Braun & Clarke, 2006) was used with the interview and diary data with the focus on finding common themes that were shared by more than one informant.

Common themes that arose from the interviews included the following:

5.2.1. The positive impact of the pilot project on well-being

Participants reported that they felt valued and did not feel judged personally by fellow participants or by the Escape team. They felt valued in their own right as human beings and willing to learn from each other. There appeared to be a provision of unconditional positive regard to participants, as is evidenced by the following quote by one participant:

"...this art group has been a healer. It's helped to heal me and I've had companionship here and...there's been no demands on me and I've been allowed to work at my own pace".

Feelings of being inspired were also expressed by participants and this seemed to be connected to the participants' levels of well-being as well, as the following quote from a participant suggests:

"...it [the session] gives you a great sense of inspiration and also we have an inspirational teacher, you know, art teacher, and then every week she comes errm, you can sense this inspiration that's inside of her and then errm you feel the inspiration".

Participants appreciated not being patronised by fellow participants and the Escape staff when discussing the work produced; it was viewed as an environment to get and offer mutual support that was constructive and critical. One participant reflected on this dynamic:

"I've done art classes in the past and you can do something that's really rubbish and the teacher will say 'oh yes, that was really nice' [said in a condescending tone by the interviewee], then if they [the artist/link coordinator in the pilot sessions] don't think it's looking particularly well they'll well say 'try doing this or try doing that'. They won't turn around and say 'that's that's really nice', which is what some people have done. They're honest with you and they'll say, 'well, that's not quite right, do you wan help tweaking it that way or that way' so I value the teacher [the Escape staff] for that".

5.2.2 Focusing on the Creative process

The positive impact of the pilot Programme was also reflected on concerning the ongoing problems that the participants were facing. This was something that various interviewees noticed in that the sessions were a diversion for participants in being less aware of their own problems. Any difficulties or personal issues were not 'on the table' among the participants for discussion

as the focus was on engaging with the art. The participants seemed to appreciate the normality of being in a situation where their problems were not the main topic of conversation. Any personal problems could come out in normal conversation because participants generally felt safe to talk about them if there was time and space to do so but it was not the main focus for the activities for most of the sessions. With one of the groups, the participants did not know each other and this led to reticence among them with the artist noting in conversation that *“they don’t know what to expect. A lot of them were just quiet, you know, just quite silent and just taking things in”*. In one of the groups, it took until the fifth session for a breakthrough to take place and for group members to reveal something personal about themselves. Through the use of metaphor, the artist was able to provide participants with a safe space to see their art as a way of learning about themselves and to be able to trust others to reveal something personal about them to others. The artist reflected on this breakthrough moment in the diary and also in the interview,

“...people started to come out with amazing stories, I mean, very traumatic stuff and they felt at that point, must have felt comfortable enough and secure enough and safe enough to start sharing and it was almost like they suddenly felt they had permission to start revealing things that were difficult”.

The importance of using the Programme as a means of coping with a health condition and in giving a sense of purpose to one’s life was a theme that arose from the interviews. One service provider noted how essential the session was to the well-being of a participant, who was having problems with his health condition,

“One gentleman...had a tough week with regards to his condition and his carer said that he [the participant] definitely wanted to come along to this even though he hadn’t had the best of weeks...so that in itself can be helping, I believe, the patient through that time while maybe things are a bit low it’s, well, ‘I’m going...I’m definitely going to get there’ and that is almost, is like a goal for them, isn’t it?”

This issue of feeling the need to attend, even when not feeling well, was also echoed by some of the participants who were interviewed; there was a strong ‘pull’ for some participants to keep attending the sessions and these beneficial effects were also noted with the exceptional instance of one participant. This person had attended one of the pilot sessions in the morning and then went to attend another one of the pilot sessions in the afternoon. It was evident that this participant had found the sessions had given an opportunity to fill the day with nourishing activities; the morning session was different in the use of art forms when compared to the afternoon

session, so there was a range of artistic activities that this person could engage in throughout the day.

Another theme that arose was the interpersonal element of the sessions with the socialising and the provision of mutual support being a key element of taking part, in addition to the actual creation of artwork. One participant said that he appreciated being able to meet, and talk with, someone who had a similar health condition. Given that his health condition had a lack of information concerning how to deal with it and there was little in the way of support groups for this condition, this participant appreciated being able to exchange information and tips with the other person who attended the sessions. Another participant in the interview said that she appreciated the camaraderie in the group and being able to laugh and share a joke.

5.2.3 Achieving individual goals

Another theme from the interviews centred on the act of creation and the pride associated with achieving a goal through these creations. This is epitomised by a participant who said, “...it doesn't matter if it's [the artwork] not shop quality...because the important thing is it's something you have made, you have created”, while another participant reflected in a similar vein on the book that she had made, “I wouldn't say it was excellent but to me I'm proud of it, you know, something to show”. An impressive feature of how the theme of creation recurred and was being sustained by some of the participants by giving them a sense of a mission in life was evident when the interviewer was being shown work by one interviewee; this work had been continually sculpted and added to from week 1 until week 11 when this person's interview was being conducted. The interviewee had used the task of creating this work as a means of opening her eyes to new possibilities to refine the work and lead to a creation of which she would be proud. It was evident from many of the interviews with the participants and from observing what took place during some of the sessions that participants derived a great deal of pride from their creations. The act of being involved in creation was also being made sustainable by some participants in that there was an effort by some participants to transpose some of the activities in the sessions into their home lives (e.g. one of the Escape staff noticed that a participant had purchased materials to carry on the participant's work at home, whereas other participants in the interviews had noted that they were a lot more imaginative and full of ideas after attending the sessions and that this sometimes spilled over into their lives outside of the sessions).

5.3 Perceptions of the Health Managers

5.3.1 Labelling of the Programme – having a transparent identity to all

Through the interviews with the service providers and participants, it was evident that there was some confusion over what the Programme entailed and what it was meant to achieve. Was it using the arts as a route to well-being or something labelled explicitly as art therapy? For instance, ‘art

therapy' was used as a phrase by one of the service providers when talking about the Programme. One of the participants recounted how he was introduced to the Programme by a health professional who jokingly said that this was something that they would like to prescribe for the participant. Conversely, the Programme could have been seen by some as educative rather than primarily therapeutic. In two of the pilot sites, participants referred to the artists as 'teachers' and the sessions were called 'classes'. However, this was not necessarily how the Escape staff saw these sessions or their roles. For instance, one artist mentioned, *"I was called a teacher at one point"* but the artist thought that the participant was being facetious when using that phrase and was not actually seeing the artist in that way. The artist then went on to explain how she saw her role in the context of the sessions:

"I don't think of myself as a teacher, at least I hope not. I see myself as a facilitator, as an enabler, as somebody that is there to provide for whatever... a struct-, to provide a structure first of all, a framework, for what they...to work within... but within that framework there has to be an enormous amount of freedom and I really work hard to maintain that... by not being too directive".

Also, perhaps the service providers saw the sessions as a means of having a break from having to tend to service users' needs; this was evident as a possibility on a number of occasions as a possibility when talking with service providers and the Escape staff. In a sense, the service providers may not perceive the participatory arts sessions as anything more than a mere distraction rather than a Programme that could confer some tangible benefits to the participants. Escape staff perceived that the attention that some service providers paid to learning about the content and format of the sessions was relatively cursory and it is possible that this lack of attention to what transpired in the sessions could have perpetuated a lack of clarity among service providers as to what the Programme entails. According to the diary entries, some service providers, medical students and nursing students took the time to visit and watch the activities that took place in the sessions, and occasionally joined in. This was an encouraging sign but the perceptions of the Escape staff were that this did not occur that often and that there was a lack of appreciation among some service providers regarding the value of the Programme. It was noteworthy that one of the artists reflected on her disappointment in the service providers not acknowledging how far some of the participants had progressed. The artist recounted an instance of one participant who had profound mental health problems and who had made significant progress in trusting the artist to put that participant in what he could have felt would have been a vulnerable position; the artist was impressed by seeing how far the participant had come in being able to show trust in another human being when previously the participant was very reluctant to interact with others.

Overall, how some service providers may have been presenting targeted people, who might like to participate, with information about the Programme was perceived by Escape staff as potentially problematic. For example, one Escape staff member saw a potentially neutral, or utilitarian way, of informing people about the Programme as a means of ‘fixing’ the person as perhaps hindering some of them from attending. The Escape staff member thought that the following dynamic could be occurring when health professionals were telling patients about the Programme,

“if you’re presenting them [the Programme workshops] by saying ‘we’re running these workshops and I think it would be in your interests to come and attend’ cos, you know, it’s fairly off-putting, it’s like saying to an overweight person, ‘you need to go to the gym’. It’s like confronting someone with an ordeal, you know, and it depends again how it’s presented. If it’s presented in the light of ‘we’re running these fun art-making workshops and it’s a good fun and everybody enjoys the social aspect and it’s a bit of time out for yourself that you can every week to just come and enjoy yourself without it being ‘you must do this for your mental health’. It’s subtle, but it’s powerful, isn’t it?”

5.3.2. Perceptions of support from service providers

In two of the pilot sites, the Escape staff did not perceive that they had the full support of the service providers in staging the Programme sessions on the service providers’ premises. This may be due to a variety of reasons but in those two sites it did not appear as if there was much interaction between Escape staff and the service providers. Some service providers claimed in their interviews that they had not got around to seeing what had been done in the sessions and in learning about how the participants were faring. However, this perspective can be contrasted with some service providers who were able to find the time to attend and perhaps even participate in the session. For instance, one service provider who was able to visit one of the pilot groups on a number of occasions and did join in said *“I’ve enjoyed coming along because they’re all different characters, they’ve all gelled well”*.

Concerning the different forms of perceived lack of support, some of the Escape staff interviewed in one of the sites recounted problems in accessing the booked room in time for when the session was due to start; Escape staff also said that service providers acted in ways that were not conducive to the smooth running of the sessions; it was claimed that some service providers were talking loudly while the artist and link coordinator were trying to support the participants with the session’s activities, while at other times participants were being called away for seemingly innocuous reasons, which was likely to have interrupted the participant’s progress in that session. The Escape staff did not think that they (and the participants) had been given protected time and space, with the possibility that the participants could be

interrupted at any moment. Overall, in one of the sites, the Escape staff perceived themselves as being 'unwelcome guests'. The allocation of time and space for the sessions was perceived as being provided in a half-hearted and non-supportive manner in which the service providers could intrude in the activities at will (e.g. calling one of the participants away from the session to complete a census form); likewise, there was also perceptions by Escape staff of poor communications and relationships between them and the service providers.

However, a theme of perceptions of lack of support from service providers can be contrasted with a theme that arose among some of the service providers who were highly supportive of the Programme; they demonstrated this with their views on the Programme, as well as with their actions. For example, one service provider continued to use a range of positive concepts to represent how she had seen the inherent worth of the Programme. Typical quotes from this service provider indicated her respect for the Programme with statements like *"I think some people [participants] have come alive..."* and *"It's actually celebrating our patients have got a creative side and...other patients will relate to that"* and, when talking about a specific participant's experience of the Programme, the service provider noted that *"she's found coming here has been even more inspirational and...she's found this fantastic"*. In at least two of the pilot sites, the service providers would attend some of the sessions and see how the participants were faring and would also observe the kinds of activities that were involved in the sessions. In many respects, some of the service providers were openly supportive, whereas other service providers appeared more lukewarm about the Programme and its merits.

5.4. Designing to be inclusive and participative

It was observed by all types of interviewee (i.e. service provider, participants, and Escape staff) that the overall ethos of the Programme was one that was highly inclusive and enabled all those involved to feel that they could take part in a non-threatening environment. A quote from a service provider was especially revealing about this approach, when it was said that *"I think the tutors have been fantastic. There's no sides... there's no levels."* When the service provider was asked about what was meant by 'sides' and 'levels', she said that was meant by 'sides' and 'levels' involved *"We're teaching you. We're showing you"*. Instead, the service provider saw the following dynamic transpired:

"...it's all very seamless, it just flows, everybody's helping each other, sitting down and enjoying it, there's no sort of um, it's not prescriptive, it's very fluid and I think that's what the aim of the project was from my understanding so that the people that come along didn't feel under any pressure, they felt it was flexible, that they wanted to stay for 10 minutes or the whole session, that was up to – how they felt and most people, to be fair, once they've got into the artwork got engrossed and they've done more than one piece".

There were challenges in maintaining the dynamic of being fully participative and inclusive. For example, one participant exhibited very challenging behaviour by making loud noises throughout the session and by putting the other participants 'on edge'. This instance was problematic as many of these participants in the session were struggling with mental health problems and the need to include everyone may have made it very difficult for everyone who attended. As it was, the person exhibiting the challenging behaviour did not attend after that one time. However, it did appear to affect the participants in some respects (e.g. one of the participants did relate in the completed questionnaire after that particular session that they felt guilty about their negative feelings towards the person who was behaving in a challenging way).

The cohesiveness of the groups that attended also appeared to be quite critical to the success of the sessions. For example, in one of the pilot sites, the participants already knew each other from visiting the venue on a regular basis and some of them will have had an experience of working with the Escape staff beforehand (e.g. both the service provider and one of the participants noted that they had had positive encounters with one of the Escape artists working there before). By contrast, group members who did not know each other that well before attending appeared to take a little while to build up a rapport with each other. However, the rapport-building process did not appear to take too long, as one of the service providers observed that,

"some of them [the participants] have been a bit apprehensive to start, very quiet, um within probably I'd say week 2, week 3, people were opening up and were quite looking forward to it".

5.5. Dealing with the evaluation process

The questionnaires were seen as intrusive by some and potentially interrupting the flow in being able to get participants engaged with the activities in the Programme. Although the questionnaires enabled standardised methods of data collection to be carried out in a systematic way, this was not to everyone's satisfaction; these measurements were seen as problematic by reminding participants of their problems, which then did not induce a 'feel-good factor' at the beginning or end of the sessions.

This concern with the tools being used at the start and end of the sessions was conveyed through a quote from an Escape staff member:

"Putting yourself in their shoes, if I had to come to a workshop session and I was wanting it to be fun and enjoyable and productive, the first thing I wouldn't want to do would be to sit down and write about how I was feeling. I think that would be enormously off-putting".

Despite this potential problem with the evaluation process, there was still an acknowledgement that it was not a significant barrier overall and was soon integrated into the session's activities, as one Escape staff member noted:

“The form was very awkward. It was a bit of an imposition for most people but, as the weeks went by, people got used to it and they just did it, you know, as a matter of course”.

5.6. Planning for the Transition to the Drop-in Sessions

It was clear from the interviews with participants, Escape staff, and some service providers that there was a concern about how to the next steps to be taken after the pilot sessions had finished and how to sustain the Programme in the longer term. For some session participants, there was a preference to keep the sessions based at where they had been taking part, especially among those taking part at the DGH and the health centre. There were concerns among Escape staff about the sustainability of the Programme in being able to attract pilot participants to the drop-in sessions at St Nicholas Community Centre in Nuneaton. Some Escape staff thought that perhaps having the drop-in sessions in the Nuneaton town centre may prove to be a barrier to attending, albeit a psychological one. However, there were encouraging signs regarding attendance at St Nicholas Community Centre by pilot participants from further sites further afield, with some of them attending the Arts Trail (see Appendix 1) and expressing a willingness to attend the drop-in sessions.

By contrast, the sustainability of enabling pilot participants from the clinic to attend the drop-in sessions appears to be less promising. None of the participants from that pilot site attended the Arts Trail to see their work exhibited (see Appendix 1). Attendance of the drop-in sessions by clinic participants in the drop-in sessions would be reliant on the help from support workers. From interviews with Escape staff, it is likely that, if any of the clinic service users wanted to attend the drop-in sessions, then they may get lifts from some of the service staff for the first few sessions. However, travel arrangements would need to be arranged by the service user in the future if that service user wanted to continue attending.

For those participating at the other two pilot sites, it would appear that there is a good level of willingness and interest in making the time to attend the drop-in sessions. At the DGH, a few interviewees identified the convenience of fitting in the Programme attendance on the Thursday afternoons with other clinic appointments at the Hospital on the same day. However, it did not look as if the situating of the drop-in sessions would be a deterrent for the DGH and H&WB centre pilot participants – some of them attended the Arts Trail and it was evident from interview data that the participants were willing to travel quite a long distance, if necessary, to take part in the Programme activities.

Some participants who were interviewed for this evaluation appreciated the drop-in nature of the sessions that are planned in that they were not expected to attend every session if they could not and that there would be an ‘open door’ policy for whenever they were able to attend. This is likely to be an incentive to some participants if they have missed a few drop-in sessions as they will presumably not be deterred from still attending, even if they have missed engaging in some of the activities before the sessions that they actually attend.

There was sadness among some participants in their interviews that the pilot Programme was coming to an end and that they would need to wait for a period before the drop-in sessions started. One participant, for instance recounted how she was feeling during the eleventh week of the pilot Programme when noticing that the pilot Programme was nearing its end, *“bit sad... bit sad when you’ve got used to coming, you know, and you look forward to it, gets to out of the house”*. Another participant echoed these sentiments as well, *“I’m going to miss it, it’s going to be a wait, a month or two before the next course starts so I think I’m going to miss it cos it’s a really nice day so when you come here and let your emotions on paper”*.

An encouraging sign for the sustainability of the Programme is the commitment and enthusiasm that participants, Escape staff, and service providers appear to have for this kind of Programme. A typical quote from one service provider illustrated this,

“I think there is a definite need for something like this...I go back to the person that it [the Programme] made a huge difference to...it, I think there needs to be more things like that. If it can impact one person like that then it can impact more...it can kind of help a lot more people into recovery and sort of maintaining their well-being”.

Clearly, there is a significant impetus among those interviewed for there to be a long-term establishment of this Arts and Health Programme in the local area.

6 Analysis and Interpretation of salient findings

This evaluation is addressing a gap in the arts and health research literature by using a range of methodologies, including standardised scales, to assess the impact of a participatory arts Programme on health and well-being. The most significant impacts that were detected among the participants in the four pilot sites was the reduction in mental ill-health symptoms and the increase in quality of life relating to mental health. There were also consistently higher levels of positive mood states before and after each session and these were generally higher than negative mood states at either point before or after a session. Feelings of being engaged in the moment in a state of flow were of moderate level throughout each of the sessions but these feelings were not significantly different when comparing flow levels at the start and end of the pilot Programme. Life satisfaction was also not significantly different when comparing levels at weeks 1 and 12 of the Programme, but this was perhaps to be expected as other factors may have affected participants' life satisfaction levels. However, trends from the qualitative data were able to show that some of the participants were able to get a strong sense of purpose when attending the sessions; some participants enjoyed having a longer-term project with which they could continue working on and it was noteworthy that a few participants who were interviewed were keen to keep working on their artwork outside of the sessions as well.

The increase in positive mood states after session 1 and the substantial decrease in negative mood states after the same session could be explained by this introductory session being set for the participants in a non-threatening and participative way by the artists and link coordinator. Positive mood states were at their highest, on average, before session 11 and it is likely that participants had a keen sense of anticipation with the pilot Programme nearing its end and the prospect of their work being displayed by the Arts Trail. Certainly, at the time of week 11 when many of the interviews were being conducted with participants in some of the sites, there was a great deal of pride and satisfaction among the participants over what they had achieved. By contrast, the highest level of negative mood states was at its peak before the first session due to perhaps some participants being uncertain about the session content and format and what they would be able to do. As is clear from the substantial decrease, on average, in negative mood states among participants after the first session, these feelings were soon dissipated. It is clear, from the general trends of positive emotions and lower levels of negative emotions among the bulk of the participants before and after the sessions, that they gleaned many different positive emotional experiences from taking part.

However, rather than the temporary, mood-like states experienced before and after each session, the most telling contribution that the Programme appears to have provided was the beneficial impact that participation appeared to have in the ensuing periods between each session. The General Health Questionnaire measured the degree of mental ill-health symptoms over the seven days before the questionnaire had been completed. What was most noteworthy was the week-on-

week average level of reduction in these mental ill-health symptoms, except for those in one of the pilot sites with whom the mental health problems were particularly profound at the outset. The account, in Appendix 1, of the processes of working in that specific pilot site has shown how difficult it had been to support participants to engage with activities that are able to challenge and nourish them. It is likely, from the findings obtained with the General Health Questionnaire and the SF-12, that this Programme can offer considerable benefits to those with ongoing mild to moderate mental health problems or to those with chronic physical health problems such as many of those who took part in the DGH.

Despite there being difficulties with the use of standardised instruments with some of the participants and the potential for interrupting the 'flow' of the sessions, there was some merit in obtaining this information as it provided systematic confirmation of the specific value that the Programme was able to offer. The assessment of quality of life by using the mental health and physical health scales of the SF-12 was pivotal to being able to demonstrate how the Programme can significantly boost mental health, whereas there were no significant improvements in quality of life related to physical health. This finding shows the discriminative ability of the two SF-12 scales to be able to discriminate between two potential impacts of the Programme. Overall, it became apparent, from analysing the diary data, interviewee responses and a few questionnaire responses, that there was a possible social desirability bias among some participants in providing an overly positive message about the Programme. However, if the social desirability bias was present throughout all of the questionnaire responses, then there would not be the fluctuations that did exist in many of the scores obtained on mental health and well-being. If socially desirable responses were that endemic, then the physical health-related quality of life scores could also be significantly different from the 1st session to the 12th session. As the two scales of the SF-12 were calculated using a complex algorithm, it would be impossible for the participants to second-guess what the items were measuring, so it would appear that most of the responses were answered in a truthful manner. In essence, the use of standardised measures has shown that it is likely that an actual impact of the Programme on mental health has been detected, rather than reflecting socially desirable responding or just a general 'feel-good factor'.

7. Future Directions for Evaluating Impact

The data collected so far for this evaluation have provided some unique opportunities for tracking changes in health and well-being among residents of north Warwickshire who were able to take part in this Programme. There have been challenges with the provision of this Programme; the report in Appendix 1 and the qualitative data analysed for this evaluation report have offered some insights into these challenges. There will undoubtedly be further challenges in running the Programme in its new, drop-in, format from early May 2011 onwards and the evaluation will be aimed at tracking these, and data on a range of operational considerations, so that the transferability of this Programme to other settings can be analysed.

Overall, this evaluation has uncovered benefits and challenges from implementing a Programme for arts and health in the north Warwickshire and the proposed plan for the next phase will aim to see the extent to which this Programme can provide significant and sustainable benefits to those in the region.

To meet the end of undertaking a comprehensive assessment of Programme processes, as well as outcomes, we would recommend the following methodologies to be employed over the period of the drop-in programme at St Nicholas Community Centre, which will commence in May 2011.

- 7.1 Analysis of the Social Return on Investment (SROI) for this Programme in terms of the social, economic and environmental effects on the local area;
- 7.2 Development of a methodology for analysis of the quality of artwork produced and displayed at the Arts Trail and also with work that was created during the Programme;
- 7.3 Continue using standardised methodologies but make them less frequent than was the case with the pilot evaluation; practically, it will be less viable to use standardised questionnaires before, and after, each session. Alternative methodologies for the systematic evaluation of the effects of the Programme on health and well-being could include administration of standardised scales via the telephone at a mutually convenient time for the participants and the researcher.
- 7.4 Use participant observation and interviews to collect further qualitative data on what transpires during the sessions; these data will enable sophisticated analyses to be undertaken into how the content and format of specific sessions, or a combination of sessions, are likely to lead to longer-term impacts on health and well-being.
- 7.5 If funding permits, the evaluation from the drop-in phase should be extended to March 2012, at least. This will result in more robust impact research over

a greater time period, than has hitherto been possible. The importance of longitudinal studies cannot be over-emphasised despite the self-evident current difficulties of public and health sector finance.

- 7.6 Evaluation of the drop-in Programme that uses a form of standardised assessment of health and well-being, but one that is taken in a manner that is less likely to interfere with the 'flow' of each session.
- 7.7 Assessment of the quality of the work produced from the pilots and the drop-in sessions and we will report back on this.
- 7.8 Consideration on how prospective participants and service providers may perceive the identity of the Programme, with its overall ethos and curriculum of activities that are to be undertaken over the next 6 months.

8. References

- Arts Council England (2007). *The arts, health and well-being*. London: Arts Council England. Available from: <http://www.artscouncil.org.uk/publications/>
- Bakker, A. (2005) Flow among music teachers and their students: The crossover of peak experiences. *Journal of Vocational Behavior*, 66, 26–44.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Cayton, H. (2007). *The report of the review of arts and health working group*. London: Department of Health. Available from: <http://www.dh.gov.uk/en/Home>
- Diener, E., Emmons, R., Larsen, R., & Griffin, S. (1985) The Satisfaction with Life Scale. *Journal of Personality Assessment*, 49, 71-75.
- Eades, G., & Ager, J. (2008). Time Being: difficulties in integrating arts in health. *The Journal of the Royal Society for the Promotion of Health*, 128 (2), 62-67.
- Farivar, S.S., Cunningham, W.E., & Hays, R.D. (2007) Correlated physical and mental health summary scores for the SF-36 and SF-12 Health Survey, V.1. *Quality of Life Research*, 5 (1), 1-8.
- Goldberg, D. & Williams, P. (1988) *A users guide to the General Health Questionnaire*. NFER-Nelson: Windsor, Berks.
- Hacking, S., Secker, J., Spandler, H., Kent, L., & Shenton, J. (2008). Evaluating the impact of participatory art projects for people with mental health needs. *Health and Social Care in the Community*, 16 (6), 638-648.
- Jackson, S.A., Martin, A.J., & Eklund, R.C. (2008) Long and Short Measures of Flow: The Construct Validity of the FSS-2, DFS-2, and New Brief Counterparts. *Journal of Sport and Exercise Psychology*, 30, 561-587.
- Scholten, P, Nicholls, J., Olsen, S. & Galimidi, B. (2006) *Social Return on Investment: A Guide to SROI Analysis*. Amstelveen: Lenthe Publishers.
- Seligman, Martin E.P. (2002). *Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment*. New York: Simon and Schuster.
- Staricoff RL. (2004). *Arts in Health: a Review of the Medical Literature*. London: Arts Council England.
- Walford, E. (2010) *Arts and mental health*. Available from: http://www.towersabove.co.uk/research_on_arts_and_mental_health.html
- Ware, J.E., Kosinski, M., & Keller, S.D. (1996) A 12-Item Short-Form Health Survey: Construction of scales and preliminary tests of reliability and validity. *Medical Care*, 34(3), 220-233.
- Warwickshire County Council (2010) *FINAL Arts and Health Programme Brief 2010-12*. Available from: <http://praxisartsandhealth.org.uk/blog/wp-content/uploads/FINAL-Arts-Health-Programme-Brief-2010-12-2.pdf>
- Warwickshire County Council & NHS Warwickshire (2009) Warwickshire Joint Strategic Needs Assessment. Final Draft 30th April 2009. Available from: [https://www.warwickshire.gov.uk/Web/corporate/pages.nsf/Links/65F248FF15BE120C80256F150034262D/\\$file/Warwickshire+JSNA+-final+30+04+09.pdf](https://www.warwickshire.gov.uk/Web/corporate/pages.nsf/Links/65F248FF15BE120C80256F150034262D/$file/Warwickshire+JSNA+-final+30+04+09.pdf)
- Watson, D., Clark, L. A., & Tellegen, A. (1988) Development and validation of brief measures of Positive and Negative Affect: The PANAS Scales. *Journal of Personality and Social Psychology*, 54, 1063-1070.
- Yin, R. (2009) *Case study research. Design and methods*. 4th edition. London: Sage.

Appendix 1

Processes involved in the Arts and Health Programme

1. North Warwickshire Arts & Health Pilot Projects

As the initial stage of developing a Central Integrated 'Drop in' Arts Project in Nuneaton, Escape Community Art in Action ran four pilot arts projects targeting groups of individuals with a range of physical / mental health issues. Each Pilot offered a range of creative activities which would attract participants with varied previous experience of arts participation and allow them to engage in a personal journey which would have a positive impact improve their feelings of wellbeing.

The pilots also gave us the opportunity to establish evaluation of responses to the arts intervention activity prior to moving on to an integrated 'Drop-in' project. The process of collecting data for the evaluation was a time consuming and arduous task for participants as well as staff. It was largely managed by the link coordinators but required the support of the project artists to ensure the programme of activity provided time for the completion of the evaluation forms. As a result of the time needed for this the sessions were planned to last for three hours, allowing time at the beginning and end of sessions for form filling. This made it possible to provide at least two hours contact time with the arts activity and the artists for each participant. We asked all the participants to support this process and explained the importance of collecting evidence in order to support the future development of arts activities in the community. Although the process was never enthusiastically embraced by participants or members of the team they did all understand the importance of engaging in the process and the majority were willing to maintain this support throughout the pilots, with a few exceptions.

The Pilots were sited at four venues, working with four different organisations, which provide clinical or community services for people with varying levels of mental or physical health conditions. We established a protocol for working with the host organisations which included identifying a named contact within the organisation to facilitate rapid resolution of practical issues. As a result the planning of the sessions ran reasonably smoothly and we were able to meet with each contact to make practical arrangements for the sessions at each venue.

We discussed how we could identify suitable participants with each organisation and the most appropriate method of promoting the project. This included referrals for those under direct care of organisations and distribution of publicity for people under floating support. Escape prepared colourful posters and fliers which they could all use to promote the sessions project which were distributed to all but one of the organisations to support process. The needs of the each group were considered in the best delivery criteria for each group, suitable activities to offer and the artist with the appropriate skills.

2. The Content of the pilot interventions

The artists delivering the activities were tasked with providing a range of creative skills and media over a twelve week period which would engage participants in a variety of interests and offer each individual the opportunity to develop skills within their own capacity at the same time as challenging expectations of their abilities. The artists devised programs which allowed individual voyages of exploration and creativity without any preconception of outcome. Each artist was asked to develop collaborative opportunities for those participants willing to get involved and to prepare some work for exhibition at the end of the pilot.

The objectives of the activities were to allow individuals to feel comfortable with the activities so they could find new ways of expressing themselves and discover or rediscover talents they already had. Through this process participants were often surprised by their own achievements which led to an increase in their self esteem as the project progressed.

This approach is quite different from art therapy. It is designed to provide a distraction from daily problems and miseries and offer an opportunity for individuals to discover their own self worth and possibly unexplored interests. An awakened enthusiasm for developing creative work has the potential of offering people personal strategies to combat aspects of poor health and wellbeing beyond the project.

The skills offered through the pilots included print-making, a range of textile techniques, photography, creative writing, hand made book making, collage, painting and drawing and ceramics. The collaborative work developed during the pilots included a large textile hanging, a Ceramic wall feature and portfolio books of work by all participants

At the end of the pilots work from all four pilots was exhibited as an Arts Trail running through a number of central community spaces in the centre of Nuneaton. This Trail include the chosen venue for the Integrated 'Drop in' project (St Nicholas Community Centre) that will follow these pilots involving an on-going weekly session which has been planned for a minimum of 6 months. All the spaces used for the trail are familiar to many of the pilot participants and frequented by the wider community in Nuneaton. It is hoped that this familiarity will encourage current participants to feel encouraged to make the move to the new venue and that they will be joined by other members of the community to develop a more integrated group.

3. Individual Project profiles

As the projects developed each Venue posed different possibilities and challenges within the remit given to the artists and link coordinators. Each artist worked with a link coordinator to develop a scheme of work appropriate to the specific needs of

participants. Each group had different needs and interests so the artists were selected for their abilities to deal with the different groups.

3.1 The Health Centre

The project was welcomed by the lead General Practitioner (GP) and the practice manager. The health centre is in the middle of a large sprawling housing area on the outskirts of Nuneaton. The area is historically one of deprivation and has suffered recently from major redevelopment which has led to considerable upheaval for many of the residents and as a result many we met felt disenchanting and isolated.

The practice manager offered us a side room which was adequate although rather small and had no water access. It did however have a large amount of storage space which meant Julie de Bastion, the artist selected for this group, was able to move her equipment and store of materials in for the duration as well as storing work in progress. To address the small space the practice supported Julie in spreading into the reception area on occasions.

In addition Escape did some local promotion of the project and, with the exception of one participant who attended through a referral, all of the others came along under their own volition. The numbers at this group remained under the minimum we would have liked throughout the project. Julie felt this was an advantage as far as those who did attend as the space would have been rather limiting if attendance had been higher however she was disappointed that more people had not had the opportunity to take part. The group consisted of members of the local community who were unused to feeling that things worked in their favour and were depressed and isolated.

Julie's very gentle approach worked really well with the group and brought out the best in all of them although several did not complete the twelve weeks due to illness. One participant had a prearranged family trip to India already arranged before coming to the project so missed six weeks. She took work with her to complete and came back for the last session so she could include her work in the final exhibition.

Julie started her sessions with a story box activity which involved a wealth of choices (fabrics, trims, buttons, wallpaper etc) for the participants and allows them to create something very personal with limited skills or experience. From this she offered them a range of activities through which to develop their ideas which included collage, printmaking, creative writing and the making of hand-made books. Every member of the group responded to this and with the support of Julie and Jenny, the link coordinator, they produced work which they felt really proud of. Out of the small group involved in this project two members came to the launch event and were keen to tell us how much they appreciated the opportunity to be involved. They are both keen to come to the 'Drop in' project when it moves to the centre of Nuneaton.

Although there was some concern about this group feeling able to travel to the centre of Nuneaton for the integrated project, three or four out of the small group

have said they would like to come and two members of the group came to the launch event. These two both expressed how they valued the project and the impact it had on their lives.

3.2 The Health & Well-Being (H&WB) Centre

Our key contact was a manager of the Health & Wellbeing Centre, which provides support for people living in the community who have mental health issues. The manager was very supportive at the start of the pilot and ensured all practical arrangements were dealt with. She was very proactive in promoting the project to users of the centre and to partner centres. She circulated the publicity widely around the organisation, including support staff who work with outreach clients. As a result we had a large focused group from the offset. In addition we had a couple of participants who had attended a previous project delivered at the centre who acted as ambassadors and encouraged people to come so our reputation preceded us in a positive way.

Barbara Fidoe , a textile artist , was selected for this project . We felt a completely different activity from the previous project run at the centre should be offered to the group. In addition the large space offered excellent scope for the demands of fabric printing. Barbara started the sessions by getting the group to develop idea sheets with collage images and then offered them a broad range of textile skills including screen printing, fabric collage, stitching, tassel making and paper beads. From these each member of the group was able to develop several pieces of work some of which were finished as personal cushion covers which they will all get to take home. In addition Barbara helped them develop a very colourful collaborative work which will be returned to hang in the H&WB Centre after it has been exhibited as part of the Trail.

Members of this group were keen to continue involvement with the activities and expressed an interest in coming to the 'Drop in' at St Nicholas Community Centre. Several of them turned up at the Launch event and spoke about their appreciation of the project and were very pleased to see their work on display.

Ros Ingram and Ali Allen were selected to work at the DGH and the clinic. They interchanged their roles as artist / link coordinator at the two venues, Ros as lead at the DGH and Ali as lead at the clinic. This meant that these two groups had the advantage of being offered a range of skills contributed by both artists.

3.3 The District General Hospital (DGH)

One of the key liaisons, a manager within the Hospital, was very supportive of the project and worked with the clinical staff to encourage referrals and support for patients to attend the sessions as well as circulating publicity material around the hospital to relevant user groups. She took part in some of the sessions herself which gave her an added insight into the way Escape works.

The group we worked with included some challenging individuals. The previous experience of the group was quite varied and included several members who had

already had some art training. This allowed the artist to develop the work through aspects of skill sharing within the group as the pilot progressed.

As this manager was keen that work developed through the pilot should be displayed in the hospital it was appropriate that the activities we offered would revolve around a media that could accommodate this environment. Ros Ingram, a ceramic/ mosaic specialist was selected to work with this group. Ros was able to offer a broad range of activities so the participants could make personal choices and work with her and Ali to establish the direction of the project over the twelve weeks. The group worked with painting, drawing, collage, thrown pottery and use of recycled materials during the initial sessions quickly establishing a theme around birds and flights of birds. This led to the development of a flight of ceramic birds some of which have been installed as a permanent legacy within the hospital buildings.

Participants were able to choose which pieces of work were exhibited and which work they wish to keep them. The theme provided a focus for the work throughout the sessions and offered the participants opportunity to develop their own personal work as well as working collaboratively. In addition to the Flight of Birds, Ros has collated many of the experimental pieces of work into a book so they can be exhibited as well. Ros and Ali developed a very good relationship with this group as was evident at the Launch event when participants from this group turned up.

The space made available was a bright open space in the conference building which was part of the lower foyer area. It was not self contained so members of staff and public in the building were able to see what was going on. There was an adjacent kitchen area where the group could make drinks and access water. The one practical down side of the venue was no storage space so everything had to be brought in each week and limited parking and access which meant the staff had to drop everything off and go and park at the other end of the site which took a lot of time.

A large number of this group have expressed an interest in attending the 'Drop In' at St Nicholas Community Centre and taken an interest in what activities will be available. Many of this group turned up to the launch and were very enthusiastic and appreciative in their response to the project and the outcomes. There were several members of this group who voiced their understanding of the impact of the project on their own personal journey.

3.4 The Clinic

The pilot was sited at a day-centre clinic for people with mental health difficulties. The lines of communication with the organisation were not as clear as at the other venues and led to poor support for the project. This, in turn, impacted on a poor participant attendance.

This group was the hardest group to engage with and required careful nurturing to bring out the best in them. The participants were under heavy medication which impacted on their ability to sustain motivation. Most of the participants were very disengaged to begin with, unable to make eye contact with the team and very

reluctant to communicate. The need to use diversionary tactics by members of the group, listening to an ipod and doodling made it quite hard for the artist to engage with the group.

Ali Allen was selected as lead artist for this group working with Ros Ingram; both had considerable experience working with different levels of engagement and were able to use diverse creative ways to help this group to get involved.

An initial ice breaker activity offering a range of mark making materials and lots of visuals for participants to look at. This provided Ali with an opportunity to establish individual interests. It was a slow process engaging the individual members of the group and gaining their trust. Ros was able to offer a pottery throwing session which helped to enthuse several members. Making some pieces during the first weeks of the session which were returned to them helped to break through to the group's sense of pride in their work. Ali and Ros were very disappointed that the support staff did not value the achievements of this group and felt this intervention was compromised by the lack of staff engagement in the process. It was evident that none of the members of this group were present at the launch event of the Trail. They would have required the support of the organisation to attend.

4. The Next Phase

Throughout the pilots Joanne Lole, project coordinator, has been developing links locally and promoting the project with a view to establishing the next phase of the overall project. This will involve establishing a more integrated activity for a wider public. It will provide an opportunity for the targeted groups to get involved as part of a wider community with the objective of challenging barriers of expectation and community involvement.

The 'Drop in' phase of this project will start on the 5th May 2011 at St Nicholas Community Centre in the centre of Nuneaton, a bright new contemporary building with easy access and a welcoming management team. Escape has booked the remaining available regular weekly slot on a Thursday Morning. There are a number of other community meetings going on in the same building throughout each week, offering activities for all ages including a counselling service for people with mental health issues each week.

The first session will be delivered by Spencer Jenkins a local artist who has done some previous work with Escape. He will be offering willow construction and wood carving activities. The programme over the next six months will include ceramics and textiles as requested by participants attending the pilot sessions and will then be developed through consultation with participants attending the 'Drop in'

Escape is hopeful that a number of people from the pilots will attend and that the project will attract members of the wider community. Prior to the start of the next stage Escape will be involved in promotion through local community events and circulating publicity widely in the area.