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Arts, Health and Wellbeing Beyond the Millennium:

How far have we come and where do we want to go?

Full Report

The RSPH Working Group on Arts, Health and Wellbeing, June 2013
Published by the RSPH and the Philipp Family Foundation

Philipp Family Foundation
Everything in life is connected

Preface

It's a pleasure and privilege for me to write this preface as Chair of the Royal Society for Public Health's Working Group on Arts, Health and Wellbeing. This group convened to help prepare the RSPH lecture for the International Conference on Culture Health and Wellbeing in Bristol in June 2013.

The Royal Society for Public Health has provided sustained support over the years to the arts and health, and this report, produced as a result of the Working Group's discussions, builds on this support. It also provides a resource to enable the Royal Society to consider its future policy options for how the arts and humanities can contribute to health, health gain and wellbeing in the UK and beyond.

The Conference and the RSPH lecture is an opportunity to take stock of how far we have come since 1998, when, as Secretary of the Nuffield Trust, I convened a conference at Cumberland Lodge Windsor bringing people from the UK and the USA and from different backgrounds – the arts, philosophy, theology – together with practitioners from many of the health professions, to learn about and assess activities, perceptions, beliefs and models of effective practice in medical and health professions, education, the place of the arts in therapy (both in the community and the health care environment) in caring for people of all ages and backgrounds and in promoting better health and wellbeing. During the deliberations, foundations were laid for a strategy to promote the arts into a pivotal role across the spectrum of British healthcare and public health systems, to complement the scientific and technological models of diagnosis and treatment that had driven medical policies and practices for much of the 19th Century. The conference resolution "the Windsor Declaration" promoted the practical application of ethics and humanities in medical, health and professional education, in public health and community development and in caring for people of all ages and backgrounds and in promoting better health and wellbeing.

What is clear from the Working Group's report is that the arts and health scene in the UK and internationally has dramatically changed in scale and intensity. The economic crisis of recent years, however, has posed new realities for health globally and a recognition that market forces alone do not solve social problems and greater equality must become the new economic and social imperative. This is a time of opportunity for the arts and health to play a crucial part in creating social capital, more resilient individuals and communities and a secure and stable world.

I commend the report as a significant contribution to inform international research, policy and practice on healthy and creative aging, health inequalities and culture and the social determinants of wellbeing. Thanks also to all members of the Working Group and staff at the Royal Society for Public Health for their support, time and contributions to the report.

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Chair, Working Group on Arts, Health and Wellbeing

RSPH, London

9th April 2013.

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References

1. Introduction

The practice of using the arts to promote healing and happiness is as old as the arts themselves. For early civilizations, aesthetic beauty in objects or surroundings and the soothing rhythms of words, movement and music contributed to the balance and harmony between bodily systems and environment which was believed to maintain good health.

The burgeoning interest in arts and health in the last century was part of a swing away from the reductionist medical model, to once again considering mind, body and spirit when treating disease. With the current emphasis on primary prevention and health promotion, the arts and health field is flourishing, as this report will show. Arts activities are being used to encourage individuals to take responsibility for their own health through lifestyle choices and a reassessment of personal values. The arts and health field is making an important contribution to the wellbeing agenda in many countries, as the social injustices behind inequalities in health are addressed. The central role it now plays, and the exciting potential for further development, is summed up in the following current policy statement of the Royal Society for Public Health (www.rsph.org.uk):

1.1 RSPH position on arts and health

Access to and involvement in creative activity and the arts in all its forms is an important component in both the overall health and wellbeing of society and for individuals within it. Whatever setting, whatever stage of the life course, it has an impact. This impact has been evaluated in different ways over time and the body of evidence is substantial. Throughout the RSPH's work in the area of improving population health via community-focused interventions, an often underplayed component, has been the place of arts-led initiatives. These can be low profile, small scale and imaginative in their funding but provide extensive outreach, particularly in their support for hard-to-reach communities. They are often not measured or included as part of a community's asset value.

The RSPH believes that there is a need therefore to position the strong inter-relationship between arts and individual and community health as one of the key building blocks towards sustainable, resilient communities. There is also an art to fostering our wellbeing. One of the key steps we are being encouraged to take is to develop a nationally recognised education pathway for all arts and health practitioners. Steps in this direction we have already developed include six evidence-based workshops covering a range of arts, culture and heritage topics and we present an annual Arts and Health Award to celebrate arts-based health improvement initiatives. In February 2012 we also hosted a one day seminar on new developments and outreach programmes in the arts and health.

In England, current public health policy makes the case for a parity of esteem between mental health and physical health. With the central role that the arts can play in wellbeing, we believe that the creative arts need to be a put on a similar footing through both policy commitment and national action plans. The RSPH intends to campaign for this to become a reality over the next five years.

1.2 The Windsor Conferences, 1998 and 1999

In 1998 and 1999, at the end of a decade of increasing activity in the field of arts for health, two conferences were held in Windsor which laid the foundations of a strategy to *"promote the arts from the margins into the very heart of healthcare planning, policy-making and practice"* (Philipp et al, 1999).

The conferences, convened by the Nuffield Trust and subsequently known as Windsor I and II, recognised the need for a **culture shift** in the delivery of healthcare, where people would matter more than structures. The aim of the proposed strategy was

"to elevate the arts into a pivotal role across the spectrum of Britain's healthcare and public health systems, to complement the scientific and technological models of diagnosis and treatment that have driven medical policies and practice for much of the 19th Century" (op cit).

Among its anticipated benefits would be:

- More compassionate, intuitive doctors, nurses, and other health practitioners;
- Patient empowerment through creative expression;
- Reduced dependence on psychotropic medication such as tranquillisers and anti-depressants;
- Growing confidence and self-reliance of individuals and communities; and
- Providing an approach and support to help combat social exclusion.

Output from the conferences, as well as detailed, fully referenced reports (Philipp et al, 1999; Philipp, 2002), included:

The **Windsor Declaration**, with a 12-point Action Plan covering:

- **Professional education –** humanities to be incorporated into medical education;
- **Arts in therapy and healthcare settings –** dissemination of best practice and evidence;
- **Arts in community development and health –** promoting arts for personal health and strengthening communities

Following the first conference, the **Centre for Arts and Humanities in Health and Medicine (CAHHM)** was established at Durham University in 2000, by Professor Sir Kenneth Calman, former Chief Medical Officer, Department of Health, England, and then Vice Chancellor at Durham. Funded for three years by the Nuffield Trust, its remit was to develop research in arts and health and medical humanities and make a case for their value. Other developments such as the Centre for Medical Humanities, University College, London, also followed.

2 Background to the development of arts for health

2.1 The role of the arts in public health policy

In the 1980s, the 'arts and health movement' gained momentum following implementation of the World Health Organisation's (WHO) **Health for All** strategy, which highlighted **inequalities in health** and the need for **health promotion**, defined as *'the process of enabling people to increase control over, and to improve, their health*' (Ottawa Charter, 1986). A biopsychosocial view of health (Engel, 1977) had emerged in the latter part of the 20th century, to explain the rise of functional illness, behavioural and psychological problems which had no apparent somatic basis but which were causing disability and invalidity absence from work to increase in spite of the decline in many organic disease rates (Wade, 2009). As attention focused on the holistic aspects of health, with the emphasis in healthcare shifting towards health promotion and the prevention of ill health, public health strategy adopted a **healthy settings** approach, based on the **Health for All** suggestion that *'Health is created and lived by people within the settings of their everyday life; where they learn, work, play and live'*, applying it to cities, schools, universities, prisons and hospitals. A role began to emerge for the arts as a tool for improving public health, reducing social inequalities and promoting social inclusion (Hamilton et al, 2003).

In 1998, the UK government Public Health White Paper: ***Saving lives: Our healthier nation*** set out an action plan to tackle inequalities in health which included:

- Local Authority (LA) and National Health Service (NHS) **partnership working** to tackle **social, cultural and environmental factors** affecting health;
- **Health Action Zones and Healthy Living Centres;**
- **Personal responsibility** for health.

Health Action Zones (HAZs) were the Government's first flagship policy to tackle health inequalities and establish new ways of partnership working at a local level, and some included arts and health projects in the activities offered. HAZs were later incorporated into the development of Primary Care Trusts.

Healthy Living Centres, which initially targeted the most deprived areas, provided a range of opportunities for promoting health and wellbeing, many of which involved the arts. An early example was the Bromley by Bow Centre in Tower Hamlets, an example of inner city revitalization which began with art, when in the 1980s a church gave workspace to local artists in exchange for classes for local people (see: http://www.bbbc.org.uk). The building of **social capital** which resulted from these small beginnings was described in terms coined by Germaine Greer as: ***"mining people for their energy and goodwill - the inner city gold"***.

The 2004 public health white paper ***Choosing Health: making healthier choices easier*** set out a new approach to public health, endorsing the principles of **partnership working** and **empowerment** and shifting responsibility to individuals for their own healthy living. The emphasis in healthcare moved towards **health promotion** and **the prevention of ill health**, with support promised for emotional wellbeing.

2.2 Wellbeing as a health indicator

Health was defined by WHO in 1948 as "complete physical, mental, social and spiritual well-being" and an extensive literature has accumulated on precisely what is meant by wellbeing and how it should be measured. The hedonic approach, which has its roots in the 4th century BC, defines wellbeing in terms of pleasure versus pain, and the maximization of happiness (Ryan & Deci, 2001). This paradigm assesses subjective wellbeing (SWB) with measures of affective state, which concern relatively short-term feelings, and a cognitive element of satisfaction with life, which extends to a longer-term assessment. An alternative viewpoint, based on Aristotle's theory of eudaimonism believes that wellbeing consists of more than just happiness and requires the actualisation of human potential (Ryan & Deci, 2001). Although contentious, one model of eudaimonic wellbeing, Ryff's Psychological Wellbeing (PWB) operationalises this on six dimensions: autonomy, personal growth, self-acceptance, life purpose, environmental mastery and positive relatedness (Ryff, 1989). It is claimed that this construct also promotes physical wellbeing through its influence on physiological systems.

Wellbeing has featured increasingly as a desired outcome for public health policy. In New Zealand for example, local authorities have been required under the Local Government Act 2002, to address wellbeing under four dimensions and to demonstrate in their annual reports what they are doing for each of these:

- economic;
- social;
- cultural; and
- environmental.

Sustainable development entails living within environmental limits to ensure wellbeing for all, now and in the future, and so subjective wellbeing is an indicator for the UK's national sustainable development strategy ***Securing the Future* (2005)**. More recently, the need to measure the concept at population level has led to the development of new measurement tools, such as the **Warwick Edinburgh Mental Wellbeing Scale** (Tennant et al, 2007). This brief (14 or 7 item) scale for assessing positive mental wellbeing covers aspects of positive mental health in terms of thoughts and feelings, and includes both hedonic and eudaimonic perspectives (available from http://www.healthscotland.com/documents/1467.aspx).

In 2008, the New Economics Foundation (nef) was commissioned by the UK Government's Foresight Project on Mental Capital and Well-being, to review the work of scientists from across the world and develop a set of simple, evidence-based actions which individuals could build into their daily lives to promote positive mental health. The ***Five Ways to Wellbeing*** are: Connect, Be Active, Take Notice, Keep Learning, Give. http://www.neweconomics.org/projects/five-ways-well-being It has been noted that *'these five actions correspond closely to behaviours that can emerge in well-designed participatory arts projects'* (Cameron et al, 2013).

The public mental health framework ***Confident Communities, Brighter Futures*** (DoH, 2010) states that mental health is intrinsic to wellbeing which it defines as: *'a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and wider environment'*. Proposals outlined for improving the mental health and wellbeing of the whole population include interventions which enhance social capital and build social networks. Participation in the arts and creativity is given as an example of how promoting participation and purpose can enhance engagement for both individuals and communities (op cit).

The **Marmot Review**, which looked at health inequalities in England post-2010, stated that

"Economic growth is not the most important measure of our country's success. The fair distribution of health, well-being and sustainability are important social goals" (Marmot, 2010).

Following the example of Bhutan, where Gross National Happiness is measured instead of GDP, and France, the first country in Europe to start measuring the population's wellbeing (Stieglitz et al, 2009 in DoH, 2010 p7), the UK government have added general wellbeing (GWB) to the gross domestic product (GDP) as a measure of the nation's health. In April 2011, indicators of wellbeing were included in the Integrated Household Survey (IHS) and will be used for social cost/benefit analysis of new policies.

The WHO Regional Office for Europe has set up an expert group to look at the measurement of, and target setting for, wellbeing (WHO, 2012a) to inform health policy in Europe. The report of their first meeting notes that: *"the overall approach to health and well-being should take account of the two-way relationship between those concepts – health influences overall well-being, but well-being is also a predictor of future health"* (op cit).

2.3 Social Capital

The concept of **social capital** is an important indicator for public health. It is a multifaceted construct which includes aspects such as sociability, social networks, trust, reciprocity, and community and civic engagement (Morgan & Swann, 2004) and is constituted by the extent to which people are embedded within family relationships, social networks and communities, and have a sense of belonging and civic identity (Morrow, 1999 in Morgan & Swann, 2004). Social capital has the potential to explain how community level factors may be related to health inequalities, although it has been the subject of considerable contention (Gillies, 1997; Baum, 2000 in Swann & Morgan, 2004).

Three distinct strands of social capital have been described:

Bonding social capital is characterised by strong bonds within groups or families;

Bridging social capital describes less strong, outward bonds, between and across groups, friends or businesses;

Linking social capital recognises the importance of positive connections between those with differing levels of power or social status (Morgan & Swann in HDA, 2004).

In the UK, a programme of work on social capital and health was commissioned from the Health Development Agency (HDA) to increase understanding of the construct, how it might be measured, its relevance for different population groups and health outcomes, and whether it might be used to support participatory approaches to health improvement in practice. Reports from the reviews of international empirical research undertaken by this programme (HDA, 2004) highlighted the complexities of measuring social capital and its associations with health and other indicators. It was concluded that although there was some evidence that building social capital in local communities would have positive effects on people's health and wellbeing, positive relationships were only found for some indicators of social capital and for some health outcomes. It has also been noted that not all networks are beneficial to the whole community, for example the Mafia, or other powerful groups, build social capital for themselves, but exclude or marginalize others (HDA, 2004).

Nevertheless, the belief that an important part of a community's wellbeing comes from this important resource persists and community engagement remains central to government policy on reducing health inequalities (Popay, 2011). Systematic reviews of research into the impact of community engagement and health for the National Institute for Health and Care Excellence (NICE) found evidence that engaged individuals had increased self-efficacy, confidence and self esteem, improved social networks, a greater sense of security, improved access to education, and self-reported improvements in physical and mental health and quality of life (Popay, 2011).

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The role that arts projects could play in building **social capital** was highlighted in a review by the Health Development Agency in 1999 (HDA, 2000). Participating in community arts is thought to be able to help strengthen social capital by addressing cultural and social problems in society such as alienation, frustration, anger, disruption, humiliation, dislocation, and marginalization (Eames, 2003). The protective effects of high levels of social capital are found in communities which support collective efforts for cultural wellbeing and the strengthening of cultural capital (Eames, 2006).

Public Health guidance from NICE, ***PH9 Community Engagement 2008***, recommends arts and health workshops for increasing social capital. This guidance is due for review this year and expected to be updated when the findings of an ongoing National Institute for Health Research (NIHR) funded research study evaluating the impact of community engagement approaches on the social determinants of health and health inequalities are available in 2014.

The use of social capital in the evaluation of an arts intervention is exemplified by a recent study on the contribution of art to both social and cultural capital (Goulding, 2012). It was reported that older persons introduced to contemporary art developed **bonding social capital** with each other, **bridging social capital** with group leaders, and **linking social capital** with gallery staff and researchers. Their individual cultural capital developed in terms of an increase in knowledge and understanding of contemporary art (op cit).

2.4 Empirical evidence for the benefits of arts and health

Robust evidence is important, both to inform effective policy making, to demonstrate the impact and value of the arts and to improve practice (Philipp, 1997; ACE, 2010). The NHS in particular expects practice to be evidence based.

In 1999, the Health Education Agency (HEA) reviewed good practice in **community-based arts projects** (HEA, 1999). Although the research revealed

"an extremely active field of effective partnerships, dynamic enthusiasts and highly experienced experts", it reported that "to date there is no single sound and established set of principles and protocols for evaluating outcomes, assessing the processes by which outcomes are achieved and disseminating recommendations for good practice to workers in the field".

Following this review, CAHHM commissioned a report on evaluation practice from the Health Development Agency (HDA). The report (Angus, 2002) found that although the majority of people working in community based arts for health appreciated the need to evaluate their projects, they struggled to find appropriate methods for doing this. Evaluations were frequently inadequate and many projects did not have clearly stated aims (see also **Section 4** below).

In 2007 a **Prospectus for arts and health** was produced jointly by the Department of Health and Arts Council England (ACE). It includes examples of projects and case studies and states that: *"Although some pieces of evidence are less rigorous than others, the reality is that there is a considerable evidence base, from both the UK and internationally, with hundreds of research studies and evaluated projects that clearly demonstrate the benefits of using the arts in health".*

Overviews of a range of evaluations are given in the Prospectus, covering art therapies, other art interventions in healthcare settings, art in the healthcare environment and community arts projects. In some cases the projects have been evaluated by University researchers to ensure the use of rigorous methods.

A useful list of key research into Arts in Healthcare between 2000 and 2010 has been compiled by Public Art Online and is available on their website at: http://publicartonline.org.uk/resources/research/artsandhealthmarch2010.php

The claimed benefits of art in healthcare settings are summarized on the above website as:

- Well designed healthcare environments feel less institutional and improve the wellbeing of patients, staff and visitors;
- The arts in hospitals improve patient health, recovery and wellbeing including clinical outcomes;
- The arts can help the healthcare environment function more effectively;
- Participation in the arts is beneficial to patient health and wellbeing; and
- The arts contribute to a quality work environment for staff and support staff recruitment and retention.

Included on the site are overviews of:

- A review of the medical literature, for example, of art in healthcare settings (Staricoff, 2004);
- A study of the effects of visual and performing arts in healthcare (Staricoff et al, 2005);
- Research which looked at architecture, art and design in hospital buildings (Macnaughton et al, 2005);
- A systematic review of research literature on visual arts and design in mental healthcare (Daykin et al, 2006);
- An evaluation of qualitative research on the impact of arts in mental health care (Daykin et al, 2008);
- Evaluation of the 3-year Invest to Save: Arts in Health (Kilroy et al, 2007); and
- A study of the role, challenges, training and support needs of hospital arts co-ordinators in the UK (Aston, 2009).

A direct link for each of these reports is provided on the above website.

A key issue which emerges from the research is that evaluation still presents challenges and there is a need to address difficulties such as the use of randomization, control and adequate sample sizes. Organisations contributing to the development of an arts and health research agenda at that time included: the National Institute for Mental Health in England (NIMHE); the UK Mental Health Research Network (UK MHRN); Arts Council England (ACE); the National Network for the Arts in Health (NNAH); and the Centre for the Arts and Humanities in Health and Medicine (CAHHM).

In their overview of the state of arts and health in England, Clift et al (2009) note the considerable difficulties involved in evaluating and researching possible links between arts and health practice, given:

- the inherently complex and sometimes subtle nature of artistic and creative endeavours;
- the huge range of art forms;
- the distinctive individuality of different healthcare and community settings;
- the diversity of individuals participating in projects;
- the huge range of specific health issues that might be addressed; and
- the wide spectrum of health interventions from prevention and promotion, to treatment, rehabilitation and palliative care.

They describe seven different approaches which have contributed to the evidence base for arts and health:

- Retrospective qualitative evaluations of arts and health projects;
- Prospective evaluations of arts and health projects;
- Experimental evaluations in arts and health;
- The move towards economic effectiveness studies;
- Systematic reviewing of evidence;
- Development of theoretical frameworks for arts and health; and
- Emergence of an academic community of arts and health researchers (Clift et al, 2009).

A useful Appendix to this paper includes a list of university research groups as well as government departments, national agencies, Arts and Health networks, Arts and Health organizations and projects, and professional bodies for the creative art therapies.

A considerable body of research has shown the positive impact of arts interventions in medical settings, which has included clinical outcomes such as reductions in blood pressure, heart rate, cortisol levels, anxiety and depression as well as indicators such as reduced need for medication and recovery time. There is also increasing evidence for the benefits of participatory and community based arts. Evaluating arts interventions in the community faces different challenges (see **Section 3.3.4** below) and looks for different outcomes, although wellbeing features in both sectors. Much of the work in arts in the community is linked to public health policy and aimed at health promotion, reducing social exclusion and building community cohesion (Camic, 2008).

The research approach chosen depends not only on the setting, but on the purpose for which it is commissioned and its intended audience. While the NHS expects its evidence to come from the gold standard method of randomised controlled trials, in the USA where healthcare is differently funded, evaluation has, it seems, not played such a significant part in arts and health.

Qualitative methods of evaluation have improved greatly over the last few decades and it is now accepted that, for the most complete picture of what happens when people experience an arts intervention, both qualitative and quantitative methods will be needed. A recent paper by Cameron et al (2013) stresses the importance to the evidence base of action based research, like their recent independent evaluation of projects in London, which looked at the impact of participative and public art on both individuals and communities from public health viewpoint (see also **Section 4**). One objective of their evaluation was to inform the commissioning process in order to increase support and funding for sustainable future arts projects.

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An important development for improving the evidence base for arts and health is the establishment of a UK research network to develop high quality projects. Coordinated at Nottingham University, this initiative has so far secured funding from the ESRC to hold four seminars which will take place over the next two years in Nottingham, Bristol, Glasgow and London. Further funding for three years from the LankellyChase Foundation, secured through the Public Engagement Foundation [PEF], allowed a Co-ordinator to be appointed in April 2013 (http://artsandhealthresearch.ac.uk/artshealthandwellbeing/index.aspx).

Internationally, over the past decade, there has been a steady accumulation of evidence for the benefits of arts and health activities. This can been seen in the interest in arts, culture and wellbeing research and practice initiatives in Australia, Canada, Finland, France, Germany, Japan, New Zealand, Norway, Sweden, the UK and the US as well as African countries.

Reviewing current literature on creative arts activities for adults in North America and Europe, Stuckey et al (2010) reported methodological shortcomings but an overall indication that creative engagement can decrease anxiety, stress and mood disturbances.

The overview of the state of the arts and health in England mentioned above (Clift et al, 2009) was one of a series published between 2009 and 2011. Others in the series were:

Sonke J, Rollins J, Brandman R & Graham-Pole J (2009):
The state of the arts in healthcare in the United States. Arts & Health: An International Journal for Research, Policy and Practice, 1:2, 107-135
To link to this article: http://dx.doi.org/10.1080/17533010903031580

Wreford G (2010): **The state of arts and health in Australia.** Arts & Health: An International Journal for Research, Policy and Practice, 2:1, 8-22
To link to this article: http://dx.doi.org/10.1080/17533010903421484

Cox SM, Lafrenière D, Brett-MacLean P, Collie K, Cooley N, Dunbrack J & Frager G (2010):
Tipping the iceberg? The state of arts and health in Canada. Arts & Health: An International Journal for Research, Policy and Practice, 2:2, 109-124
To link to this article: http://dx.doi.org/10.1080/17533015.2010.481291

Cuypers KF, Knudtsen MS, Sandgren M, Krokstad S, Wikström BM & Theorell T (2011):
Cultural activities and public health: research in Norway and Sweden. An overview. Arts & Health: An International Journal for Research, Policy and Practice, 3:1, 6-26
To link to this article: http://dx.doi.org/10.1080/17533015.2010.481288

2.5 The increasing role of the UK government in promoting arts and health

The need for the arts to permeate policy across Government departments was highlighted in the Windsor Conference Action Plan.

UK government policy relating to arts and health is discussed in a review of the impact of visual arts and design on patients and staff in Mental Health care settings (Daykin and Byrne, 2006). available online at: http://hsc.uwe.ac.uk/net/research/Data/Sites/1/GalleryImages/Research/Final%20report%20on%20the%20literature%20review.pdf

The review summarizes the key themes of policy at that time as:

- Reducing inequalities and addressing social exclusion through participation in the arts;
- The impact of physical environments and building design on patient outcomes;
- Patient and public involvement; and
- Strengthening the evidence base for arts based approaches.

In 2007, a working group was set up to review the role of the Department of Health, England, in promoting arts and health in the light of increasing activity in this field, the Government's plan for a patient-led NHS, partnership working and increasing emphasis on improving public health and wellbeing. The key findings of this report (DoH, 2007) are now on the website of the recently formed Alliance (see below).

The report concluded that

"the Department of Health has an important role to play in promoting and supporting the development of arts in health, working in partnership with others"

and called for a Prospectus to be published.

Arts Council England (ACE) produced ***A Prospectus for Arts and Health*** jointly with the Department of Health in 2007 (see also **Section 2.4**). At the same time ACE published its first national strategy for arts and health, ***The Arts, Health and Wellbeing Strategy*** with the key aims of:

- integrating arts into mainstream health strategy and policy making; and
- increasing and effectively deploying resources through funding and quality assurance (ACE, 2007a).

In 2009, Clift et al expressed disappointment that the national leadership in linking arts with healthcare, which the Department of Health and Arts Council England promised in these documents, had not materialised. Following publication of the Prospectus, which, it has been pointed out, was endorsed by two junior ministers rather than the Secretaries of State, ACE appeared to shift its priorities to supporting 'high quality' artistic endeavour rather than fostering community involvement in the creative arts (Clift et al, 2009). Arts initiatives also experienced a squeeze on funding in the years leading up to the 2012 Olympic Games.
In 2008, in response to a House of Lords debate on arts and health, and a call for 'political leadership', an arts and health group was established within the Department of Health. Launching a new resource **Open to All** for raising mental health and social inclusion awareness amongst the staff of museums and galleries, Alan Johnson, then Secretary of State for Health, said that participation in the arts should be part of the mainstream in both health and social care and that it had an important role to play in transforming the NHS *"from a service that's excellent at recognising illness and treating it, to one that can more successfully prevent illness and promote health and wellbeing"*
(Available at: http://www.artsforhealth.org/news/alan-johnson-speech.pdf).

The Arts Council's 2010 strategic framework for the arts in the next decade, ***Achieving great art for everyone***, acknowledges cuts in funding from central government and has a very different focus from ***The Arts, Health and Wellbeing***. Arts for health is no longer mentioned, although the benefits of art to mental health, social cohesion, sense of identity, happiness and wellbeing are referred to. The focus is on communities, with children and young people a particular target, and the challenge is identified of promoting equal access to arts participation and involvement, since those currently most active are from the most privileged sectors. There is also a commitment to push for equality in training for careers in the arts (ACE, 2010).

The most recent policy on public health further strengthens the culture shift which has been evolving since the Windsor conferences, in which the focus is on people rather than structures. Following the 2010 White Paper: ***Equity and Excellence: Liberating the NHS***, which pledged to put patients and the public first, giving them greater choice and control, the Marmot review ***Fairer Society, Healthy Lives (2010)*** reviewed the evidence to inform the development of a health inequalities strategy for England and gave two policy goals:

- To create an enabling society that maximises individual and community potential; and
- To ensure social justice, health and sustainability are at the heart of all policies.

The subsequent ***Health and Social Care Act 2012*** gives a new focus to public health. A new national body, Public Health England, an executive agency of the DoH, is leading the new public health service, with local authorities responsible for improving health in their local populations. This is expected to include innovative public health improvement schemes in collaboration with local partners, including for example the Clinical Care Commissioning Groups, other public sector organizations and charitable organizations. (see also **Section 5**).

2.6 Art and Public Health Outcomes

The findings from various studies have already recognised the value of work done in this area and the ability of arts based interventions to contribute to improving population health. However, research suggests (LGA, 2011) that due to the lack of awareness and capacity, organisations in the arts and culture sector are less proactively engaged with strategic commissioning. Continuous effort is required not only in influencing health and social care commissioners to maximise utilisation of the evidence base, but also in developing awareness and understanding of commissioning opportunities amongst arts and cultural institutions.

2.6.1 The Public Health National Outcomes Frameworks and links to mental health

Earlier this year, the Department of Health, in partnership with the Public Health Observatories in England, has released an updated set of Public Health Outcomes Frameworks (PHOF). The Public Health Outcomes Framework ***Healthy lives, healthy people: Improving outcomes and supporting transparency*** sets out a vision for public health, desired outcomes and the indicators that will help professionals understand how well public health is being improved and protected. It concentrates on increased healthy life expectancy, and reduced differences in life expectancy and healthy life expectancy between communities. This update, together with the *Adult Social Care Outcomes Framework*, and the ***NHS Outcomes Framework***, constitute a structure for measuring improvement across the system and ensuring the health and social care challenges are addressed.

There is a wealth of material on the positive impact of arts/culture in health on public mental health and wellbeing. Arts and health not only provide a unique empowering approach to engage with individuals or groups, but also enhance human abilities to take responsibility for their health and wellbeing and support sustained behavior change.

Improved mental wellbeing can reduce and prevent health and social inequalities which impact on individuals, communities and vulnerable groups. It would also offer key opportunities in the delivery of health, wellbeing, social and economic outcomes for local government, health authorities and other stakeholders.

Mental health and emotional wellbeing is an integral part both within Public Health and Adult Social Care Outcomes Frameworks (qv Table 1, brief overview), and is associated with a range of improved outcomes. Both Public Health, Social Care and NHS Frameworks also contain more general measures, applying to all areas of health and care. Given the high level of mental health need, improving mental health and wellbeing will make a vital contribution to achieving these general measures (No Health Without Mental Health, 2012).

No health without mental health, a cross-government mental health outcomes strategy for people of all ages (2011) also supports the vision for improving mental health through evidence-based practical recommendations, as well as providing the framework on improving outcomes. Given that the objectives of the mental health outcomes strategy's are consistent with the indicators from the three Outcomes Frameworks, each will help to deliver the other. Whilst it is not straightforward, it will be crucially important for art/culture and health initiatives to demonstrate measurable progress against mental health and wellbeing related or any other indicators in some way. The Outcomes Frameworks provide a platform for doing so.

Public Health Outcomes Framework for England 2013-2016	**Adult Social Care Outcomes Framework 2013/14**
Domain 1 Improving against wider factors that affect health and wellbeing and health inequalities - Social contentedness	Domain 1 Enhancing the quality of life for people with care and support needs
Domain 2 People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities - Emotional wellbeing of looked-after children - Self-reported wellbeing	Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.
Domain 4 Healthcare public health and preventing premature mortality - Dementia and its impacts	People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.

Table 1. Indicators relating to mental health and emotional wellbeing

2.6.2 Improved commissioning

The transfer of public health into local government in England will create more challenges, as well as opportunities, for arts in health as part of community empowerment strategies and outcomes-based commissioning to reduce health and wider inequalities and help improve the lives of local communities. According to the Department of Health and Local Government Association (2012), bringing together public health skills in analysis with council expertise in commissioning is seen as having great potential for added value, particularly since councils are increasingly interested in evidence-based interventions to make the best use of limited funds.

Sustained investment in the arts results in significant economic savings even in the short term (Department of Health, 2011), occurring in a wide range of public sectors e.g. health, social care, criminal justice etc, and strengthens the case for future commissioning of arts in health initiatives.

Coupled with recent financial crisis and governmental budget deficit, future arts and health initiatives, especially if commissioned on a larger scale, will need to demonstrate clear benefits towards delivery of outcomes and efficiency, and cost-effectiveness for local economies.

From a decision-maker's perspective, the challenge is no longer whether the arts has a beneficial impact, but whether resources spent on arts initiatives will have more impact and deliver the return on investment than other projects or areas. For example, if the objective is to reduce admissions to care homes, which intervention would be able to achieve this with minimal resource? Or, if we aim to reduce admissions to mental health care units / memory clinics, are arts interventions more effective than increased levels of physical activity in the defined cohort?

Therefore, it is vitally important we not only build on the existing work already in place in order to further validate impact, but also to strengthen the evidence base and research around comparison studies.

2.7 International health policy

In Europe, the World Health Organisation (WHO)'s health policy framework **Health 2020**, published in 2012, includes the following themes in two of its four priorities:

- Investing in health through taking a life-course approach and empowering people;
- Creating resilient communities and supportive environments.

In an editorial on the arts and global health inequities Clift, Camic and Daykin (2010) expressed disappointment at the omission of any mention of the arts in the Commission on the Social Determinants of Health's report ***Closing the gap in a generation*** (CSDH, 2008), commissioned by the WHO to recommend actions to address health inequalities. While the arts may not appear to be a useful tool to combat such issues as lack of sanitation, child mortality or bonded labour, the authors argue that they have been used to address issues of poverty, violence, abuse, drug misuse and inter-group conflict, all of which contribute to health inequities within and between countries. Examples are given of initiatives in Africa, Pakistan, India and South America, in which music, drama and performing arts have raised awareness and inspired people to take action, or been used for health education and empowerment of local people. In a subsequent editorial, Camic (2013) called upon arts and health researchers and practitioners to develop arts-based programmes to address domestic, national and international violence, and cited this as an "urgent issue" that needs to be actively confronted.

Another interesting example is a UNESCO initiative to help Syrian refugee children integrate into Lebanese schools, and at the same time to preserve their cultural heritage, using shadow theatre puppetry, an ancient Syrian tradition. A short film can be seen on the UNESCO website at http://www.unesco.org/new/en/culture/ (see also **Section 5**).

Much of the work in arts and health has been aimed at tackling the key targets of national and international health policy, for example mental health, emotional wellbeing, drug and alcohol misuse, healthier lifestyles to reduce obesity and heart disease, supporting families, healthy aging and engaging individuals and communities. With public health policy focusing on health promotion, social capital and community involvement, and in the current climate of multiculturism, the arts, culture and heritage have a great deal to contribute.

Increasingly, social inclusion through the arts is being considered to help population groups who are marginalized, disenfranchised, or otherwise excluded due to racial, ethnic, religious, cultural or gender issues.

Arts-based activities can be particularly supportive of issues surrounding identity, such as sense of belonging and being part of a community rather than apart from it. There are associated gains for self esteem, confidence and morale (Philipp, 1999) (see also **Section 4**).

3 Progress in the field since the Windsor Declaration

Participants at the first Windsor Conference endorsed a 12 point action plan spanning three areas for practical application: professional education; the arts in therapy and the healthcare environment; and the arts in community development.

3.1. Professional education

The Windsor Declaration's Action Plan proposed that:

- Humanities should be part of medical undergraduate education, with philosophy, theology and literature included in the five year curriculum;
- A mixture of arts and science A levels should not be a bar to acceptance at medical school; and
- A national database of practice and research in medical humanities should be created, to spread awareness and knowledge and encourage life long learning amongst medical professionals.

Since then new short courses, special study modules and research opportunities have emerged. They include the following areas:

3.1.1 The medical curriculum

The argument for teaching humanities in the medical curriculum is that while a doctor must have scientific knowledge of how a body works and what the best way to treat a disease is, "*a 'humane' doctor is required, with the understanding, assisted by interpretative ability and insight, and governed by ethical sensitivity, to apply this scientific evidence and skills to the individual patient"* (Macnaughton, 2000). The study of literature, history or philosophy would introduce students to different ways of perceiving the world and encourage a critical and questioning attitude to help develop judgment, but it is acknowledged that if these subjects were compulsory, they would be of no value to students who had no interest in them (op cit).

It has been argued that there is a more compelling need in psychiatry than in other medical specialties for an appreciation of the areas of human knowledge that deal and trade in the personal, for example literature, history, linguistics and philosophy (Oyebode, 2009).

In the UK, humanities have been introduced as short courses and special study modules rather than a part of the core medical curriculum and there are also opportunities for intercalating with an arts degree. Some medical schools have also established similar opportunities for studying the arts in health and wellbeing, including for some, application of the arts for oneself, and, more generally, for wider dissemination of information about the art of wellbeing.

Arts and humanity courses have also been part of nursing training for some time (Chinn & Watson, 1994).

In the USA it is far more common for humanities to be taught in medical schools (Oyebode, 2009). It has been reported that almost 15% of successful medical school applicants have majored in humanities or social science but do as well as colleagues with science backgrounds during medical school and residency on objective measures of achievement such as academic scores. In 2004, 88 out of 124 medical schools had required humanities courses and 55 offered electives, including writing, literature, music, arts and ethics. At the authors' own school, Mount Sinai Medical School in New York, a required course in the geriatric medicine internship includes guided visits to an art museum with exercises in the art of observation. Narrative medicine, which involves the use of literature and writing to increase self reflection and empathy, is also gaining in popularity. There is no consensus on the benefits of studying humanities but the goals of different medical schools have included improved empathy, professionalism and self-care, the latter increasing resilience as a protection against stress, isolation and burnout. Impact is difficult to assess and when courses are electives, students choosing them may already possess greater empathy and communication skills (Schwartz et al, 2009).

3.1.2 University research

Following on from the Nuffield Trust initiative, special interest areas have emerged within the arts and humanities field. After its period of initial funding from the Nuffield Trust, CAHMM continued at Durham University as the **Centre for Medical Humanities**, addressing *"an emerging field of enquiry in which humanities and social sciences perspectives are brought to bear upon an exploration of the human side of medicine. These perspectives have a key role to play in analyzing our expectations of medicine, and the relationship between medicine and our broader ideas of health, well-being and flourishing"* (www.dur.ac.uk/cmh).

In 2002, a new body, the Association for Medical Humanities in the United Kingdom and Ireland, was launched, linked to the journal Medical Humanities, an edition of the Journal of Medical Ethics. The Association's aim is to promote the medical humanities in education, healthcare and research and an annual academic conference is held (http://www.gla.ac.uk/departments/amh/).

As an academic discipline, medical humanities has flourished. In the UK, it has benefitted from changes in government policy in 2011, which encouraged collaboration with other disciplines in order to meet the new requirement for government research funding, which is the ability to demonstrate impact in terms of social, economic, cultural and environmental health and quality

of life benefits (Macnaughton, 2011). It is felt that this intellectual collaboration can contribute to a re-evaluation of medical practice, policy and research in a way that the inclusion of humanities in medical education alone could not, although these outcomes will in turn lead to curriculum change and result in doctors with better understanding of their patients (op cit).

In 2008, Durham University and King's College London were awarded major five year grants of approximately £2m each, by the Wellcome Trust, to establish interdisciplinary research centres in medical humanities. In Durham (see http://www.dur.ac.uk/cmh/), the research programme **'Medicine and human flourishing'** has five clusters:

- Imagination and creativity;
- Practice and practitioner;
- Policy, politics and the collective;
- Transfigurings; and
- Mind/Body/Affect.

One of the largest project awards which the Wellcome Trust made, the sum of £1million over three years from October 2012, was to the interdisciplinary 'Hearing the Voice' project. This project is investigating the phenomenon of hearing voices in the absence of any external stimuli, from a range of perspectives including philosophy, literature, theology, psychology, cognitive neuroscience, psychiatry and the medical humanities. The project incorporates researchers from all three Durham faculties along with clinicians, academics and experts-by-experience from national and international partner institutions.

At King's College the six research strands are:

- Illness narrative as life-writing;
- Concepts of health;
- Distress and disorder;
- Nursing and identity: crossing borders;
- Cultural and historical forces in psychiatric diagnosis; and
- Case studies of medical portraiture.

see (http://www.kcl.ac.uk/innovation/groups/chh/index.aspx)

Other Centres for the Medical Humanities have emerged in the UK as well as elsewhere. In the UK they include Leeds (http://www.leeds.ac.uk/arts/info/125123/centre_for_medical_humanities/) and Glasgow (http://www.gla.ac.uk/schools/critical/research/researchcentresandnetworks/mhrc/).

Medical humanities teaching has been consolidated at Aberdeen (http://www.abdn.ac.uk/medical/humanities/) and at Leicester (http://www2.le.ac.uk/colleges/artshumlaw/teaching/postgraduate/humanities) and new lectureships and fellowships have been created at Exeter and Edinburgh.

The quality and accountability of university research is enhanced by assessment under the new Research Excellence Framework, which focuses on relevance and the demonstrable impact which findings will have on society and the economy.

The journal **Medical Humanities**, launched by the BMJ publishing group in 2000, is a leading international journal with Editorial Board members from around the world (http://mh.bmj.com/).

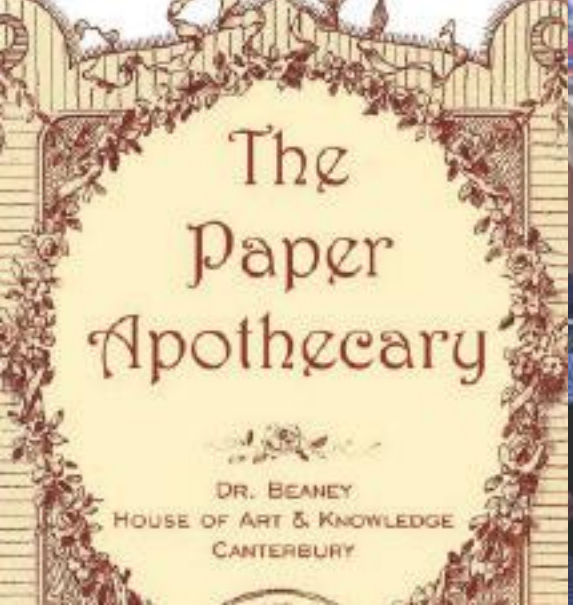
For further reading on current thinking and the conceptual shift to a 'critical' medical humanities:

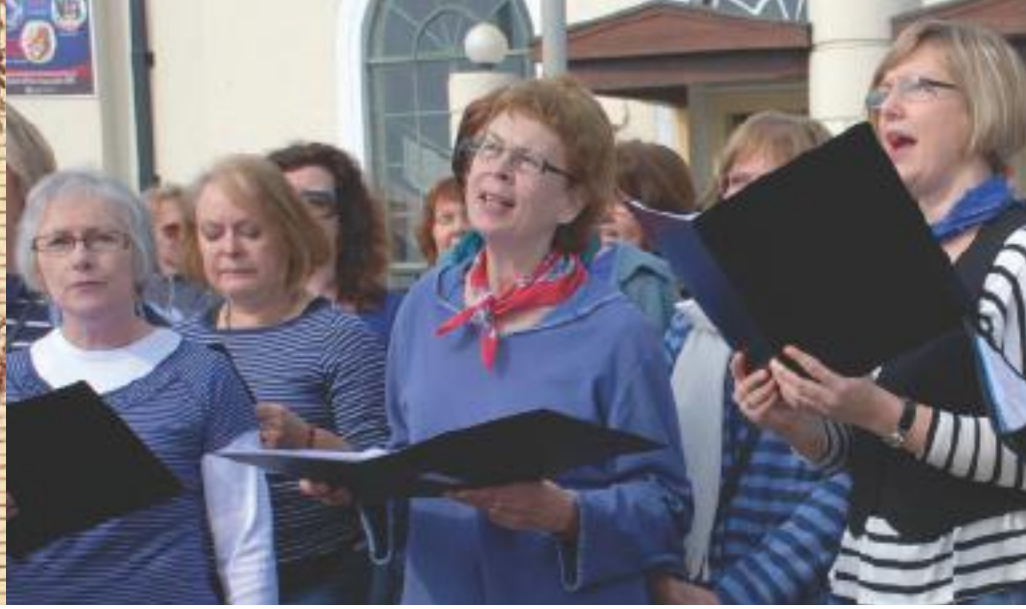
- Neurocritiques? Neuroentanglements? Thinking through collaboration with cognitive neuro-sciences/scientists (http://medicalhumanities.wordpress.com/2012/12/10/neurocritiques-neuroentanglements-thinking-through-collaboration-with-the-neurosciences/).
- 'Recovery' in mental health: who judges, on what grounds, with what evidence, and which arguments? (http://medicalhumanities.wordpress.com/2012/10/01/recovery-in-mental-health-who-judges-on-what-grounds-with-what-evidence-and-which-arguments/).
- The letter to the scientific/medical editor: a neglected genre within medical humanities? (http://medicalhumanities.wordpress.com/2012/08/16/the-letter-to-the-scientificmedical-editor-a-neglected-genre-within-medical-humanities/).

3.1.3 Graduate programmes

Masters or doctoral level programmes in arts and health, medical humanities, arts, health and wellbeing are now offered in several UK universities including Durham University, University of the West of England, Canterbury Christ Church University, Manchester Metropolitan University, University of Central Lancaster, Birmingham City University and University College London.

In Wales, University related training courses include:
MA Arts Practice (Arts, Health and Wellbeing), University of South Wales at Pontypridd
MA Art Psychotherapy and MA Music Therapy, University of South Wales at Newport





3.1.4 Courses from the Royal Society for Public Health (RSPH)

As part of its **Training Solutions Programme**, the Royal Society for Public Health has recently launched a new training programme, **New Horizons in Arts, Health and Wellbeing** focusing on multidisciplinary training for public health, healthcare, heritage and arts sector practitioners. The first event, in March 2013, was Innovative Practices in Arts, Health and Wellbeing: Spotlight on Museums and Art Galleries. The event focused on museums and art galleries as resources for public health and healthcare programmes and included a seminar by the programme's director and two workshops from recent recipients of the annual Royal Society for Public Health **Arts & Health Award**. The multidisciplinary event was aimed at staff from museums, galleries and mental health services. Workshops planned for 2013-14 and beyond include: developing arts in health promotion; singing, wellbeing and health; arts on prescription; art galleries and older adults; developing a hospital-based arts and health programme; approaches to evaluation; dance and health; and heritage on prescription, among others.

A **Guide to Training Solutions** has been produced to help communities to improve their health and wellbeing and is available for download: www.rsph.org.uk/en/training-solutions/index.cfm

A one day RSPH conference **Arts and Wellbeing: recent developments, future challenges** was held in February 2012. A major three-day international conference, **Culture, Health and Wellbeing** (Bristol, June 2013) focused on arts, culture, health, and the social determinants of wellbeing - how cultural interventions contribute to wellbeing and a healthy society.

The RSPH also has an annual **Arts and Health Award**, which was launched in 2008 see (http://www.rsph.org.uk/en/about-us/policy-and-projects/projects/arts-and-health-awards-2013.cfm).

3.1.5 Training for arts practitioners and arts programme coordinators

The increasing work of artists and arts practitioners in healthcare settings or with groups of vulnerable people in the community, created a need for training and support for these groups. As recognized by writers Flint, Hamilton and Williamson (2002) "*writing workshops intended for educational and recreational purposes in healthcare settings will still experience a therapeutic content, whether this aim is explicit or not. Many writers who choose to teach their craft are not well-equipped to deal with clients who may be experiencing, for instance, depression, mental or physical illness, bereavement or the after-shocks of trauma*". Swindells et al (2013), evaluating the role of eudaimonic wellbeing in community arts participation, report participants describing the artist facilitators as *"expert collaborators rather than conventional instructors"*, as they were able to adopt a non-intrusive approach to allow individual participants to shape their own development.

The growing need for structured training, professional development, support and possibly professional supervision for artists and arts practitioners working in healthcare settings has been recognized, as is the need for professional development for increasing numbers of arts managers and coordinators (ACE, 2007b; Penn, 2010). A study of the role of hospital arts co-ordinators in 2009 included interviewees from the USA, Canada, Australia and Ireland as well as the UK (Aston, 2009). The report highlights the frequent ethical dilemmas and lack of training as well as the many rewards of the job. Training for workers in the arts and health field is now widely available, ranging from postgraduate University based courses to short training and CPD courses provided by independent consultancies such as Willis Newson in Bristol (http://www.willisnewson.co.uk/).

In the USA, the National Association for Poetry Therapy (NAPT), a membership organization, (http://www.poetrytherapy.org) has for many years promoted the use of poetry for healing and personal growth. It offers training accredited by the National Federation for Biblio/Poetry Therapy (http://www.nfbpt.com).

In the UK, Victoria Field who qualified as a Certified Poetry Therapist with NAPT, offers a variety of training opportunities in poetry therapy (www.poetrytherapynews.wordpress.com).

Out of the Blue Writing is based in Wales and provides training for those wishing to credential as a Poetry Therapy Practitioner (http://jill-teague.blogspot.co.uk/).

PoetryReach is based near Dublin, Ireland, and offers training for accreditation by iaPOETRY as Poetry Practitioner (www.poetryreach.wordpress.com).

In the UK, *Lapidus* was established in 1996 to support poetry and health practitioners and received Arts Council funding for a period of 10 years (www.lapidus.org.uk).

Engage is a membership organization which promotes access to, understanding and enjoyment of the visual arts in the UK (with separate branches for Wales and Scotland) and in 20 countries worldwide (http://www.engage.org).

Short courses in the UK this year include:

- A one-week CPD course in Therapeutic Writing in July and February at the University of Falmouth (http://t.co/w7OYS8em).
- Short courses in Writing in Health & Social Care offered by Ty Newydd, National Writers Centre for Wales (www.tynewydd.org.uk).

A list of courses and other resources for arts and health workers has been compiled by Josie Aston (http://www.josieaston.co.uk/arts-and-health-resources/).

Support in the form of dissemination of information on best practice and other resources, as well as the opportunity to network, is provided by the numerous **regional Arts and Health Forums** which now exist (see **Section 3.2.5** below).

An example of partnership working in this area is the NHS Bristol and Bristol City Council funding of a facilitated peer supervision programme for arts practitioners working in healthcare settings, which promotes reflective practice and provides an opportunity to share practice and discuss issues (http://bristolartsandhealth.wordpress.com/category/news/page/2/).

Both in the UK and internationally, arts and wellbeing programmes are also offered in other sectors. For example in the heritage sector, and in particular in museums and art galleries, a range of in-house and outreach programmes is available (see also **Section 4**). A government funded resource ***Open to All*** provides mental health and social inclusion awareness training for the staff of museums and galleries (http://www.opentoalltraining.co.uk/).

3.1.6. Dissemination of best practice and research

Published research and best practice in arts and health has increased significantly over the last five years with much of the research occurring in the UK, Australia, Norway, Sweden, the US and Canada.

Three journals have been established with direct links to arts and health:

- **Arts & Health: An International Journal of Research, Policy and Practice** http://www.tandfonline.com/toc/rahe20/current published three times a year by Routledge since 2009 with an international audience, editorial board and list of contributors. It is the official journal of the US based Global Alliance for Arts & Health (formerly Society for the Arts in Healthcare).
- **The Journal of Applied Arts & Health** http://www.intellectbooks.co.uk/journals/view-journal,id=169/ published three times a year since 2010, with a mostly UK focus.
- **Music and Medicine** http://mmd.sagepub.com/ An interdisciplinary journal published quarterly by Sage.

Other journals, notably the RSPH's **Perspectives in Public Health** (January 2013) and the **Journal of Health Psychology** (2008) have devoted special issues to arts, health and wellbeing. The RSPH's journal **Public Health**, published an arts and health supplement funded by the Philipp Family Foundation (PFF) in 2012. Many other well-known journals, for example the **American Journal of Public Health**, the **British Medical Journal**, and **The Gerontologist**, have published substantive articles in this area.

The Medical Humanities Research Network Scotland (MHRNS), established in 2011, is a cross-disciplinary and inter-collegiate initiative which aims to enable greater and more sustained collaborative research within Scotland in the medical humanities (http://www.gla.ac.uk/schools/critical/research/fundedresearchprojects/mhrns/).

A new arts and health research network is being established in the UK. Co-ordinated from the University of Nottingham, it aims to help academics, service users and practitioners to develop high quality research projects. Four ESRC funded seminars on **Arts, Health and Wellbeing** will take place over 2013-14 (http://artsandhealthresearch.ac.uk/artshealthandwellbeing/index.aspx).

The International Health Humanities Network was established in 2012 to provide a *"global platform for innovative scholars, medical, health and social care professionals, voluntary sector workers and creative practitioners to join forces with informal and family carers, service-users and the wider self-caring public to explore, celebrate and develop new approaches in advancing health and wellbeing through the arts and humanities in hospitals, residential and community settings."* http://www.healthhumanities.org/

3.1.7 Funding

Funding for arts and health research has been limited over the past 15 years but has recently seen an important increase. Some of these opportunities have specifically fostered international partnerships:

- The NIHR (UK) though the Research for Patient Benefit Programme (RfPB) awarded the first ever funding for an randomized controlled trial in this area that investigated the impact of community singing programmes for older people: www.canterbury.ac.uk/research/centres/SDHR (lead researcher Prof Stephen Clift, Canterbury Christ Church University). Study results became available in September 2012.
- In 2008, the Arts and Humanities Research Council (AHRC) funded a novel controlled study examining the impact of museum object handling and wellness among hospitalised medical and psychiatric patients. Helen Chatterjee at UCL Museums and Dept of Biology was the primary investigator: http://www.ucl.ac.uk/museums/research/touch/heritageinhospitals Her research is now influencing the development of heritage object handling programmes in the UK and throughout Europe.
- In early 2012, the NIHR-Public Health funding stream posted a first ever call for proposals in the area of Creative Enterprises in Open Access Settings (Cultural Activities and Health). Although several proposals were received, none were funded.
- In 2013, the Arts and Humanities Research Council (AHRC) issued a call for 20-40 short-term projects addressing cultural value and specifically included health and wellbeing in their prospectus. The AHRC has also recently indicated an interest in funding innovative multidiscipline arts, health and wellbeing research.
- In the United States, after over a year of planning and consultations, a national call for proposals in arts, health and wellbeing research was opened in October 2012, with funding support from the National Institutes of Health, National Endowment for the Arts and other federal funders.

Image used with the kind permission of Dr Helen Chatterjee, Deputy Director, UCL Museums

- In October 2012, a call for proposals was made for joint UK-USA projects from the Arts and Humanities Research Council (UK) and the National Endowment for the Humanities (USA): NEH-AHRC Joint Funding Initiative: Bridging Cultures: Using Humanities Scholarship to Study Health and Well-Being in the United Kingdom and the United States (http://www.neh.gov/grants/research/collaborative-research-grants).
- In 2011, the European Commission's Grundtvig programme for adult education provided funding to enable international stakeholders to share knowledge, expertise and best practice with partners from across Europe working in the field of Arts and Health, in particular the health and wellbeing benefits of music. Kent and Medway NHS and Social Care Partnership Trust (KMPT), in partnership with Sing for Your Life and the Sidney De Haan Research Centre for Arts and Health, were awarded funding for their two-year 'Octavia' project which will 'train the trainer' on the physical and mental health benefits that can result from singing in groups (http://www.kmpt.nhs.uk/default.aspx.locid-0ejnew09w.Lang-EN.htm).

3.2 Arts in therapy and healthcare settings

In hospitals and other healthcare settings, art is used in several ways. The traditional therapies such as art, music and drama therapy, are part of clinical treatment given by professionally trained therapists to help people find alternative means of expressing thoughts and feelings. Over the last few decades, other applications of arts have included:

- Enhancement of the clinical environment with visual art or design;
- Participative and non-participative activities for patients which aim to improve wellbeing and sometimes clinical outcomes;
- Arts activities to improve staff morale and skills; and
- Educational events using art to convey health messages.

3.2.1. Art and design in a hospital environment

In 1984, Ulrich published the findings of a study which showed that patients recovering from abdominal surgery had better outcomes, in terms of emotional wellbeing, need for pain relief and length of hospital stay, if their windows had a view of nature rather than a brick wall. In a presentation to an Arts Council England Architecture week event in June 2003, Ulrich outlined subsequent research which built on this 'nature as art' finding and the impact which this has had on hospital design in the USA (http://publicartonline.org.uk/resources/reports/rephealthcare/ulrich_intro.php).

An independent evaluation by Arts for Health at Manchester Metropolitan University of the Exeter Health Care Arts Project (Scher & Senior, 2000) provided insights into the interactions of patients, staff and visitors with arts included in the environment of a rebuilt district hospital. It included responses of clinical staff about the effects of art on the healing process, therapeutic benefit and morale, and gave useful guidance on methodology for future projects.

Major benefits for staff, service users and visitors were shown by the two academic evaluations of the King's Fund *'Enhancing the Healing Environment'* initiative. Longer-term benefits which emerged were:

- the humanising of the hospital environment, by including distractions and improving levels of privacy and dignity;
- evidence of the therapeutic impact of good design;
- the potential for improved environments to reduce aggressive behaviour and improve staff recruitment and retention;
- increased sense of ownership of the hospital environment;
- demonstration of how small-scale projects can act as catalysts for major change; and
- the development of new skills in leadership and facilitation (ACE, 2007a).

The publication *Improving the patient experience: the art of good health* (Arts Council of Wales, 2009) provides advice and guidance on innovative ways in which the healthcare environment can be improved for patients and staff. It is available from: www.artswales.org.uk

3.2.2 Literature Reviews

(See also **Section 2.4** above)

Key reviews of the literature on arts in the healthcare environment have included the following.

In 2004, in ***Arts in Health: a review of the medical literature*** Staricoff reported evidence of **clinical outcomes** in cancer care, cardiovascular care, intensive care, medical procedures, pain management and surgery. These included improved vital signs, reduced anxiety and depression and reduced cortisol levels. Other outcomes included reduced need for analgesics and shorter hospital stays. Art forms were mostly music, with some visual arts. Different art forms have been shown to have different effects.

The review also reported:

- some evidence of benefits to health practitioners;
- in mental healthcare behavioural changes were observed which reduced the need for medication and physical restraint; and
- different art forms showed different effects.

In 2006, in ***The impact of visual arts and design on the health and wellbeing of patients and staff in mental healthcare: a systematic review of the literature***, Daykin and Byrne identified seven key themes in relation to researching the impact of arts in health care environments. These were:

- Key impacts and outcomes of arts in health care;
- The contribution of arts to health care environments;
- The benefits of patient participation in arts;
- Appropriate and inappropriate art;
- Tensions between 'art', 'participation' and 'health';
- The importance of participatory processes and the role of consultation and control in mediating complex responses to the arts; and
- The need for robust research, including qualitative research, which draws on appropriate models of arts processes.

Twenty-three empirical studies were identified for inclusion in the report, of which 10 focused on the impact of design and environment of health care facilities. Evidence from this research suggested that artwork in the healthcare environment could:

- Affect anxiety and depression;
- Produce changes in clinical indicators such as blood pressure; and
- Lead to changes in behaviour.

Artworks were not always noticed, but were generally perceived positively by patients and staff, who felt they enhanced wellbeing, reduced stress and distracted patients from worries.

From the small number of studies of participatory arts in health care included in this review, the following benefits were identified:

- Achievement, pride and engagement;
- Enhanced communication, relationships and compassion for others;
- Improved atmosphere in healthcare settings;
- Empowerment and personal transformation; and
- Feeling of energy, capability and enhanced coping with hospitalization.

Four non-intervention studies included in the review examined characteristics and perceptions of patients and staff of different healthcare environments. Key findings were:

- Arts were seen to contribute to sustainable, supportive and healing environments; and
- Safety, comfort and control were identified as underlining perception and satisfaction with the healthcare environment.

Conclusions and recommendations were:

- Most of the quantitative research was limited by small sample sizes, lack of randomization and other methodological shortcomings. The diversity of settings, interventions and outcomes measures ruled out any synthesis of data.
- A small number of robust qualitative studies were found, but a general tendency to under report methodological procedures was found.
- There is a strong need for rigorous research addressing the impact of arts on mental health, and particularly for good quality qualitative data.
- Further research is needed to explore the impact of participatory processes in arts-based strategies to improve health care environments.

In **Arts and Music in Healthcare: an overview of the medical literature 2004 – 2011**, Clift and Staricoff (2011) found one hundred and three studies offering strong evidence of the effect of **music interventions** in a hospital environment on physical and psychological patient outcomes. They reported:

- decreased stress levels;
- decrease in anxiety and depression;
- reduced drug consumption; and
- reduced length of stay

in various settings, including maternity, neonatal, children, cardiovascular, surgery and pain management, lung disease and oncology.

Conclusions were:

- **further rigorous research is needed** showing clinical outcomes in hospital settings for interventions using different art forms: visual arts, literature and poetry, creative writing, dance and drama; and
- a strategy is needed for recruiting patients and staff and tailoring objectives and measurements to each participating unit.

The Cochrane database has only a few systematic reviews of arts for health, as only the work of accredited therapists lends itself to the rigorous methodology of randomized controlled trials (RCTs). Two cover drama therapy and three music therapy, but apart from some evidence that music therapy reduces depression, results are not conclusive. All call for more, larger and better quality studies.

3.2.3 Evaluation projects

An example of a major evaluation research project is Art Lift, a three-year partnership project between Gloucestershire Local Authorities, the Gloucestershire Primary Care Trusts, six art venues in the county, a GP and Arts in Trust, the arts service of Gloucestershire Hospitals NHS Foundation Trust. The project was funded by Arts Council South West and Gloucestershire County Council, and its aims were:

- to examine the effects of artist residencies on patient attendance figures;
- to examine the impact of the arts on health and wellbeing, including anxiety; and
- to explore patients' subjective experiences of the project.

15 artist residencies were created in three healthcare settings: primary (GP surgeries), acute settings (hospitals) and mental health. Art forms included pottery, painting, poetry and literature and other arts.

The project was evaluated by the University of the West of England (UWE). A mixed methods approach was used, including quantitative data from the Hospital Anxiety and Depression Scale (HADS), and qualitative data from focus groups and interviews with participants. Focus groups were also undertaken with the artists, and telephone interviews with some of the GPs and practice managers involved.

The findings supported the use of arts and artists to enhance healthcare settings:

- The project helped to reduce anxiety and depression in some patients;
- Benefits identified by the participant focus groups included:
  - Opportunity to feel a sense of pride and personal achievement
  - A distraction from problems
  - Reinvigoration of interest in the world
- GPs noticed changes in participants with unexplained medical conditions, and fewer consultations with these patients; and
- Participants stated a preference for art in a 'safe' healthcare setting over community settings.

The report noted the importance of training and support for artists, including understanding of the additional challenge of formal evaluation. It identified the following challenges to providing arts activity in healthcare settings:

- Negotiating the complexity of ethical approval;
- Finding suitable space for art in health premises; and
- Participant recruitment.

The need for adequate resourcing of evaluation was noted, as was the **need for further research**.

Image used with the kind permission of Dr Helen Chatterjee, Deputy Director, UCL Museums

3.2.4 Artists in residence

Internationally, many hospitals offer artist residencies, sometimes as part of wider arts programmes. They are usually of a limited term, and may involve the artist in one to one or group work with patients, and/or producing art for the host setting. The benefits described from residencies include:

- Improving the hospital environment;
- Transforming the experience of being in hospital; and
- Improving communication between staff and patients.

The Arts Council England Prospectus for Arts and Health describes the role of artists in residence as *"explaining and normalising healthcare"* (ACE, 2007a). An example given is the programme at the John Radcliffe Hospital, Oxford, which *"provides patients with a way of expressing emotions and worries which may be hard to articulate'* as well as helping to *"explain complex procedures through images and provide a normalising experience within stressful and invasive environments."*

Charitable organizations such as Music in Hospitals (http://www.music-in-hospitals.org.uk/) and Paintings in Hospitals (http://www.paintingsinhospitals.org.uk/) have also done much to improve the quality of life of patients and staff in hospital environments.

An illustrated example of a varied hospital arts programme can be found in the case study of **Arts in Trust**, the arts service for Gloucestershire Hospitals NHS Foundation Trust between 2002 – 2010 (http://www.willisnewson.co.uk/arts-in-trust-project.html).

3.2.5 Dissemination of good practice

In 2009, the Centre for Medical Humanities was commissioned by Waterford Healing Arts in Ireland to produce *Participatory Arts Practice in Healthcare Contexts. Guidelines for Good Practice*. This document provides an ethical framework for practice for practitioners engaging in participatory arts in a range of healthcare contexts. The guidelines are structured around the following five headings:

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

Available online at: (http://www.waterfordhealingarts.com).

The first of the networks set up to encourage the sharing of information, expertise and resources was the National Network for the Arts in Health (NNAH), established in 2000 with membership open to both individuals and organisations. Since its demise in 2007, many organizations have taken the work forward and most regions and major cities now have an active Arts for Health Forum.

The **London Arts in Health Forum** was established in 2003. It was recently funded by Arts Council England to develop the website http://www.artshealthandwellbeing.org.uk/what-is-arts-in-health which is home to the newly formed (Autumn 2012) **National Alliance for Arts, Health and Wellbeing** whose aim is to promote the role of the creative arts in health and care and support workers in the field. A campaign - **Arts in Health: improving lives** – has been launched to raise awareness of ***'the role of the arts in the prevention and treatment of illness and in health promotion'.***

The Alliance's **Charter for Arts, Health and Wellbeing** encompasses this wide remit for arts programmes, in both healthcare and community settings, and also the role the arts can play in **medical training, clinician wellbeing and awareness** and the contribution that works of art can make to the man-made and natural environment.

The website includes a directory of organizations and practitioners, case studies, and resources including links to research units and funding sources as well as practice advice and guidelines.

Other useful links to UK organizations include:

The North West Arts and Health Network: http://artsforhealthmmu.blogspot.com

Arts and Health South West: http://www.ahsw.org.uk/

Lapidus: words for wellbeing: http://www.lapidus.org.uk/

In the USA, the National Endowment for the Arts compiled a directory of outstanding arts programmes in healthcare settings: Arts in Healthcare: Best Practices (2008) (http://www.med.umich.edu/goa/NEA%20model%20program%20pg4.pdf).

A national arts and health network has existed in the USA since 1991. Recently re-named 'Global Alliance for Arts & Health' (http://www1074.ssldomain.com/thesah/template/index.cfm), it has nearly 2000 members in the US and internationally as well as regional affiliates across the US and Canada.

The Institute for Poetic Medicine is a non-profit organization dedicated to the use of poetry for healing (http://www.poeticmedicine.com/).

In addition to a close working relationship with US organisations, Canada also has its own arts and health network, Arts Health Canada (http://artshealthnetwork.ca/arts-health-101/arts-health-introduction).

Australia's national arts and health organisation, Arts and Health Australia, sponsors an annual international conference (http://www.artsandhealth.org/).

3.2.6 Case study: Breathe Magic

Breathe Magic is a 10-day intensive therapy programme for young people with hemiplegia (a paralysis affecting the hand/arm on one side of the body), run by Breathe Arts Health Research. **Breathe Magic** integrates specially adapted and scaled magic tricks into upper limb therapy exercises as a means of enhancing hand/arm function. The programme is run in the form of a 10-day magical summer camp, where the young people work alongside magic circle magicians and therapists, to enhance their motor skills, while simultaneously improving their confidence, self-esteem and psychosocial wellbeing. Research evidence has shown that the affected hand was reported to be used in 25% of bimanual activities prior to the camp, progressing to 93% post camp and retaining at 86% at three month follow-up. **Breathe Magic** has recently received mainstream NHS funding, which recognises the clinical benefits of this programme.

For more information, please visit: www.breatheahr.org

3.3 Arts in community development & health

The key action points for community arts from the Windsor Conferences included:

- Promotion of the arts as a catalyst for strengthening and energising communities;
- Enhancing the psychological, physical and emotional health and wellbeing of individuals in those communities;
- Integrating the arts into the Health Action Zones and Healthy Living Centres of the day, so that arts activity is woven into the fabric of everyday life; and
- Maintaining and extending the skills of arts practitioners.

3.3.1 Use of the arts to enhance wellbeing and strengthen communities

As already noted in **Section 2.3** above, community engagement remains central to government policy on reducing health inequalities, since research has shown that engaged individuals report improvements in physical and mental health and quality of life (Popay, 2011). As noted in the Department of Health's 2010 framework for developing wellbeing:

"Participation in the arts and creativity can enhance engagement in both individuals and communities, increase positive emotions and a sense of purpose" (DoH, 2010).

It can also help to strengthen social capital by addressing cultural and social problems in society.

The role of the arts in promoting inclusion is to provide:

- a focus for community participation, of which the potential benefits for the community can be summarised as improved social networks, a strengthened civic culture, stronger community cohesion, greater trust in fellow citizens and the institutions of government and more responsive governance;
- a way of securing individual benefits of skills, self-confidence, self esteem and wellbeing;
- a means to the end of improved life chances in spheres such as employment, access to welfare, public and private services and better family relationships; and
- a means of expression to help groups or individuals to communicate more effectively (Goodlad et al, 2002).

Arts projects in the community may have a direct health promotion objective, or they may be aimed at community participation, capacity-building or regeneration. Health benefits may be measured with indicators such as:

- Enhanced motivation;
- Greater connectedness to others;
- Perceptions of having a more positive outlook on life;
- Reduced sense of fear, isolation and anxiety; and
- Increased confidence, sociability and self-esteem (HDA, 2000).

A review in 2002 reported that the most common groups of aims for community arts projects were:

- Raising awareness of health issues and encouraging people to take responsibility for their health;
- Personal development;
- Aesthetic improvement of buildings and environments;
- Acquisition of art and craft skills;
- Social activity and participation;
- Staff development for health professionals;
- Health needs assessment;
- Communication between consumers and the health and social care agencies; and
- Cross-sector partnership working (Angus, 2002).

3.3.2 Funding for community projects

Local authorities, charitable trusts and regional arts boards are the main funders of community arts for health projects (HDA, 2000) with health service funding involved when schemes are part of primary care.

In 2007, the DoH Arts and Health Working group reported that: *"spending on arts and health is and should be seen as a legitimate, integral part of healthcare and good staff management and support, and entirely appropriate for NHS activity and investment, for instance for health promotion"*.

The Arts Council also made a commitment to facilitate funding in its 2007 Arts and Health Strategy:

"Artists and arts organisations working in healthcare settings are funded through a variety of arts and non-arts sources, and they need to explore all possibilities to obtain support for their projects. One of the major challenges faced by arts and health practitioners is to find suitable funding to enable their projects and organisations to develop, build capacity and become sustainable. We will therefore aim to improve the arts and health sectors' ability to secure this funding".

Unfortunately the last few years have seen considerable cutbacks in funding in all sectors. The public mental health framework set out in *Confident Communities, Brighter Futures* (DoH, 2010) proposed to include measures which would: *"broaden the range and level of research funding across all sectors including charitable funding to ensure it is commensurate with the proportion of NHS resource spent on mental health (11%)"*. It also proposed to increase the level of research on prevention.

In their survey of arts and mental health projects in England, Hacking et al (2007) found that one third of the 102 projects they identified were funded by health service sources. The projects were offering a variety of arts activities to around 4000 people with mental health needs per week for which the estimated national annual spend per 100 projects was £7 million and average staffing level was 1.5 FTE paid workers per project (Hacking et al, 2007).

A comprehensive directory of national, regular funding bodies and programmes for Arts and Health projects and research is provided by the Dorset Health and Wellbeing Partnership at: https://www.dorsetforyou.com/media.jsp?mediaid=159237&filetype=pdf

The new National Alliance for Arts and Health also provide a list of funding resources at: http://www.artshealthandwellbeing.org.uk/resources/funding-sources

A key issue for participatory arts projects in the community is finding ways to build in sustainability so that beneficial outcomes do not disappear when short-term funding runs out (Cameron et al, 2013).

3.3.3 Arts on Prescription

Much of the arts and health activity in community settings is part of an arts on prescription programme. This form of social prescribing has been in use since the early 1990s for people in the community with mental health issues or those who present in general practice with problems originating from socioeconomic deprivation or long-term psychosocial issues which do not benefit from medical treatment (Brandling & House, 2009). Social prescribing, which includes other forms of community services besides arts activity, has been defined as: *"a mechanism for linking patients with non-medical sources of support within the community"* (CSIP, 2009) and is recommended also as a means of improving the mental health and wellbeing of the whole population by enhancing social capital and building social networks (DoH, 2010).

Because arts on prescription links healthcare with social, voluntary or private sector resources in the community, it is a model for multisectoral working which fits well with current government policy for public health. It bridges healthcare and community arts, with some projects open to self-referrers and not all activities taking place in healthcare premises.

A contextual review of social prescribing in a report from CHM which evaluated the *Arts for Well-being* social prescribing scheme in County Durham (White & Salamon, 2010) included the following key points on mental health:

- In the UK, the annual cost of mental illness is £77 billion when lost productivity is included;
- Mental illness represents 20% of the burden of disease, higher than cancer or cardiovascular disease; and
- One third of GP consultations concern mental health, many of which are not bio-medical problems but influenced by a myriad of social factors.

Dr Malcolm Rigler was one of the first GPs to recognize that much of the distress that he saw in his surgery was the result of social, psychological and emotional problems rather than organic disease. He pioneered the use of the arts at the Withymoor surgery on a new estate in Dudley, West Midlands, creating a social resource for the community which at the time had no space for such purposes (see **Section 3.3.7**). Involvement with the arts can help vulnerable and at-risk groups to develop alternative responses to mental distress, and increase levels of social contact and social support for the marginalised and isolated (CSIP, 2009). This in turn should reduce waiting lists for counselors and psychological services and reduce the frequency of GP attendance (op cit), although the latter may not happen in the short term since *"lifelong habits of seeking help from the NHS do not change quickly"* (Brandling & House, 2009). Although social prescribing has not shown NHS savings in the short to medium term (Brandling and House, 2009), it has been argued that cost effectiveness should not be its primary focus (Hacking et al, 2007 see below) and it has wider implications for public health.

Although some evaluations of arts on prescription have reported that participants particularly appreciated the healthcare settings of the arts activities, in which they felt 'safe', finding suitable premises has been one of the drawbacks. Other practical challenges which have been reported include:

- recruitment of participants;
- over demand;
- transport in rural areas;
- attrition;
- short term funding leaving participants feeling abandoned;
- fear or dislike of evaluation by participants;
- evaluation not built into design or adequately funded; and
- confidentiality issues.

The CISP publication *Social Prescribing for Mental Health – a guide to commissioning and delivery* (CISP, 2009) recommended that evidence of effectiveness of arts on prescription schemes should address three key areas:

- the impact of participation in the arts on self-esteem, self-worth and identity;
- the role of creativity in reducing symptoms (e.g. anxiety, depression and feelings of hopelessness); and
- arts and creativity as resources for promoting social inclusion and strengthening communities.

A recent extension of arts on prescription is the development of programmes in museums and galleries (see **Section 4**).

Mental health is not the only Public Health priority area in which the arts have been employed for health promotion purposes. Arts have also been used for emotional resilience building or to deliver health promotion messages with **young people**, another Public Health target group. The performing arts in particular have been widely used in schools and youth centres, addressing issues such as the effects of drug addiction, bullying, relationships, sex education, and loneliness. All forms of arts activities have been used extensively with older people in community settings or care homes (see **Section 3.3.5** for links to literature reviews of these areas).

3.3.4 Evaluating arts for health in the community

As with arts in healthcare settings, the need to build a robust evidence base to improve practice and encourage funding is paramount, but there are different challenges for research and evaluation in the community. Quantitative methods are useful for assessing the extent of any change associated with arts participation, but qualitative methods are needed for assessing how and in what context change occurs (Hacking et al, 2007). A combination of both will give the fullest picture of 'what works for whom, and in what circumstances'.

In spite of the umbrella terms 'arts for health' or 'arts and health', few of the community projects reviewed by Angus in his review of evaluation in community based arts for health activity (2002) explicitly stated that they were aiming to affect health and wellbeing, although the aims given might facilitate such effects. A common aim was for personal development, and in particular, raised self-esteem or self-confidence. The report recommended that evaluation practice should be improved and should be based on explicit models of health and wellbeing (rather than medical models), with stated aims and rationale for how these would be achieved.

Much of the early evidence of the benefits of participatory arts in the community came from 'anecdotal' evidence, and many smaller projects still tend to collect only limited qualitative data in their evaluations. There is a need for better design and methodology in evaluation but the value of participants' own words have been defended as 'serious personal testimony' rather than anecdotal evidence (Clift, 2012 in Cameron et al, 2013).

More schemes are now partnered with academic departments for research expertise, yet there are inherent complexities in evaluation as described by White and Salamon in their interim report on the evaluation of the Arts for Well-being social prescribing scheme in County Durham (White and Salamon, 2010).

To be effective, arts interventions need to be tailored to the context, but the wide range of aims and of variables pertaining to both participants and art activities, plus the differing methodologies used in evaluation and research make it difficult to synthesize results, a point noted by several recent reviews (Froggett et al, 2011). It has been observed that evaluation is still not clearly understood by everyone concerned in a project. Most reviews and evaluations call for more research and improved methodology.

Improving evaluation methods. Standardisation in outcomes and methods would make it easier to compare results across studies, and the inclusion of control or comparison groups would add validity to findings. A common observation from participants is that much benefit is derived from being in a supportive group, which has a confounding effect when the evaluation target is arts participation. One method which has been adopted is to use a waiting list as the control group, as, for example, in a recent study by Margrove et al (2013).

Randomised controlled trials (RCTs), the gold standard method for medical research in the NHS, are not easily applied in a community setting, although the Sidney De Haan Research Centre for Arts and Health at Canterbury Christ Church University recently used a community-randomised trial approach to assess the health benefits of singing for older people. This method was also used by the researchers evaluating **Be Creative Be Well** (see **Section 4.3.6**) who paired each neighbourhood where the arts intervention had been delivered with a similar neighbourhood where nothing happened (Ings et al, 2012).

Other recommendations for improving evaluation research include:

- the inclusion of indicators which capture **process** – how the project took place and the quality of the experience itself;
- larger samples;
- longer follow-up to ascertain whether improvements are sustained;
- inclusion of the viewpoint of artists and participators in research;
- training for arts practitioners and co-ordinators; and
- three year funding packages to encourage sustainability.

Evaluations of community arts projects have also underlined:

- the importance of the artist as facilitator;
- the importance of quality of art work produced; and
- the importance of individual champions to a project's sustainability.

For those smaller projects which do not have academic partners and do not have funding for an external evaluation, the task of evaluating their own work, probably a requirement by the funders, may fall to the arts practitioners themselves. Hacking et al (2007) reported that of the 102 projects identified for their national study, most had tried to evaluate their work but many were struggling, using participant-completed questionnaires at only one point in time and reinventing the wheel by devising their own measures for similar outcomes. Only two of these studies had used validated outcome measures, although a willingness to try to use standardised measurement was identified (op cit).

Help is available to arts practitioners from many of the Arts and Health forums, some of whom have held seminars and workshops on evaluation techniques (see also **Section 3.1.5**).

Various guidance and toolkits are available on the Internet, or from the arts forums.

Examples are:
An Evaluation Guide for Community Arts Practitioners. From Arts Victoria, 2002.
www.arts.vic.gov.au

Arts and Health Evaluation Toolkit. From the Praxis arts and health network, 2009.
http://www.staa.org.uk/documents/praxisArtsandhealthevaluationtoolkitv2009.pdf

Artspulse Toolkit. From Rotherham Metropolitan Borough Council, 2012.
https://www.rotherham.gov.uk/downloads/file/2174/atrpulse_toolkit

A consultancy for best practice in the arts for health is offered by the Centre for Medical Humanities at Durham University:

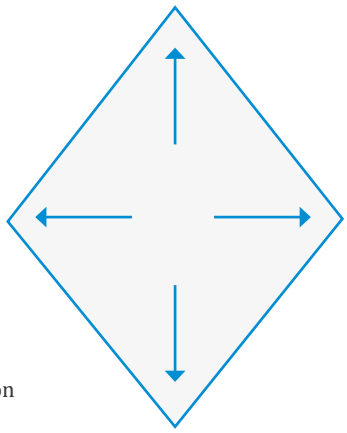
'Common Knowledge', Centre for Medical Humanities, Durham University

Common Knowledge was set up in 2000 as the arts in health component of the Tyne & Wear Health Action Zone. It has since coordinated several workforce development programmes of experimental work using arts based approaches to examine health. It aims to draw together different perspectives to increase capacity for arts based approaches to health promotion by engaging artists, health professionals of all kinds, teachers, local government, and the voluntary sector to devise and deliver imaginative health interventions.

Common Knowledge works in real contexts to address such major questions as: What does health mean? How can engagement with the arts improve health status and lead to health gain? Participants are often supported to undertake pilot projects. Evaluation of these is provided through the Centre for Arts and Humanities in Health and Medicine at the University of Durham. Common Knowledge holds 'revelation days' to explore new ways of working (examples include: arts-on-prescription schemes, participatory evaluation, emotional literacy for health). Most of the projects completed have been documented and evaluated (see CAHHM Archive at www.dur.ac.uk/cmh) and many present original insights into working on health issues via the arts. Arts in health projects generally have not been very good at setting clear aims and objectives, or articulating where they see their work is placed in either a bio-medical or social model of health. Common Knowledge is an attempt through action research to address this problem. In the evaluation of Common Knowledge, a diamond figure, kindly forwarded by CAHHM, is used to illustrate a multi-faceted view on health – people see it in different ways.

Key dimensions of arts/health

Unity is health – projects that start from the point of using creativity to enhance social relationships. These reflect a growing school of thought that good relationships are a major determinant of health.



Creativity and well being – projects that emphasise creativity as a route to well being. These aim to work with individuals to better understand their health, using creative approaches as a means to expression. Art is seen as a potential therapy.

Engaging groups – projects that engage groups to bring communities and health promotion closer together. They use creative methods to explore, disseminate, and communicate messages about health.

Supporting care – projects that support the process of care by working on the softer aspects of ill-health that health services, under the strain of heavy demand, cannot reach. Projects in the third group share some common ground, but aim to communicate with communities as a whole.

In the top half of the diamond, the predominant focus is on creativity and in the bottom half, on health. On the left, projects aim to engage with groups, seeing health as fundamentally linked to community. On the right are approaches more focused on holistic views of individual health. There is a multitude of approaches between them. Examples include: a Newcastle GP holding sessions for referrals to use voice as an alternative means of expression to combat stress (top right); a project using writing and painting with cancer patients (bottom right); a project working with the elderly with poetry and photography in order to understand their experience in homes (bottom left); and engagement between people around communal creative tasks that can generate healthy discussion and engagement (top left). Articulating the insights of Common Knowledge programmes are important to develop thinking and to enable those in the UK with similar aspirations (and ideas which are not mainstream) to feel less isolated in both the practice and research of arts in health.

Further information on Common Knowledge can be found in White M. *Arts Development in Community Health – a social tonic*, Radcliffe, Oxford 2009.

Research Participants

As already noted, much of the arts and health work in the community is provided to enhance or promote **mental health** in line with public health policy.

Many community arts for health studies have focused largely on **older people**, as ageing is another priority for public health. Two recent reports **An evidence review of the impact of participatory arts on older people** (Mental Health Foundation, 2011) and **Agenda for Later Life. Policy priorities for active aging** (Age UK, 2012) agree that a strategic framework for promoting active ageing is needed to tie together disparate policies.The performing arts have been used for health promotion with **young people**, for example for managing stress and difficult emotions, or reducing risk behaviour

The **Taking Part** survey from the Department for Culture, Media and Sport, which provide quarterly and annual statistics on arts attendance show that engagement in the arts is increasing gradually year on year.

3.3.5 Recent literature reviews

Clift et al (2008). **Singing and Health. A systematic mapping and review of non-clinical research**. Available from: http://www.canterbury.ac.uk/Research/Centres/SDHR/ResearchProjects/CompletedPojects/SingingAndHealth.aspx

Daykin et al (2008). **The impact of participation in performing arts on adolescent health and behaviour: a systematic review of the literature**. Available from: http://eprints.uwe.ac.uk/4998/2/Paper_for_Health_Psychology_June_07.pdf

Stuckey and Nobel (2010). **The Connection between Art, Healing and Public Health: a Review of Current Literature**. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804629/

Mental Health Foundation (2011). **An Evidence Review of the Impact of Participatory Arts on Older People**. Available from: http://www.baringfoundation.org.uk/EvidenceReview.pdf

Bungay and Vella-Burrows (2013). **The effects of participating in creative activities on the health and well-being of children and young people: a rapid review of the literature.** Available from: http://rsh.sagepub.com/content/133/1/44.abstract?patientinform-links=yes&legid=sprsh;133/1/44

3.3.6 Examples of evaluation research into community arts for health

Invest to Save: Arts in Health was a three-year partnership project between Manchester Metropolitan University, Arts Council England North West and Department of Health North West Public Health Group, from 2004 – 2007 (Kilroy et al, 2007).

Participants were predominantly older, white females, looking to improve their quality of life or address lifestyle issues associated with ageing, coping with depression, or associated changes in life.

Mixed methodology was used including validated psychometric scales for Wellbeing, Anxiety & Depression, General Health and Job Satisfaction and appreciative enquiry methods involving semi-structured interviews with participants, artists and teams.

Perceived benefits included:

- greater confidence, self-esteem and interest in life;
- feeling more engaged and involved in general;
- more empowered to make choices in relation to health; and
- greater capacity to cope with illness or infirmity.

A key **output** was a model of '**transformational change**' (Kilroy et al, 2007) which describes a *'creative flow state'* which can be achieved through engagement with an arts activity, and in which lifted mood and expectation *'opens up perceived possibilities for change'*. Summary report available from: http://www.miriad.mmu.ac.uk/investtosave/reports/

Recommendations included:

- Partnership working;
- Support/development for practitioners;
- Best practice guidelines; and
- Investment for sustainability.

The results of this project were recently revisited by Swindells et al (2013) who re-examined the qualitative data from a eudaimonic wellbeing perspective, to throw further light on the quantitative finding of significant improvement on this measure using the Ryff Scale of Psychological Wellbeing (Ryff, 1989).

A national study, **Mental Health, Social Inclusion and Arts** was carried out by Anglia Ruskin University and the University of Central Lancashire to identify appropriate indicators and outcome measures, and to develop and implement an evaluation framework (Hacking et al, 2007).

Indicators of improved mental health identified in the preliminary survey were:

- increased mental wellbeing;
- decreased mental distress;
- decreased levels of service use; and
- decreased use of medication.

Indicators of increased social inclusion were:

- higher levels of social contact likely to build bridging and bonding social capital;
- reduced levels of perceived stigma and discrimination; and
- higher levels of engagement in employment and education.

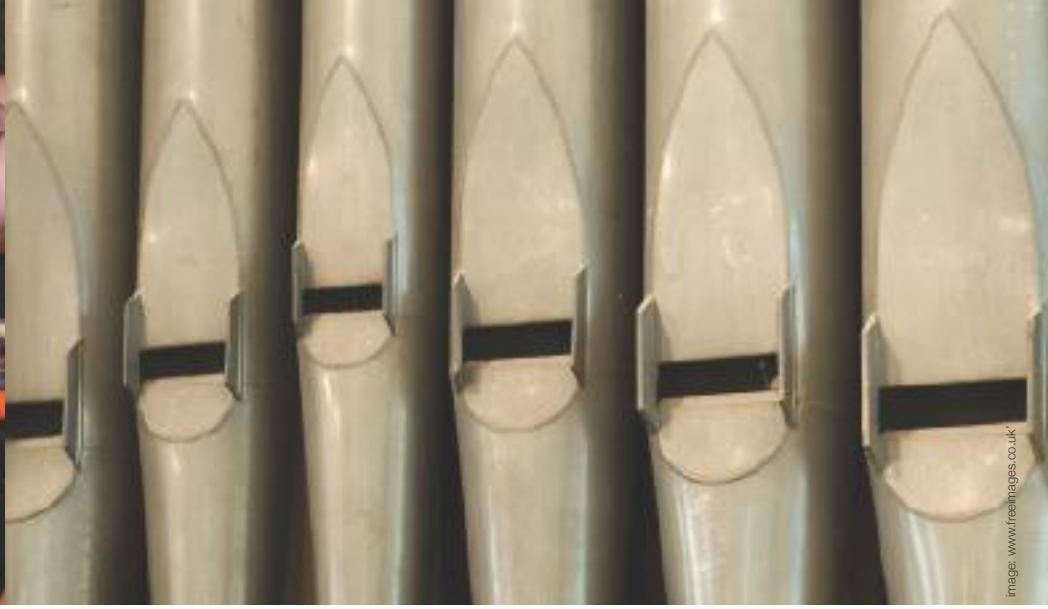
'Distance travelled' indicators, deemed to measure empowerment, were:

- increased levels of confidence and self-esteem;
- enjoyment of arts participation;
- learning/skills gained; and
- pride in work produced.

In the subsequent outcomes study in which the authors implemented their evaluation framework, very strong evidence was found for empowerment and less strong evidence for improvement in mental health and social inclusion. Six of the studies provided qualitative case studies which concluded that attempting to measure changes in levels of service use or medication was not meaningful. They concluded that the contribution of arts participation to recovery was about participants leading the kind of lives they wanted to live. The most common themes to recovery were identified as:

- Finding hope, meaning, purpose and value;
- Finding new coping mechanisms; and
- Developing new identities within and beyond mental health (Hacking et al, 2007).

A brief critique of this research is provided by White and Salamon (2010) in their evaluation of the Arts for Wellbeing social prescribing scheme.



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An independent evaluation of **Be Creative Be Well: Arts, Wellbeing and Local Communities** (Ings et al, 2012)

The **Be Creative Be Well** project was part of the community-led Well London programme and comprised 100 or so small, participatory arts projects in some of London's most disadvantaged areas. The programme was *"shaped by local conditions and local people"* with art forms ranging *"from painting workshops to dance classes, parades to musicals, personal poetry to communal sculpture"*. The evaluation focused on the story of the programme, the qualitative outcomes of artistic engagement and the impact on wellbeing of taking part in participatory arts.

The artists brought their own particular sets of values, experiences and practices to their projects so that what emerged from their work with particular residents was unique. From the many different variables and widely varying experiences and impacts, the researchers wanted to assess:

- the programme's success in encouraging behavioural change into healthier lifestyle choices; and
- what particular contribution creativity and the arts made to this process.

In order to do this, they used a framework based on the five ways to wellbeing (nef, 2008) since it was noted that the five actions corresponded closely to behaviours that can emerge in well-designed participatory arts projects (see also **Section 2.2**). A community-randomised trial approach in which each neighbourhood where Well London has been delivered was paired with a similar neighbourhood where nothing happened, in order to compare them in terms of health and wellbeing at the end of the trial.

Some of the frustrations of evaluating community arts projects can be seen in the researchers' comment that: *"The most successful projects were those where the artist brought both artistic and emotional intelligence to the task, combining the catalytic charge of their artistic energy with a sensitive and creative approach to engaging people on their own terms. In theory, this combination of energy and engagement should work every time but in practice local conditions shape, support and thwart what actually happens on the ground".*

However, the findings reported was optimistic:

"Even when projects involved comparatively few residents, there were individual breakthroughs – people who were inspired to try new things, change jobs, refresh their outlook on life and gain useful creative skills. In nearly all the projects visited, there was a new sense of possibility evident in the neighbourhood – a hint of what could be".

The report is available from: http://www.artscouncil.org.uk/media/uploads/pdf/BCBW_final.pdf

The Scottish Development Centre for Mental Health (SDC) evaluated West Lothian Council's project **Survivarts** which aimed to provide adult survivors of sexual abuse with regular arts activities to improve their general wellbeing. It built on an earlier project in which people with chronic depression, referred by Community Psychiatric Nurses (CPNs), took part in art activities to try and improve their general wellbeing and quality of life and reduce CPN workloads. Learning from that project, which informed the process of setting up and running Survivarts, covered issues such as:

- getting people to come for the first time;
- the best times/days to run classes;
- the need for support and supervision for artists working with traumatized people;
- establishing boundaries;
- the need to evaluate in order to make the case for future funding; and
- exit strategies.

The four different two-hour workshops which ran once a week were: storytelling; visual arts; crafts; and dance. Participants initially signed up for six weeks and could then re-enrol if they wanted to continue. If needed, one-to-one counselling was available via another project, Open Secret.

The evaluation of Survivarts took place between June and December 2009 with the aim of exploring the impact of the process involved in setting up and running Survivarts and the experience of the participants. This was done with focus groups, and thematic analysis of Survivarts' own evaluation material which comprised an artist's log and the 'Welcome questionnaires' and 'Evaluation forms' completed by participants at the first and last session.

The findings showed that the arts classes were successful in improving wellbeing for many participants, who learned new skills and improved in confidence and social skills. Other outcomes mentioned by participants were: increased motivation to engage in other activities; positive changes in the way others see them; a sense of purpose; and a reason to get up in the morning. The biggest challenge faced by Survivarts was short term funding.

Helpful good practice guidance is included in the report which is available from: http://www.gold.ac.uk/media/Survivarts%20Evaluation%20Final%20Report%20Feb%202010.pdf

Citizen Power Peterborough was a community project specifically aimed at strengthening the community. The two-year partnership between the RSA Action and Research Centre, Peterborough City Council and Arts Council England (2010-2012) was a unique programme of work, led by, and for, the people of Peterborough, in which artists, community groups, local residents and others worked together to find new ways of community cooperation, dialogue and collaboration.

The six projects were:

- Sustainable Citizenship: how communities can help solve environmental problems;
- Recovery Capital: how the personal, social and community capital can help tackle problematic drug and alcohol use and generate the support necessary for recovery;
- Peterborough Curriculum: improving educational opportunity for, and the civic participation of, young people by connecting what they learn in school with the place where they live;
- Civic Commons: creating spaces for political and social debate, discussion and local activism;
- Arts and Social Change: the role of the arts in creating a sense of belonging and imagination in a place; and
- ChangeMakers: unlocking the hidden wealth of community leaders.

A report of the project is available from: http://www.thersa.org/__data/assets/pdf_file/0007/409273/citizen_power_peterborough.pdf

3.3.7 Two case studies

Withymoor: A Health Hive

When Dr Malcolm Rigler began his practice at Withymoor, Dudley in the early 1980s, he was convinced that much of the illness experienced by his patients was psycho-social in origin. The surgery served a large, new estate which had no facilities for exercise, or natural meeting places, and for many residents the dream of home-ownership led in reality to financial burden, isolation and an unhealthy lifestyle. Dr Rigler's solution was to adopt a 'salutogenic' approach, focusing on positive health and wellbeing and using the creative arts to facilitate communication between doctors, patients, staff and the community.

The waiting room was transformed into a welcoming place to learn about healthy lifestyles and wellbeing, with a mural painted by school children, a bulletin board, plants and a play area. The new ambience encouraged people to talk to each other and exchange information. Boring and authoritarian health leaflets were replaced by more dynamic methods of health education, using visual and performing arts to empower patients to take responsibility for their own health.

Visiting artists initiated story telling sessions and a craft group where socially isolated women made cards to welcome new mothers and babies to the surgery. Artist residencies produced witty and accessible health education posters and a book of writings for the waiting room, in which children and adults shared their experiences of sickness and health. An event was organized for the whole community, in which paper lanterns, made in workshops at the surgery, were carried in procession around the boundaries of the estate, followed by a jazz band. This became an annual event which brought neighbours and families together to celebrate belonging to a community.

Tones K and Green J (2003). Withymoor: A Health Hive. A Review of Creative Arts in Primary Health Care is available for download at www.rsph.org.uk/artsandhealth

Sidney De Haan Research Centre for Arts and Health: The value of singing for people with chronic obstructive pulmonary disease (COPD)

The Sidney De Haan Research Centre for Arts and Health has recently completed a feasibility study in East Kent (south east England) to explore the value of weekly community singing for people with COPD. An uncontrolled observational study of a weekly group singing programme was undertaken over the period September 2011 to June 2012. One hundred and six people with COPD ranging in severity from mild to moderate were enrolled in one of six community singing groups led by experienced singing group facilitators. A variety of relaxation, breathing and vocal exercises were used together with a wide repertoire of well-known, familiar songs and some material new to the participants. The singing groups came together on two occasions for large choral workshops and performance events to which family and friends were invited.

To evaluate the effects of regular singing, the St. Georges Respiratory Questionnaire (SGRQ), MRC breathlessness scale, EQ-5D and York SF-12 were administered at baseline, mid-point and end of study. In addition, spirometry was administered to assess lung function at baseline and study end to assess forced expiratory volume in one second (FEV1) and forced vital capacity (FVC). These measures were also expressed as a percentage of expected normative values adjusted for age, gender, body mass index and ethnicity (FEV1% and FVC%).

Health-related quality of life assessed by SQRG showed a statistically significant 3.3 point change in the direction of health improvement. Significant improvements were also found in FEV1%, FVC and FVC%. The observed improvements are encouraging as COPD is a progressive illness and a decline in lung function and health-related quality of life would be expected over ten months. The study provides a good foundation for designing a more robust controlled community trial which the De Haan Centre is currently planning.

For further details of the study see: http://www.canterbury.ac.uk/Research/Centres/SDHR/CentreNews/Health-benefits-of-singing-for-people-with-lung-disease.aspx

4. Culture and Heritage

4.1 Arts and health activity in museums and galleries

A relatively new but expanding area of arts and health activity in the community is the involvement of the cultural heritage sector.

Museums and art galleries have the potential to improve wellbeing and quality of life in their communities. An increasing number are now offering innovative programmes which address public health issues such as mental health problems (Roberts et al, 2011; Colbert et al, 2013), dementia (Eeckelaar et al, 2012), cancer, lifelong learning for older adults, health education and social capital (multiple citations in Camic & Chatterjee, 2013). It is argued that museums and galleries have the advantage of being non-stigmatising settings, where people can be encouraged to *"learn about themselves, their culture and society, and the larger world around them"* (op cit).

In a recent paper, Camic and Chatterjee (2013) report that the best evidence to date on the benefits to health and wellbeing of museum interventions focus around object handling or the viewing of paintings, either of which can stimulate people to create their own stories around those of the object or picture. They can also trigger memories so may be used in reminiscence or memory activities, which have been shown to affect mood, self-worth and a general sense of wellbeing (multiple citations in Camic & Chatterjee, 2013). Other reported contributions which museum visits make to wellbeing are:

- Sense of connection and belonging;
- Human capital: using and improving skills;
- Optimism and hope;
- Moral values, beliefs;
- Identity capital, self-esteem;
- Emotional capital, resilience;
- Opportunity for success;
- Recognition of achievement;
- Support;
- Quiet, rest, sanctuary;
- Social capital, relationships;
- Meaningful pursuits;
- Safe, rich museum environment; and
- Access to arts and culture. (Wood, 2007 in Camic & Chatterjee, 2013).

Some museums offer outreach programmes where objects from the collection are taken into hospitals or nursing homes to be handled at the bedside (Chatterjee et al, 2009). A pilot study to assess the impact of such a scheme on patient wellbeing identified two main themes in the qualitative data collected: **impersonal/educational** benefits in which facts about the objects were ascertained by touch which facilitated an intimate and imaginative connection with the item and its origins, and **personal/ reminiscence** where the objects assisted with counselling or helped to restore a sense of identity through reminiscence.

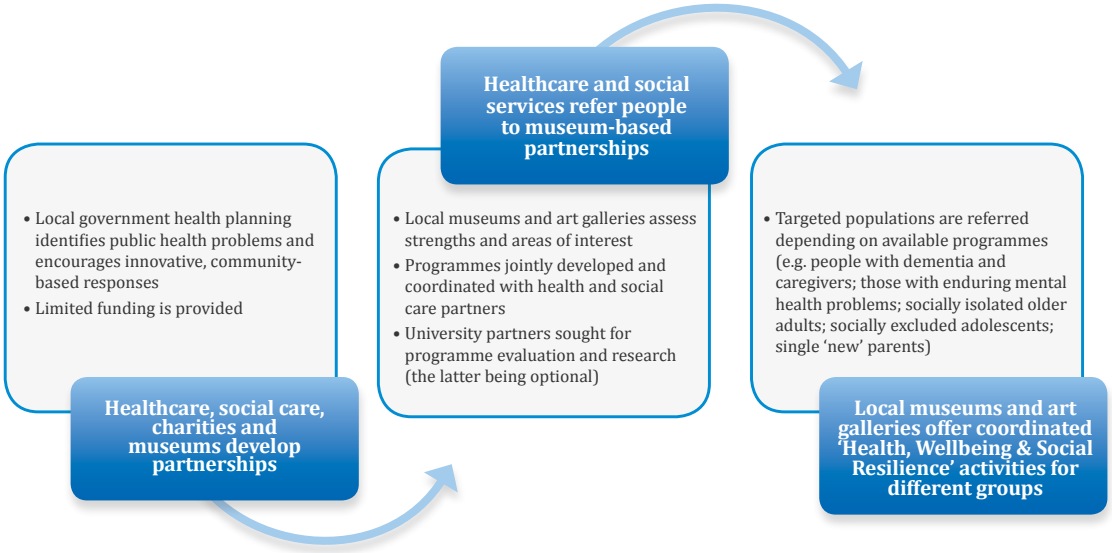
Chatterjee's report highlights the need for museum workers using objects in this way to be aware that reminiscence can bring up powerful emotional memories, as has been found with creative writing projects (see **Section 3.1.5**). This has implications for training in public health, culture and heritage and health care sectors. Her evidence-based work and those of her colleagues at UCL have developed a foundation for new health and wellbeing practice opportunities for museums and health care sectors to work in partnership (Chatterjee & Noble, 2013; Ander et al, 2013).

4.2 UK policy context

The UK government believes that museums and galleries have a key role to play in addressing social exclusion and in 2008 launched the **'Open to All'** training package for gallery staff as a resource to help them in tackling exclusion and improving access for people with mental health problems. The government's 'Big Society' agenda recognizes the importance of voluntary and community organizations and committed to helping them to find "new forms of finance to help meet their day to day needs and facilitate sustainable growth" (NCVO, 2010). This need is recognized and addressed in the final section of this report, Where do we go from here?

It is suggested that, with the responsibility for Public Health moving to local authorities, museums could become complementary partners in public health activities such as health promotion and health education. A framework has been proposed in which local health-care authorities, health-care funders and museums and galleries would coordinate resources, knowledge and expertise (Camic & Chatterjee, 2013).

Figure 1: *Framework for museum and gallery involvement in public health* (Camic & Chatterjee, 2013)



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4.3 The evidence base

The culture and health framework proposed by Camic & Chatterjee (Fig. 1) includes an optional suggestion that museums and galleries should seek university partners for programme evaluation and research. The framework would provide research opportunities, through which the development of improved evaluation strategies could be coordinated to encourage the further development of evidence based practice (op cit).

4.4 Examples of recent research which has included university partnerships

Roberts S, Camic PM and Springham N. (2011). **New roles for art galleries: Art-viewing as a community intervention for family career of people with mental health problems.** *Arts and Health: An International Journal for Research, Policy and Practice,* 3(2), 146-159.

The study looked at the psychological and social aspects of art viewing in a public gallery, to ascertain whether this could be an activity to support family carers of people with mental health problems. Grounded theory was used to analyse interviews with eight carer-participants and two facilitator participants, together with audio-recordings of the gallery sessions. Art viewing engaged carers on emotional, aesthetic and educational levels; processes such as mentalising, reflexivity and externalizing were identified in their responses to the activity.

Eeckelaar C, Camic PM and Springham N (2012). **Art galleries, episodic memory and verbal fluency in dementia: an exploratory study.** *Psychology of Aesthetics, Creativity and the Arts,* 6(3), 262-272.

This study explored whether art viewing followed by art making, in an art gallery setting, had an impact on the episodic memory and verbal fluency of people with dementia. Findings suggested that episodic memory could be enhanced through aesthetic responses to visual art, but effect on verbal fluency were more ambiguous. Family carers reported that their relatives with dementia showed improved mood, confidence and reduced isolation during the gallery sessions.

Colbert SM, Cooke A, Camic PM and Springham N. (2013). **The art gallery as a resource for recovery for people who have experienced psychosis.** *The Arts in Psychotherapy*, 40 . DOI: 10.1016/j.aip.2013.03.003.

An art-gallery based group for people with experience of psychosis was used to explore whether this could facilitate modification of stigmatizing dominant narratives of psychosis in participants' personal narratives, promote recovery, wellbeing and a subjective sense of social inclusion. The narratives of mental health and gallery staff were included. Participants reflected on paintings related to their life experiences; literary and social context narrative analysis of interviews at the conclusion of the group suggested that some individuals used art-related concepts to modify the dominant narrative within their personal narratives. The intervention promoted recovery and wellbeing and addressed bonding social capital.

Camic PM, Tischler V and Pearman CH (in press). **Viewing and making art together: an eight-week art gallery-based intervention for people with dementia and their caregivers.**

The study examined the impact on social inclusion, caregiver burden and quality of life and daily living activities for the person with dementia, using mixed-methods of pre-post standardized questionnaires and interviews. No difference was found between the benefits of visiting two types of gallery – traditional and contemporary – with both sites revealing potential benefits in terms of social inclusion and self-reported enhancement of cognitive capacity and quality of life.

4.5 Three case studies

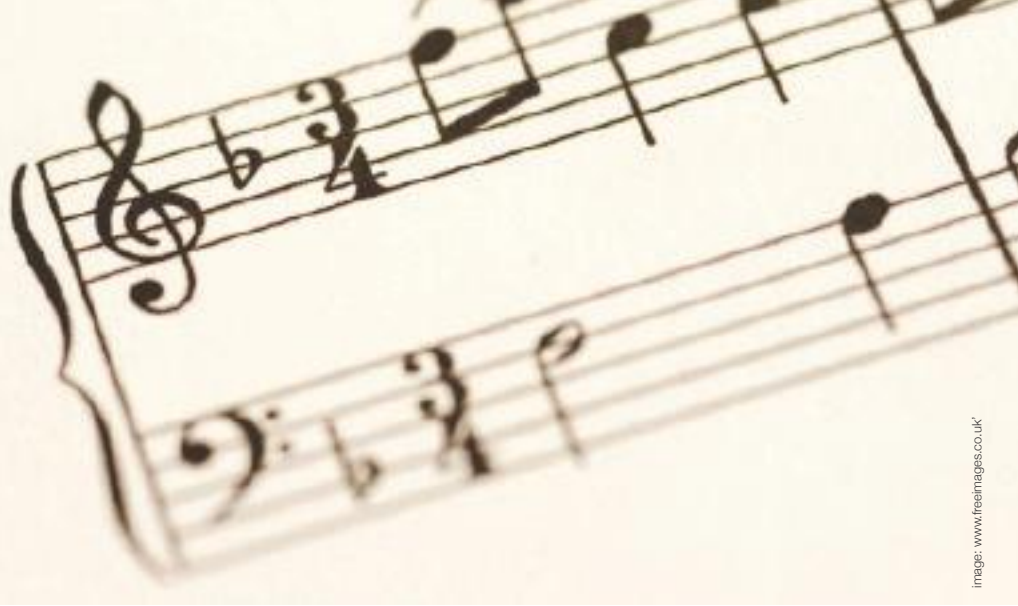
Renaissance North West: Who Cares? Health, wellbeing and museums

Between 2009 and 2011, six museum or art gallery members of Renaissance North West, ran individual programmes within the overall framework of a major project: *Who Cares? Health, wellbeing and museums* which aimed to bring together museum collections, gallery spaces, health professionals and museum professionals to provide valuable experiences for vulnerable and disadvantaged groups. Each of the projects aimed to address cultural access and inclusion as well as enhancing health and wellbeing, since: *"when local people come to feel ownership of such buildings their function clearly changes from culturally exclusive repository to public resource and they become a source of collective pride rather than inhibition"*. Strategies to improve public access included introductory sessions, high impact exhibitions and the creation of child-friendly spaces.

An evaluation by the Psychosocial Research Unit at the University of Lancaster (Froggett et al, 2011) reported that the museums' contribution to wellbeing drew on both the symbolic cultural significance of their collections, and on the personal symbolic significance the collections held for individuals. The key task for museum staff was to provide a relational environment in which the cultural and personal could be brought together. A full report is available from:
http://www.greatermanchesterartshealth.org.uk/CubeCore/.uploads/For%20Cube/case%20studies%20docs/Who%20Cares%20Report%20FINAL%20w%20revisions.pdf

Dulwich Picture Gallery: Good Times: Art for Older People

Good Times: Art for Older People at Dulwich Picture Gallery responds to an ageing population which is increasingly isolated and vulnerable. *Good Times* partners over 90 centres, engaging with many people including those with age-related illnesses, such as Dementia. A menu of specialist tours, talks and workshops are offered, on and off-site, developing skills and confidence as well as encouraging friendships. One strand of the programme, *Prescription for Art,* reaches isolated individuals by linking with doctors' who 'refer' patients for creative sessions at the Gallery. The health benefits of these programmes continue to be the focus of research partnerships. The evaluation was carried out by the Oxford University Institute of Ageing and can be accessed at: http://press.dulwichpicturegallery.org.uk/downloads/This%20Is%20Living-Good%20Times%20Art%20for%20Older%20People.pdf



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Beaney House of Art and Knowledge, Canterbury: The Paper Apothecary

The Paper Apothecary, funded by The Happy Museums project and The Beaney, worked with artist performers Animate Arts to place wellbeing at the centre of Canterbury's recently refurbished museum and library. A full-size apothecary built entirely from paper, acted as a catalyst to create a seed bank of ideas for how The Beaney opens its doors to real dialogue with the community it serves. Two hundred and fifty 'Happiness Investigators' and 'Cultural Doctors', including 120 school children, investigate the museum's collections, library and heritage to issue 'happiness prescriptions' and explore how contact with cultural experiences can kick start healthier and happier communities.

Detailed evaluation is currently being written and more information can be found on the website: http://www.canterbury.co.uk/Beaney/The-Paper-Apothecary.aspx or by contacting mitch.robertson@canterbury.gov.uk

5. Where do we go from here?

5.1 Bringing the framework together and looking forward:

In 1996, Sir Kenneth Calman, then Chief Medical Officer, Department of Health, England, observed that arts and health was a subject **'whose time has come'** (Philipp et al, 1999). A decade and a half later it is clear that this subject is no longer a new arrival, but an established part of health and social policy and practice. Examples of 'having arrived' include the establishment in 2011 of the UK Network for Arts and Health Research; the launch in March 2013 of the Royal Society for Public Health's *New Horizons: Innovative Practices in Arts, Health and Wellbeing* as part of their Training Solutions programme; the international conference in June 2013, attended by over 300 delegates, in which this report has been launched; and the recent announcement from Oxford University Press that it will publish the first international textbook on arts, health and wellbeing practice and research as part of their highly respected Textbooks in Public Health series (Clift & Camic, 2014, in preparation). An enormous amount of activity has taken place in arts and health since 1999 and in the UK much progress has been made:

- There are now several interdisciplinary centres of excellence for research into medical humanities, some of which have attracted substantial funding;
- Bringing visual, performance and participatory arts into hospitals for the benefits of staff and patients is now common practice, with many Trusts having dedicated Arts programmes;
- Art is being used in numerous, innovative ways to regenerate, strengthen and enrich some of the poorest communities and improve the quality of life of disadvantaged and vulnerable people;
- Training provision is increasing, and targeted at all levels of involvement with arts and health;
- Arts for Health forums thrive in most regions, to facilitate networking and the dissemination of good practice, now coordinated by the National Alliance.
- The evidence base is growing, improved by partnership working with academic departments, and dissemination of good evaluation practice.

Government policy, with its move towards primary prevention and the promotion of wellbeing, has created a valuable opportunity for the arts to be part of mainstream healthcare. The Marmot Review of health inequalities and the social determinants of health brought health and wellbeing to the forefront of public health policy both in the UK and internationally. The consequent focus on healthy communities, and their role in the promotion of good health as well as the prevention of ill health, has provided opportunities to show just what the arts can contribute to this area, as inspiring projects like *Be Creative, Be Well* and *Citizen Power Peterborough* clearly show.

The evidence base is undoubtedly growing. One welcome contribution will be the proposed systematic review of therapeutic writing for people with long term mental or physical conditions from the Centre for Primary Care and Public Health at Barts and The London School of Medicine and Dentistry, which will include a realist synthesis and economic evaluation (personal communication). Recent reviews show a consensus that there is still a need for more, better quality research: more studies are needed, with different art forms, larger numbers of participants, longitudinal designs, and mixed methods of collecting data from all involved, recording details of process as well as impact and outcomes, to ensure that maximum information is gathered. The process of how arts projects have been implemented is particularly important given the many challenges which they often present. The improved efficiency that comes from building on the experience of earlier projects is highlighted in the report of Scotland's ***Survivarts*** (Scottish Development Centre for Mental Health (SDC), 2010). There are now a number of excellent examples of evaluations from academic partners, and the role of arts and health networks such as the National Alliance, and the new arts and health research network in the UK is invaluable for the dissemination of good practice to researchers, arts practitioners, project coordinators and policy makers. Nobody should still be reinventing the wheel.

Timely evidence is essential for informing policy decisions, targeted interventions and universal services (Thorpe & Mackie, 2012). At the same time a balance needs to be achieved to ensure that the point of arts interventions is not lost in the emphasis on evaluation and measurement. There is a role for everyone in partnership working so that, as pointed out in a recent editorial: *'While public health specialists might discuss translating the social determinants into tangible assets to be harnessed for improved outcomes, others want to get back to their communities and* ***'just do it"*** (Sim, 2012).

Funding has been identified as an issue and it is unfortunate that the present economic climate caused the government to backtrack on promised support. However recent changes to the health service may bring new opportunities for funding through personal budgets and Clinical Commissioning Groups (Hebron & Taylor, 2012). In the community in particular, funding is often project-based and short term and there is a need for longer-term funding to improve sustainability. The support that the Royal Society for Public Health (RSPH) has given, and continues to give, in promoting the arts and health field through its journals, training courses and the Arts for Health Award scheme, has been cited as a reason for optimism (Clift, 2013).

Life in the current time of economic recession is increasingly stressful, and particularly so for those living in deprived circumstances. There is evidence that arts can help in building **emotional resilience, morale** and **coping skills.** One of the most exciting new directions is the expansion of work in the Culture and Heritage sector, based on community resources such as museums and galleries. This is an area with the potential to grow under the new UK public health commissioning arrangements. As pointed out by Marmot and Bell (2012), health is no longer the sole responsibility of the NHS, which cannot tackle health inequalities alone, and partnership working between primary care, local authorities and the third sector can deliver *'effective universal and targeted preventive interventions'* with important benefits (op cit).

Museums and galleries, long valued as places for education and learning, are now involved as "intervention sites" in health and wellbeing research and practice. Amongst the benefits of the work emerging from this sector are the promotion of cultural and social capital and the strengthening of identity and social inclusion. The last two have particular relevance in our culturally diverse society, contributing to inclusion and a feeling of being part of something rather than apart from it. Additional research in this sector is examining the cultural and health value of heritage objects and works of art on wellbeing, quality of life, social isolation, cognition and emotional stimulation. It is impossible not to catch the enthusiasm of those involved in arts projects when reading some of their reports. An inspirational artist-facilitator may confound the evaluation but will contribute hugely to the success of the project.

In September 2011, a public health international conference entitled – *Health and Wellbeing – the 21st Century Agenda* was held in London. Its highlights were reported in a special Supplement of *Public Health* (Volume 126, S1: 1st September 2012), funded by the Philipp Family Foundation (Philipp et al, 2012). Many of the presentations made suggestions for future action for the wellbeing agenda which have relevance for the arts and health field:

> The rise in gross domestic product (GDP) over the last 50 years was not matched by a corresponding rise in wellbeing and quality of life. Increasing levels of mental ill-health and falling levels of mental wellbeing suggest that it is time to re-evaluate ***"what it is that makes life worth living"*** (Henderson, 2012);
>
> Sustainable development, health, wellbeing and social justice are linked and these connections need to be better understood to inform planning and policy decisions. ***"Links between health, wellbeing and the environment are not sufficiently valued by the health sector"*** (Porritt, 2012).

A survey for the Well London initiative showed that individuals who were socially disadvantaged were less likely to participate in arts or cultural activity. Arts participation was strongly associated with healthy eating, physical activity and positive mental wellbeing, with no evidence of confounding by socioeconomic or sociodemographic factors.

"If arts are to be commissioned or recommended for health improvement, it will be essential to address the social inequalities in access to arts and cultural activities in order to prevent these from further reinforcing, rather than reducing, health inequalities in the UK" (Renton et al, 2012).

There is a need for global action in relation to the ageing of the world's population. A challenge for public health is changing the nature of the current discourse on age and ageing so that ***older people within our communities are recognized and supported as a significant social resource and a driver for growth*** (Hunter et al, 2012).

5.2 The Importance of Subjective Viewpoints

Much of this present report is based on published papers in the public domain. Nevertheless, as the two preceding Nuffield Trust reports noted, the value of both science and arts paradigms is well-recognized. An arts-science spectrum of enquiry evolved with this work. It spans from the **subjective**, intuitive, individually inspirational, artistically expressive viewpoints, to the **objective**, measurable, productive, logical and scientific perspective. These two approaches are interconnected and being used increasingly to explore the following interdependent areas: health; wellbeing; conservation; heritage; ecology; and social, environmental, and humanitarian issues (Philipp et al, 2012).

The model was developed as a response to the WHO request for:

- health and development issues to be considered together (WHO, 2000);
- researchers to look into new, unfamiliar areas and work with new colleagues in new ways (WHO, 1998);
- different environmental impact categories to be considered (WHO, 1982);
- the need for increased collaboration among researchers in interdisciplinary projects to improve "the possibility of exchanging and developing ideas, approaches and methods that will produce a better and more comprehensive knowledge of health and its determinants" (WHO, 1985).
- support of the European Regional strategy of Health for All in which the components are reported to fit together as an integrated model (WHO, 1988).

Responses to the WHO request included, for example, that of Professor George Salmond, former Director General of Health, New Zealand. He noted that:

"If progress is to be made in improving the nation's health, new concepts, knowledge and skills must be introduced. Analyses are needed which would break away from the narrow confines of biomedicine and economic rationalisation, and which encompass more socially and ecologically conscious constructs. The latter would empower people and involve communities in democratic approaches aimed at enhancing well-being and health status" (Philipp, 2002).

In considering roles of the arts in health and wellbeing and how interest and participation in activities oriented to the art of wellbeing can further evolve, this WHO-based framework has been used to reason that subjective viewpoints have particular value. The views expressed in the reflections below illustrate ways in which for example museums, art galleries, libraries, nature reserves, environmental settings, archives, hobbies and collections, are not merely repositories and places to view the arts. Instead, they are considered as resources with values to personal and societal health and wellbeing that are increasingly and more widely being recognized. They are believed to be of considerable help to us in exploring our sense of self, identity, place and feelings of belonging, and our relationships to other cultures and societies. As such, with appropriate guidance, advice, and education these resources add meaning to our lives such that our self-esteem and confidence benefits and we can enjoy life and living more, understand better the views held by other people, and thereby seek to work more constructively with any differences.

5.3 Six subjective reflections illustrating how the arts interact with health and wellbeing

The following six examples of personal reflections illustrate aspects of subjective values as they relate to the arts in health and wellbeing. They explore aspects of the roles of museums, art galleries, nature reserves, archives, heritage collections and urban planning, and values for wellbeing associated with them from areas such as volunteering, aesthetic appreciation, creative endeavour and interdisciplinary project working.

Although these examples come from one country, New Zealand, they are not thought to apply only to their country of origin. Instead, as part of follow-ons to the above WHO request they have been identified as exemplars for wider consideration through an ongoing programme of work initiated in 2010 under a Memorandum of Understanding between the Royal Society of Public Health (RSPH) and a New Zealand-based charitable trust, the Philipp Family Foundation. The programme is intended to help foster the further development of RSPH learning resources, educational and training opportunities and podcasts, international networking and the wider dissemination of public health information coming from New Zealand, the UK, and elsewhere (Philipp et al, 2012).

A challenge now for arts and health practitioners, researchers, and professionals working in different disciplines such as those represented in the personal reflections below, is to explore how best to collectively and across disciplines help to strengthen further the evidence base for the importance of values to health and wellbeing and for the enrichment of living. It is the next step following the original challenge coming from a recommendation of the final symposium of the First World Symposium on Culture, Health and the Arts, held in Manchester Metropolitan University, England, in April 1999 (Philipp, 2002).

The Recommendation called *"for further research evidence of high quality for the effectiveness of the arts interventions in health care and health promotion" and recommended that the "networking could be usefully extended and coordinated with the objectives of multicentre studies and widespread dissemination of the findings in qualitative and quantitative research evidence that have been published in the peer-reviewed literature".*

Since then, as discussed in this report, worldwide there has been an enormous positive response. Now, as part of the next steps being taken, new areas for study and further development in the arts and health field have emerged. These viewpoints below will we hope help to stimulate additional interest and further work in this field. Interested readers will be rewarded by google searches of most of the places, projects and organisations mentioned in the viewpoints below.

5.3.1 MUSEUMS AND VOLUNTEERING

Mr Len Bayliss, Chairman, Otaki Heritage Bank Preservation Trust, New Zealand, former Chief Economist, Bank of NZ, and Senior Member of the Prime Minister's Office, NZ, and a Director of Several Listed Companies

Communities are more than just a collection of individuals. They are found where there is a strong sense of bonding, particularly in places where people feel they have local roots and that they 'belong'. Museums contribute to this feeling of identity and community through their artefacts, archives, exhibitions, documenting of history and heritage, research and educational roles. In doing so their social, cultural and economic impact helps to add value and enrich human experience.

Locally, with their passion and interests and wish to give back something to the community, volunteers make a huge contribution to community wellbeing. In support of it, their time, experience, dedication and skills are definitely needed in present-day society. Increasingly, they really are the glue that bonds people together.

Taking this a bit further, I think that everything we've done in the past and that's gone on around us influences and makes us who we are. It gives us the framework and tools to do something that's interesting and worthwhile. For some of us such as myself it's a key ingredient of the culture of wishing to give public service that carries on after one retires.

The Otaki Heritage Bank Preservation Trust on the Kapiti Coast, New Zealand, was started in 2003 by volunteers with the above motivations in mind. It was able to preserve and rent from the local District Council a former Bank of New Zealand and Local Government building. The heritage building, registered with the NZ Historic Places Trust, was converted by the Trust into a museum focused on local engagement. It is run by 14 trustees, some elected and some appointed by local organisations, supported by 20 volunteers, and has a growing Friends of the Museum group who contribute public support and engage actively through the quarterly newsletter.

The principal objects and charitable purposes of the Trust are:

1. Preserving the Building;
2. Providing a secure place for the Otaki Historical Society records;
3. Establishing a museum for artefacts pertinent to the Otaki area - the museum being defined as per the definition* of the International Council of Museums;
4. Raising awareness in the community of the unique historical base of Otaki and its environs;
5. Providing opportunities for students in local educational institutions to explore the origins of the Otaki community as relevant to their family or whanau**;
6. Liaising with related community institutions such as the local library and Wananga*** to establish partnerships for the benefit of achieving each other's objectives; and
7. Representing the views of the community to the Kapiti Coast District Council in negotiations with the council in respect of the use of the Building

* This definition is *"A museum is a non-profit making, permanent institution in the service of society and of its development, and open to the public, which acquires, conserves, researches, communicates and exhibits, for purposes of study, education and enjoyment, material evidence of people and their environment".*

** The Maori language word '*whanau*' is an extended family group spanning three to four generations.

*** In the education system of New Zealand, 'Wananga' refers to a publicly owned tertiary institution that provides education in a Maori cultural context.

Our model works well in our community, people appreciate it, and what the museum contributes is increasingly valued by both local residents and visitors from further afield.

5.3.2 INVOLVING CHILDREN IN THE LINKS OF ART AND NATURE SUPPORTS THEIR DEVELOPMENT AND WELLBEING AND CONTRIBUTES TO SUSTAINABLE DEVELOPMENT

Janet Bayly, Director, Mahara Gallery, Waikanae, Kapiti Coast, Aotearoa, New Zealand

'Native Habitats: Waikanae Children's Creations' was a recent exhibition and accompanying book celebrating children's creative work at Mahara Gallery, Waikanae, Aotearoa New Zealand. The project grew out of our desire to work more closely and proactively with some of our local primary schools and give them a well-supported opportunity to concentrate on developing their own creative ideas, bringing them to completion and seeing their work professionally presented in the gallery. Focusing on the natural environment of this district offered a good starting point for what we hope, given the success of the project, will become an annual event. The theme of the project also enabled us to link up with our local Nga Manu Nature Reserve. The view from Nga Manu of nature as art and a resource for wellbeing is described in the above section of this report. Sustainability, as a core value and in its widest sense, also informs the vision of the Mahara Gallery Trust and staff.

With these links we want to grow our capacity for offering art education experiences both within and outside the gallery through community outreach across the district, and working with schools, families, and the Nga Manu Trust enables us to reach across many different communities. As Nga Manu Nature Reserve is relatively close to the gallery we are now developing shared educational programmes that offer schoolchildren day-trip experiences in both the arts and environment, and link both areas as they are in the wider world, and also that involve more deeply-held human qualities. For example, young children have fundamental qualities that include imagination, enthusiasm, awe, wonder, spontaneous expression, creativity and imaginative play. If we can recapture them in our adult lives, live a little more by them, and remain mindful of the values of the natural environment, our health and wellbeing can benefit considerably.

The framework for developing a practical approach to our work with children started in 1995 when local artists, business people and arts supporters started Mahara Gallery. It was registered as a charitable trust in 1996. An exhibition of local high school students' art was an early event in the programme, and working with schools and children a long-held goal, despite the lack of dedicated education staff. The local Kapiti Coast District Council has been its core funder through a Partnership Agreement since 2002 and the Council recently confirmed Mahara as the district's public gallery and committed its ongoing support in the community's 20 Year Long-Term Plan.

image: www.freeimages.co.uk'

The project described below directly fulfils several objectives in Mahara's Partnership Agreement with the local District Council concerned with developing and fostering the practice and appreciation of the arts and cultural heritage on our local Kapiti Coast; developing local identity; and promoting and encouraging participation and achievement in all artistic forms of endeavour, in particular exploring opportunities and partnerships for youth-based projects and exhibitions.

In the project, sixteen Waikanae children became officially published artists and poets with the launch of Mahara Gallery's first picture book devoted to children's creative work: *Native Habitats, Waikanae Children's Creations* on May 4, 2012. Their work was selected from 221 artworks and 43 poems, which the children had started thinking about during visits to the gallery and then completed back in their own classrooms at Kapanui and Waikanae Primary Schools.

For some of the 264 children, some of their parents and even some of their teachers, this was their first visit to an art gallery and their first exposure to thinking about, talking about and making their own art and poetry, with the intention of presenting it as a public exhibition. Many of them found it an eye-opening experience to see, hear and discuss art and poetry 'in the flesh' in the gallery, along with local artists and poets who were brought in to help the gallery deliver the project. We promised to show every one of their artworks and poems, so that everyone got to participate in this experience and see their work honoured and celebrated.

Three months later, and only a few minutes after their work had been collected from their nearby classrooms and brought to the gallery, some students and their families started turning up at the gallery asking to see their artworks hung on the wall! We had to explain that each exhibition takes a few days to prepare and install, so they went away and came back early again as we were still putting the finishing touches before their exhibition opening four days later.

Over 200 delighted schoolchildren, their proud extended families and many school teachers crammed into the gallery to see their very own exhibition and for the presentation of sixteen awards to children whose work would appear in the book, to be launched a few weeks later. They were thrilled to see their artworks presented on the walls, and many had their photographs taken with them.

Several teachers told us later that this was the first time that a number of the children given awards had been marked out as 'special' and that they in fact faced particular emotional, psychological and learning difficulties that had made life more challenging for them, so it was extra special to see them being honoured and encouraged in this way, outside of the classroom and home setting. It was interesting that these artworks spoke so much to us as selectors, as there were many of similar aesthetic quality, but these works evidently carried something extra. We couldn't have imagined how significant this was for some of those children, how worthwhile, and what possibilities it might have introduced them (and their caregivers) to for their future.

For some of these children, aged eight to ten, even making an artwork on their own had seemed to present a particular challenge and they had been very hesitant and unconfident, when given around the theme of 'native habitats', some choices and the open-ended possibilities of self-expression. Now here was their artwork, beautifully mounted and framed on the gallery wall, each with its own unique and beautiful quality, and some being reproduced in a book!

The children's families were also very impressed that the gallery had made the same effort to present their children's work as we would a professional adult artist, and this engendered a new pride in them for their children's achievements. For the children themselves, it gave a new sense of distinction through an affirmation of their own unique way of seeing and responding to the world.

For the more extrovert and confident amongst them, the fact that they were now in a book which was not only going to be seen by people all around New Zealand, but also in England and Europe, was exciting beyond belief. One boy of about ten said they should send a book to the prime minister of New Zealand and show him what children could do and what they think. Another girl said she might now like to be a poet when she grew up.

Beyond the particular interest of the children's schools, their family and friends in this exhibition, the general public also responded with great enthusiasm, and complimented Mahara on presenting it. Like children's artwork everywhere, it charmed and refreshed viewers of all ages with those same qualities of innocent delight and joyful pleasure in creative experiment, playing with ideas, and fresh individual expression in full measure.

Many of us engaged in this area believe education is one of the main purposes of a public* gallery, and this extends across all ages and cultures, from pre-school through to senior citizens. Engaging with our indigenous natural heritage in New Zealand, which is both a local and national treasure and asset, is an important element in enriching our wider cultural heritage. As life-long learners and creative thinkers and makers, there is much we feel to be gained from growing educational partnerships that link conservation, heritage, ecology, and social, environmental and humanitarian issues with health and well-being. The understanding that evolves is an essential ingredient in what it takes for truly sustainable development.

The philosophy literature supports this interdependent approach by reporting that both art and natural beauty have their own values, that enriching our aesthetic experience goes together with developing our powers of imagination and understanding, and that if we develop our ability to respond to art we develop our potential as human beings. We are therefore, given the success of this project, taking forward this area of community engagement with a similarly-structured, follow-on project, 'Wai Ora: Water / Life'. It again involves primary school children and at their request, as suitable transport arrangements become available, the programme is expanding to include other primary schools in our District.

The artist Paul Cezanne (1839-1906) noted that '*art is a harmony parallel to nature*'. These two areas link up I believe through at least one definition of aesthetic appreciation: *'our sense of personal wonder, pleasure, enjoyment and wellbeing coming from the appreciation of beauty'.* There is still a lot of beauty in the world and we can derive a great deal of pleasure from it. This project I've described here is one practical example of ways we can help to foster appreciation of natural beauty, nature as art and the value to our health and wellbeing of enjoying nature and from it creating our own art works. These art works in turn can themselves then become something we personally treasure.

*The word 'public' is used for an artmuseum or gallery that is a not-for-profit or publicly owned and funded museum *whose core function is the presentation of art and culture for public good, enhancing civic values and supporting education and community wellbeing* (Ref: National Services, Museum of New Zealand, Te Papa Tongarewa).

5.3.3 NATURE AS ART AND A RESOURCE FOR WELLBEING

Mr Bruce Benseman, Manager, Nga Manu Nature Reserve, Waikanae, Kapiti Coast, New Zealand

There is good evidence that the natural environment offers many benefits for health and wellbeing.

Heritage, conservation, and the preservation of fauna and flora in our natural habitat are, I believe, as do many other people, particularly important for our health and well-being. There is though, an art to appreciating and enjoying it.

The term, '*biophilia*', literally meaning *'love of life or living systems'* is a term that illustrates this sort of thinking. It's used to describe the connections that human beings subconsciously seek with the rest of life. The concept links with information coming from echopsychology. This is the field which seeks to develop and understand ways of expanding the emotional connection between individuals and the natural world, thereby assisting individuals to develop sustainable lifestyles and remedy the alienation from nature that is increasingly experienced by people living in cities and towns. A good example of early work in this area and evidence of the health benefits is that of Roger Ulrich. He identified in one of his early studies published in *Science* in 1984, that patients who are recovering from surgery and who have a view from their hospital window seem to recover more quickly and need less postoperative pain relief.

Subsequently, in 1989 two authors, Kaplan and Kaplan, put forward the *'Attention Restoration Theory'* (Kaplan & Kaplan, 1989). It proposes that a natural environment provides the necessary qualities to enable a person to *'be away'* from the things which routinely require direct attention and the effort that that entails, because our effortless involuntary attention, or fascination, is held by pleasurable stimuli. This theory was associated with findings at the time that physiological responses to nature associated with changes in the limbic system at the base of the brain are associated with lowered blood pressure, reduced muscle tension and a slower pulse rate.

Since these early studies some 30 years ago, the evidence in support of the health benefits of contact with nature has been steadily growing. It has been brought together by the organisation Natural England. They summarise the benefits as being:

- it reduces stress levels;
- it encourages people to be more active, which is very good for health;
- it helps people avoid getting ill;
- it helps people keep stable once they have got an illness; and
- people live longer if they live near areas of green space.

As well as the physical and emotional benefits, contact with nature can also be spiritually uplifting. William Wordsworth for example, expressed this beautifully in his poem, *'Daffodils'*.

Here at the Nga Manu Nature Reserve we underpin this broad evidence-based framework with a very practical approach. It helps, we hope, to counteract trends in society, worldwide, leading to new health problems such as '*Nature Deficit Disorder*'. What we do is to offer visitors a unique opportunity to have a hands-on experience related to the natural history of New Zealand. They gain an understanding of the ecosystems by using examples of plants and animals that can be observed within the different habitats that make up the Reserve's ecosystems.

Approximately 700 different species of native plants can be seen, many of which are on the threatened species list. In addition, the animal life in the Reserve is a mix of both wild and enclosed species. For example, more than 56 different bird species come and go around the wetlands, bush and surroundings.

Nga Manu Nature Reserve is owned and administered by Nga Manu Trust, a registered charitable trust the main objectives of which are:

1. to preserve the unique native flora and fauna of the Reserve;
2. to provide an outdoor education resource based on conservation and preservation;
3. to support recovery programmes for the native flora and fauna; and
4. to promote public awareness of New Zealand's native flora and fauna.

Our overall aim is to educate people to help reduce the loss of species and halt depletion of our biodiversity. In achieving this we all, I think, need to find ways of reconnecting with nature and stimulating wider interest in restoring ecosystems.

It would help so much if everyone was prepared to do their little bit. After all, we live in a biological world and all our food, water, materials and minerals come from '*Mother Earth*'. She is a finite resource and it is extremely disturbing that natural species and habitats are disappearing at an alarming rate. We need to restore these ecosystems so we can all live healthily in a healthy world. If we could all engage directly and actively and think of the consequences of everything we each do, the biodiversity and regeneration possibilities would, I believe, allow the world to bounce back from what we throw at it. We can each help to keep our own locality and country how we want to see it environmentally. In other words, as someone once said: *"We have to choose whether we want to live in an aesthetic or an anaesthetic world".*

Opportunities to visit places such as nature reserves, national parks, woodlands or wilderness areas and engage with nature allow stimulation of the five bodily senses in different ways to that which often takes place in urban environments. For example, as one woman city visitor to Nga Manu Nature Reserve said to me:

"I feel at peace each time I come here. When I come in through the gate everything lets go".

We get these sorts of comments frequently. They relate to our sense of what we find relevant and helpful for our sense of emotional wellbeing. The comments made by children are particularly refreshing. They think a lot about what they have seen. It's as if something visual and textual has been created in their minds and they seem to have made something of their experience that has stayed with them all their life. I see it as an internal visualisation that has occurred. Arising from it, following the start of the Reserve in 1974, we are now getting second-generation visitors who want their own children to enjoy and take away something of what they themselves have gained. They want their kids to experience it too. As they sometimes put it to us: *"We don't want the environment trashed. We want something with quality and character that lasts"*.

It also seems to me that there is an art in ensuring that this sort of enrichment of living from environmental opportunity can be continued long-term. I think we really do need to find more and better ways of looking after the things that look after us. It's never too late. This connection with nature is something that people seem to be becoming much more aware of and interested in. Among the staff and our volunteers who help us to look after the environment and birds and greet visitors, support and undertake scientific research and provide education and other learning experiences we offer, there's a general '*feel good factor'* of *'doing something'* that gives us a great sense of pride. In essence, we live what we believe.

Thinking a bit more generally about all this, art can be thought of as the appreciation, expression or application of human creative skill and imagination. It has also been described as being *'not a thing but instead it is a way'*. Leo Tolstoy, in his essay, *"What Is Art?"* described it as *"a means of union among men, joining them together in the same feelings, and indispensable for the life and progress towards wellbeing of individuals and of humanity"*. If he's right, then our love of nature is an art form and something that can help to bring us all closer together. In fact, this sort of recognition of the relationship between art and nature goes back a very long way. Seneca, the Roman philosopher, statesman, dramatist and politician, 5BC – 65AD, following similar views of Plato and Aristotle, expressed his view all those years ago that: *"All art is but imitation of nature"*. I look at it this way: *"Without nature, art would be bland"*.

I think, in support of sustainable development, that all these sorts of connections and inter-relationships of nature and art, and how they relate to the role of nature in the art of wellbeing, deserve more attention and exploration from us all.

5.3.4 THE CONTRIBUTION OF ARCHIVES

Mrs Dianne Macaskill, former Chief Archivist, Archives New Zealand, Deputy NZ Government Statistician, Statistics NZ, and current Member, International Advisory Committee reporting to the Secretary General, UNESCO, on the Memory of the World programme

Whether it be our personal experiences, those of our family, friends or colleagues, or information and material relating to a club, society or any other organisation or group at work or in the society that we are part of, they all generate records. The purpose of collecting, collating and categorising these records is to document them and generate a resource that is then available for subsequent research, enquiry and information purposes. Professional archivists and historians generally understand archives to be records that have been naturally and necessarily generated as a product of regular legal, commercial, administrative or social activities. Archives New Zealand for example, holds over four million records that occupy more than 100 km of archives, including documents, maps, plans, films, art works, and photographs that were created by the NZ government. They document nearly 200 years of New Zealand history and are accessed by a wide variety of people including historians, genealogists, lawyers, filmmakers and other different artists. Some of these records such as land registrations, school registers, and key records from all the government departments and agencies, also help, for example, in situations where individuals need, and are seeking, publicly held material that helps them with their rights, claims and entitlements. Finding and utilising information from them can help ease a lot of personal distress.

At a much more local level within families, documents such as registrations of births, deaths and marriages, letters, diaries, photographs family portraits and publications written by individuals, are often also kept as records for subsequent generations to enjoy and explore. Some clubs, societies, factories and companies also archive their records for subsequent historical research.

These sorts of documents, archived in, for example, a public, organisational or family setting, are of considerable help if people wish to explore further who they are and what backgrounds they have come from. It helps them to better understand how as individuals, family and other groups, and as societies, we come to be the people we are. Many people get a great sense of satisfaction from their own research and finding out about their background, how their families lived, and where they fit in to it. It gives them a sense of belonging and being part of something. That something can be seen as a continuum. They can become quite passionate about exploring the records and from doing so are keen to leave something of value and worth for their relatives. Archives are therefore documentary resources that are held so as to make something discoverable. People have commented that discovering something about themselves, and the understanding that comes from this exploration, helps their overall sense of wellbeing.

In addition, as in many organisations, Archives New Zealand has a team of volunteers who help, often for one day each week. Their role is to document officially something of particular interest and that they find of personal value. They comment that the value to them is coming into an organisation, feeling part of it and being able to contribute in helping other people with their research. I think it's reaching out to others by doing something oneself that gives satisfaction and feels worthwhile.

This framework of thinking has been extended by UNESCO to its Memory of the World programme. The vision of this programme is that the world's documentary heritage belongs to all, should be fully preserved and protected for all and, with due recognition of cultural mores and practicalities, should be permanently accessible to all without hindrance. It is an international initiative launched to safeguard the documentary heritage of humanity against collective amnesia, neglect, the ravages of time and climatic conditions, and wilful and deliberate destruction. The Register is a compendium of documents, manuscripts, oral traditions, audiovisual materials, library, and archival holdings of universal value. Nominations for the register are received and considered in the context of time, place, people, subject and theme, form and style, and social, spiritual, and / or community significance. It is hoped that the archived material will be used increasingly to help reduce tensions in and between societies, cultures and countries.

I hope that this information helps to explain how I believe the art of archiving and documents in archives associated with the different arts have much to offer arts and health practitioners in their research and educational activities.

5.3.5 HOBBIES, COLLECTIONS AND HERITAGE

Mr Rod Clifton, Managing Director, Rod Clifton Motors, Te Horo, Kapiti Coast, New Zealand, and former President, Horowhenua Vintage Machinery Club, NZ

For me, having a hobby is an important part of life. It's about having something to do that's interesting and enjoyable and from which one gets a lot of pleasure, as I do with mine. Whatever the hobby is, people can be passionate about it and become totally absorbed in finding and collecting relevant material, arranging and cataloguing it, restoring, making or rebuilding something, discussing it with people who are equally passionate about the subject, sharing information with them, becoming involved in relevant clubs, societies and organisations, and enjoying the camaraderie of friendship that comes from these links. It's the fun of sharing an interest that's key and not the simple showing off of something that's been bought with money. In other words, it's working within the availability of time and money and with your skills as they develop, and for the sheer pleasure one can get from the interest. It's worth reminding ourselves too that you only get out of something what you put into it.

With a hobby, you don't keep track of and cost your time spent on it, as one has to do in many other areas of life. Instead, you just lose yourself in it. You can get totally absorbed in it and in doing so you just let yourself go. It can be seen as a form of relaxation and something that's restorative of oneself. The time spent is very rewarding. As such it has huge benefits for our wellbeing and is therefore valuable to oneself. The way I see it, there are also wider benefits for society. For example, hobbies are often linked to restoring, preserving and enjoying our local and national heritage. They become part of our identity and what we identify with. In fact, collections that build up from a hobby can acquire huge heritage value. They become part of the record of our culture and history and of what in it has gone on before our time.

For me, my principal passion next to my wife and family is the collection and restoration of antique and vintage tractors. I've now got about 200 of them. It's a hobby associated with our agricultural heritage that comes from my interest in traditional countryside skills and my nostalgia for the old agricultural machinery that after horses, broke in the countryside of so many countries. I get enormous pleasure from finding these old tractors, abandoned or in a state of disrepair, taking them apart, sandblasting the parts, repairing and repainting them, and getting them going again. For me, it's magic seeing what they can again do, for example, cutting the grass, raking and baling it, and then moving the hay bales, ploughing and all other farm work. The feeling of a job well-done is hugely satisfying when a tractor's fully restored, fired up and out the door. The stories too about each of the tractors gives them an individual meaning and their place in history. My wife tells me, good-humouredly, that it's an addiction and that I've got Old Iron Disease!

I think too, not just with hobbies, that there's a lot of pride and satisfaction in having a 'can-do' outlook. The sense of self-worth in doing something practical and seeing what comes from it, I know from my experience, can be deeply fulfilling. In many ways it's perhaps too easy for younger people these days. It seems that if they want something they want it new and can just go out and get it. I think it would be a lot better if they had to work to get something. We can and should do more to show them the worth of rewards that come from effort. As someone once said: *'Rome wasn't built in a day'*, and as somebody else put it, *'there's no gain without pain'.* Current-speak states this as '***sustainable development requires sustained effort'.***

So, for me, having a hobby, being guided in finding and developing it, and being able to enjoy it is part of body maintenance. It's fun too to contribute something that's got value for our heritage. From my observations of life and the way we live it, without something to do that keeps us actively engaged and gives us pleasure, we rapidly decline physically, morally and emotionally, particularly in times of under-employment and redundancy, when work is stressful, or after retirement. I believe that hobbies should therefore be seen as valuable arts activities as they help to maintain our wellbeing.

5.3.6 BUILDING THE ART AND ECONOMICS OF URBAN DESIGN

Mr Paul Turner, Principal, Landlink Ltd., New Zealand, and Chair, New Zealand Institute of Surveyors Urban Design and Sustainability Group

There is nowadays much greater awareness everywhere of the extremely difficult issues facing many parts of the world. They include the pressures associated with increasing and ageing populations, climate change, widespread pollution, rapid industrialisation, global climate change, ethnic, cultural, and regional tensions, under-employment, and difficulties for everyone consequent on the present global financial crisis.

It seems that with these problems, new paradigms of thinking are needed to help resolve these difficulties and the resultant health problems caused by these and additional factors, such as humanitarian and natural disasters, conflicts, famine, refugee crises and lifestyle-related diseases. Effective urban planning needs to consider ways of helping to solve these sorts of problems. The way such planning is undertaken becomes an art, and like all good art, good urban planning has a key role to play in support of the public health.

Here in New Zealand, the NZ Local Government Act 2002 included a focus on sustainability with the reference to the 'four domains of wellbeing:' social, economic, environmental and cultural. The purpose of the Act was:

(a) to enable democratic decision-making and action by, and on behalf of, communities; and

(b) to promote the social, economic, environmental, and cultural wellbeing of communities, in the present and in the future.

Each District Council is required under this Act to report annually on what it has done and is doing under each of these four, equally-weighted domains.

Recent events, in particular the Global Financial Crisis and the Christchurch, South Island, earthquake, have cast a different perspective on wellbeing in New Zealand and altered the weighting of the wellbeings when making decisions. The slant towards protecting and enhancing the environment (via legislation called the Resource Management Act 1991) remains, and has been supplemented with a lowest-cost economic focus for most Local Authorities. A reduction in Council budgetary spend on open spaces, amenity, art and high quality environments is mirrored by Council requiring developers to limit embellishments that, although often making a substantial contribution to the aesthetic quality of new neighbourhoods, can add to ongoing maintenance costs over time. The result is a threat to social and cultural wellbeing where attention to good urban design, open spaces and amenity is ignored and existing features are degraded.

The design elements also have a direct effect on health and wellbeing. For example, in 2006 the WHO Regional Office for Europe reported: *"design elements in the built environment, such as street layout, land use, the location of recreational facilities, parks and public buildings and the transport system can either encourage or discourage physical activity. People are more active when they can easily access key destinations such as parks, green spaces, workplaces and shops"*. The same report also noted that: *"other barriers to active living include fears about crime and road safety, transport emissions and pollution, problems with access and/or a lack of recreation and sports facilities and negative attitudes about physical activity and active transport".* Nevertheless, it also noted:

***"active living positively contributes to economic prosperity and social cohesion in cities. Taking part in physical activity increases opportunities for socialization, networking and cultural identity"* (WHO, 2006).**

For public health, an interdisciplinary approach with renewed working across professional boundaries is, I believe, needed.

In New Zealand, despite an unrelenting need for additional housing, construction, as in several other countries, has been relatively stagnant for the last five years, thus creating pressure on affordable housing. The Christchurch rebuild program has, for example, as a consequence of the widespread devastation, for some time focussed on core infrastructure reinstatement (pipes and cables). The focus is now turning to creating new communities in new, unaffected locations. The pressure to build housing quickly, means that there is a risk that good urban design outcomes, a chief contributor to social, cultural and environmental wellbeing, is under threat in Christchurch (375,000 people) as well as in other major urban conurbations such as Auckland (1.4m people), where, as well as large Maori and Pacific Island communities, an increasing Asian population also demands 'culturally aware' development.

Despite these sorts of pressure it is essential for sustainable development everywhere, internationally, nationally and more locally within Districts, that the four domains of wellbeing continue to be a core element of District Council plans. In the art of urban planning, to help take this framework forward and ensure as best one can that a rich and diverse network of open spaces is maintained, nine principles have been identified (Ebenhoh, 2012). They can, I believe, be adopted anywhere:

1. protecting indigenous biodiversity and its ecology;
2. promoting health and wellbeing;
3. preserving landscapes, landforms and amenity values;
4. strengthening local connectivity;
5. protecting local character;
6. promoting better quality open spaces;
7. protecting cultural and heritage values;
8. working in partnership; and
9. addressing resilience issues.

Locally, on the lower West Coast of the North Island, NZ, the Kapiti Coast District Council has recently introduced a welcomed *'Open Space Strategy'.* It is based on this nine-point framework and seeks to ensure that all residential properties are within 400 metres (5 minutes walk) of a public Open Space (Ebenhoh, 2012). This vision applies to both public and private land. Because only 13 percent of American children walk or bike to school compared with 44 percent a generation ago (Centre for Disease Control and Prevention, 2010) and more than a quarter of trips made by car are within one mile of home (US Department of Transportation, 1997), it is vital that core urban design features such as access to open space, are maintained.

In support of the above points and their association with public health, a ten year study (University of Melbourne, 2013) found that the overall health of residents of new housing developments in Western Australia, improved when their daily walking increased as a result of more access to parks, public transport, shops and services. The study found that for every local shop, residents' physical activity increased by an extra 5-6 minutes of walking per week. For every recreational facility available such as a park or beach, residents' physical activity increased by an extra 21 minutes per week. This indicates that good urban design and walkability play an important role in health and wellbeing.

New Zealand is a young country with a need for blossoming urban development. The need for our new greenfield neighbourhoods, complete with an array of housing types, employment opportunities and good urban design, to be balanced with sensitive city infill development to make the most of relatively weak public transport systems, relies on robust design criteria. There is an art to developing and utilising these criteria and ensuring that attention to different forms of appropriate public art are included in them.

image: www.freeimages.co.uk'

The recent adoption in Australia of a Communities rating tool seeks to ensure a well-rounded urban design outcome which encourages physical activity and social engagement which in turn contribute to better health outcomes in the community. It was introduced to help drive the development of more sustainable, productive and liveable Australian communities and assesses the sustainability performances of projects' planning, design and construction outcomes against the following categories: governance; design; liveability; economic prosperity; environment; and innovation.

One of the benefits of a good rating tool is that it can customise the weighting of measurement to the unique circumstances of a country, region or town. Australia for example has water supply and water quality issues while here in New Zealand parts of the country have differing flooding, erosion, topography or infrastructure pressures which create different effects and therefore different design solutions. Common to both though, are the positive benefits to public health of the connected elements of good design, walkability, connected open spaces, culture, heritage and art. Also common is the pressure to create economically viable and enduring solutions to community building.

The art of developing, introducing and adopting rating tools such as this Australian innovation deserve more attention as well-designed urban planning encourages health and active living. For example, research commissioned by the New South Wales Government Premier's Council for Active Living suggests that in Sydney, switching from private cars to walking could save an individual 14.8 Australian cents per kilometre travelled. At a community level, any reduction in the number of cars on the road would inevitably result in additional congestion cost savings. This is one example of how good urban planning can help to foster the art of wellbeing.

It seems therefore that approaches such as this Australian concept would be welcomed elsewhere, for example here in New Zealand, as it would seek to provide a more balanced design and review process.

Sadly however, short-term, fiscally determined economic pressures often get in the way of longer term planning for sustainable development and the balanced management of social, economic, environmental, and cultural wellbeing.

I believe that for improved public health and overall quality of life in many villages, towns and cities around the world, there needs to be greater utilisation of public art and what the arts have to offer us. Moreover, there is an art to good urban planning.

5.4 Areas and Ways Forward for Further Study and Development of the Arts in Support of Culture, Health and Wellbeing

5.4.1 Philosophy

Further interdisciplinary work is needed with different elements of the *'arts-science spectrum of enquiry'* to show how they fit together as an integrated model. In particular, based on work such as in the Sidney De Haan Research Centre for Arts and Health, Canterbury Christ Church University, UK, (Clift, 2012), the need to move from practice-based research to evidence-based practice is reasoned and rationale for the need of more robust, well-designed quantitative and qualitative studies is explained in this report. Nevertheless, it is often extremely difficult to control for the confounding variables and it is widely-recognised that the value of scientific inputs into the arts and health needs to be, and is judged by, a clearly structured, objective peer review process.

The value of ideas as judged by the scientific community does not necessarily always lead to practical, worthwhile ideas for the wider community. Freeing the mind and building thinking connections across society can help to build shared, innovative programmes. Rather than relying solely on the scientific community to provide knowledge in this area, perhaps we should therefore all be seeking ways of sharpening our creative thinking to help solve problems in society where, as this report and the subjective viewpoints given in the above **Section 5.3** have shown, appreciation of the arts, heightened aesthetic awareness, creative endeavour and volunteering have key roles.

Could therefore, the arts and health movement perhaps contribute proactively to what is implied by, for example, the United Nations Development Programme (UNDP) slogan: *'Empowered lives. Resilient nations'*? Or the need addressed in 1987 by Gro Harlem Brundtland, Prime Minister of Norway and later, Director General, WHO, for us all to consider our common future and the needs of sustainable development (United Nations General Assembly, 1987)? Or the *"three fundamental principles; respect for human rights, equality and sustainability"*, identified for the post-2015 UN Development Agenda as informing goals for the post-2015 agenda which the UNDP *"defined along four, highly interdependent dimensions: inclusive economic development, inclusive social development, environmental sustainability, and peace and security"* (UNDP, 2013)?

The Norwegian philosopher, intellectual and author, Jostein Gaarder (born in 1952), suggested in his book *'Sophie's World: A novel about the history of philosophy'*, first published in 1991, that the United Nations (UN) publish a short book of philosophy. Could his suggestion perhaps be taken forward in further support of the UN focus on peace and security in the world and the United Nations Development Programme advocacy for change and connecting countries to knowledge, experience and resources to help people build a better life? If so, professionals working in the arts and health field could contribute valuable material dealing with values, valuing, and value systems in contemporary society, and to a sense of logos as the principle of order and knowledge.

Some steps in this direction have already been taken by exploring the basis of human values for the Nuffield Trust, World Health Organisation, and Office for International Health Co-Operation and Development of the Italian Red Cross. (Philipp, 2007). Can and might others wish to contribute to Jostein Gaarder's suggestion?

The anthropological framework for the basis of human values which emerged from the above project included details of four core components of relevance to wellbeing:

- appreciation of different civilisations, cultures, customs and societies;
- awareness of tools a society develops for its sense of place, purpose and security;
- knowing what influences thinking and perceptions among members of our group; and
- linking within ourselves external experiences with our internal feelings.

In a related report for the WHO, it was noted that a wider understanding of the interaction of the above factors in emotional investment, and better appreciation of the enrichment to society of cultural diversity, would help communities to build and strengthen social and cultural capital (Philipp and Thorne, 2011).

In 2010, associated with these steps, it was suggested with the Royal Society for Public Health (RSPH) that interdisciplinary development of this area could possibly lead to a *'Healthy Outlooks'* programme that could perhaps sit alongside the WHO Healthy Settings framework. Its suggested aim would be *"to improve awareness and understanding of the term wellbeing and what we can each do to better access and appreciate it"* (Philipp, 2010). Since then, together with the then Associate Minister for Arts, Culture and Heritage, New Zealand Government, the Medical Director, Division of Mental Health Services, Ministry of Health, NZ, and the New Zealand College of Public Health Medicine, some progress has been achieved in exploring ways of using the arts as a public health tool and aspects of the interdependence of:

- mental health and emotional wellbeing;
- sustainable economic development;

- ways of engaging in creative endeavour to express and communicate thoughts, feelings and emotions;
- roles of aesthetic appreciation in helping to derive pleasure, enjoyment and happiness and from this, a sense of wellbeing; and
- how engaging with works of art and in the arts can influence health.

The links, a framework for them and practical suggestions have been brought together as *'Fostering the Art of Well-Being: an Alternative Medicine'* (Philipp, 2012), a freely available, downloadable book chapter, published in 2012 by InTechopen in Croatia (http://www.intechopen.com/articles/show/title/fostering-the-art-of-well-being-an-alternative-medicine).

A challenge now for arts and health professionals could be to explore how best an arts-based approach such as these examples and those from other, related approaches might collectively be developed into a more unified, cohesive framework. Could for example, Jostein Gaarder's suggestion for a UN book of philosophy become the basis for a practical philosophical and values framework that could be used for community engagement educational purposes, self-learning and personal development? If so, in addition to aspects of the above anthropological framework approach there would seem to be gains from linking it with other frameworks provided by interrelated areas in any society such as personal conduct associated with:

- standards and expectations;
- ethics and etiquette;
- cultural norms;
- professional requirements;
- the often-experienced divide between personal freedom and collective responsibility; and
- values and valuing.

To help with any next steps, further economic modelling in our present-day, fiscally challenged world seems to be needed for the arts in health, particularly if we are to address further our values in contemporary society. After all, as the WHO slogan reminds us, *'Our real wealth is our health'*. Sadly though, we often don't appreciate and value it sufficiently until we lose it. The author and painter, Ray Ching recently put it this way in a fable about 'the Kiwi and the jewel': "Precious things are without value to those who cannot prize them"(Ching, 2012).

In taking this forward, the arts have an identifiable role to help value and strengthen human capital. It is defined as: *"the physical, intellectual, emotional and spiritual capacities of any individual"* (Porritt, 2005).

5.4.2 Values, Valuing and Value Systems

In considering national frameworks that help to take valuing and value systems forward, the National Institute for Health and Care Excellence (NICE), UK, has for example, since 2012 included in its portfolio work on return on investment for public health activity. Their Director of the Centre for Public Health Excellence, NICE, has noted that although their "*public health interventions and programmes are deemed to be good value for money at national level according to the cost per Quality of Life Adjusted Years calculations, there has been a growing realisation that local decision makers require something more concrete and specific"* (Kelly, 2012). Can arts and health professionals contribute to this need?

As one of the steps being taken with new initiatives, in the freely-accessible book chapter referenced above (Philipp, 2012), ways of fostering the art of wellbeing through addressing values has been explored. In it:

- *'value'* has been defined;
- the role of empathy, rapport and intuition are noted to be fundamental to the basis of human values;
- what as both individuals and societies we value and how we undertake our valuing are identified as key issues for attempts in support of wellbeing, to build both social and cultural capital;
- *'an artistic way'* of looking at the world is noted from other work (Eames, 2003) to be increasingly used, not only to improve individual resilience but to help strengthen social capital by addressing cultural and social problems in society such as alienation, frustration, anger, disruption, humiliation and dislocation, and marginalisation from employment;
- evidence leading to the observation that protective effects of high levels of social capital are found in communities where there are high levels of trust, participation in civic life and social support is cited; and
- the United Nations Educational, Scientific and Cultural Organisation (UNESCO) definition of culture is seen as a constructive framework of headings we can address further. UNESCO defines culture as: 'the set of distinctive spiritual, material, intellectual and emotional features of society or a social group and that encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs'.

As noted in some of the personal viewpoints in the preceding **Section 5.3** of this report, cultural heritage is also an important concept when addressing values. In respect of it, UNESCO gives two further relevant definitions:

Intangible cultural heritage is *" transmitted from generation to generation, and is constantly recreated by communities and groups, in response to their environment, their interaction with nature, and their history. It provides people with a sense of identity and continuity, and promotes respect for cultural diversity and human creativity".*

Cultural heritage is *"the entire corpus of material signs - either artistic or symbolic - handed on by the past to each culture and, therefore, to the whole of humankind. As a constituent part of the affirmation and enrichment of cultural identities, as a legacy belonging to all humankind, the cultural heritage gives each particular place its recognizable features and is the storehouse of human experience. The preservation and the presentation of the cultural heritage are therefore a corner-stone of any cultural policy".*

UNESCO reports too that *"the idea of heritage has now been broadened to include both the human and the natural environment, both architectural complexes and archaeological sites, not only the rural heritage and the countryside but also the urban, technical or industrial heritage, industrial design and street furniture"* (Jokilehto, 2005).

One intriguing example of what is evolving and based on heritage, at least in the UK, is an investigation of the place of museums in the community through the Happy Museums Project. It provides a leadership framework for a growing group of museums to investigate a holistic approach to sustainability and wellbeing. The project takes a view of sustainability which looks beyond financial and resource management and considers a museum's role as steward of people, place and planet, supporting institutional and community resilience in the face of global financial and environmental challenges (http://www.happymuseumsproject.org). Increasingly around the world, museums are actively focused on enriching their communities by enhancing the quality of their facilities, collections, programmes, products and services. They play, "a pivotal role in the national heritage, education, leisure, and tourist sectors and profile… innovation and leadership internationally" (http://www.museums-aotearoa.org.nz/).

Steps have also been undertaken within the RSPH to explore aspects of value and heritage in these areas as they relate to societal values, urban planning and the public health. For example, building on other RSPH activities reported in **Section 3.1.4** and earlier work with the WHO to explore why aesthetic quality of the built and natural environment matters (Philipp, 2000), the concept of 'wellville' as a tourist destination and its links with societal wellbeing have been described (Hartwell et al, 2012; Philipp and Thorne, 2013).

A challenge for the 'arts in health' community in respect of values and valuing of their contributions to society is now to strengthen further the evidence base for the worth of building social and cultural capital, and in it, the roles of the four interdependent domains of wellbeing: viz. social, economic, cultural and environmental. The need to do so is exemplified by concern expressed that requiring local authorities to nowadays address and report on them can divert restricted resources into areas already covered by central government and the private sector. Accordingly, steps are being taken in some countries such as New Zealand, *"to make better provision for effective, efficient, and democratic local governance"* (http://www.legislation.govt.nz/bill/government/2012/0027/15.0/whole.html).

Concurrent with these steps and with community wellbeing in mind, increasing attention is being given in many societies and by many large companies and other organisations to their business modelling and investments base, and with these areas moving to a more integrated approach and giving greater attention to frameworks in support of them such as:

- genuine progress indicators;
- corporate social responsibility;
- corporate social entrepreneurship; and
- environmental, social and corporate governance.

Under changes to accounting laws proposed, for example, by the European Commission, large companies will be required to disclose more information about their environmental and social impact in annual reports. Companies with more than 500 employees will need to publish information on their policies, risks and results concerning the environment, human rights, anti-corruption, bribery and diversity on the boards of directors (http://www.accountancyage.com/aa/news/2262084) .

Associated with the reasoning below, the frameworks and requirements should be seen as particularly relevant for public health professionals. More information about them is readily available by Google searches of the terminology.

The drivers for increasing interest by many diverse groups in these frameworks and adoption of them include:

- as noted above, and by the WHO Regional Office for Europe (WHO, 2012b), the considerable fiscal constraints of governmental and other public bodies requiring governmental review of policies relating to wellbeing;
- increasing recognition of the potentials of health impact assessment as a local health policy supporting tool (de Basio et al, 2012);
- wider understanding of health inequalities and the need for equity if sustainable development can be achieved (Porritt, 2012);
- accruing interest in socially-motivated and ethical investing and the availability of ethical investment opportunities; and
- the emergence of Social Impact Bonds, Balanced Scorecards and Integrated Reporting, at least in part due to these sorts of drivers.

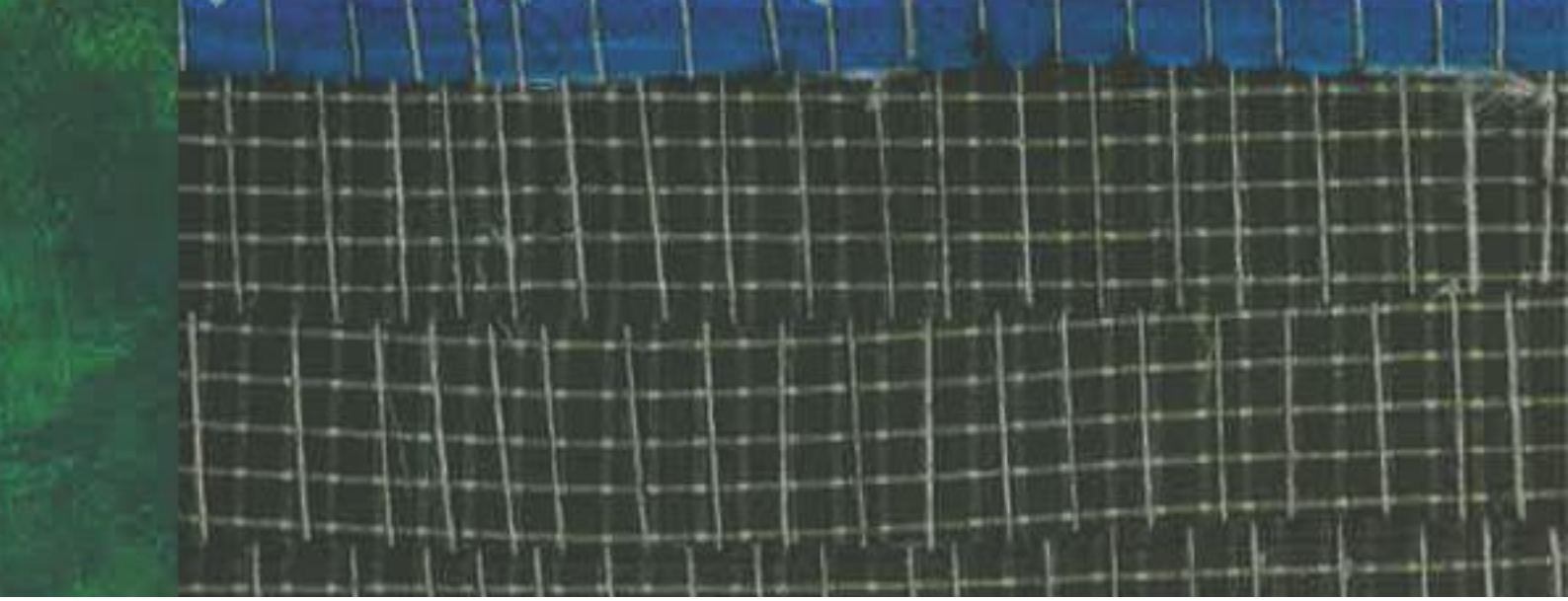
Public health practitioners increasingly need to understand how these sorts of factors impact on their work and the health and wellbeing of populations for whom they have responsibilities, and how in turn they can respond and contribute.

5.4.2.1 Social Impact Bonds could, for example, be an intriguing way forward for arts and health professionals to explore. They are contracts with the public sector in which a commitment is made to pay for improved social outcomes that result in public sector savings. These performance-based investments exist to encourage innovation and tackle challenging social issues. They do however require rigorous proof of their effectiveness and are therefore not bonds in the conventional sense. Instead, particularly in a health sense, they change the focus of service provision from what has been done to what is achieved. The programmes they finance are often in areas where prevention and early intervention can prevent strain on other public services, amounting to considerable cost savings over the long-term.

The concept of social innovation financing allows the government to partner with organisations such as innovative service providers, companies, social enterprises, charitable trusts and other foundations or investors willing to cover the upfront costs and assume performance risk to develop and undertake promising programmes, while assuming that taxpayers will not pay for the programmes unless they demonstrate success in achieving the desired outcomes. The expected public sector savings are used as a basis for raising investment for prevention and early intervention services that improve social outcomes. Repayment to investors is contingent upon the specified social outcomes being achieved.

This concept seems to have been first developed by a New Zealand agricultural economist, Ronnie Horesh, as Social Policy Bonds (http://en.wikipedia.org/wiki/Social_impact_bond). It has been taken forward by the Global Alliance for Banking on Values (www.gabv.org).

Within the public health world this framework approach seems to have direct relevance for aspects of new partnership working arrangements between health and local authority services that are emerging in some countries, such as for example in England, with the Public Health Outcomes Framework described in **Section 2.6.1** of this report. At this stage, it seems that Social Impact Bonds can in this context be seen as a way of harnessing private investment, volunteering, citizenship and altruism through the blending of social investment, public funding and social enterprise.



5.4.2.2 The Balanced Scorecard Approach builds on this framework of Social Impact Bonds. It is a strategic performance management framework that was initially designed for commercial companies to help them monitor their performance and manage the execution of their strategy. It has however, with some changes to the strategy map template, been reported to have now found widespread use in the public and not-for-profit sector (www.ap-institute.com/Balanced%20Scorecard.html).

In its simplest form, the Balanced Scorecard breaks performance monitoring into four interconnected perspectives:

- **financial**, covering the financial objectives of a provider or purchaser organisation and allowing managers to track financial success and shareholder value;
- **customer**, covering the objectives of clients, customers or patients such as in a health context their satisfaction, quality of life, freedom from ill-health and levels of wellbeing;
- **internal processes**, covering internal operational goals and outlining the key processes necessary to deliver the customer objectives; and
- **learning and growth**, covering the difficult-to-measure drivers of future success in society such as human capital, organisational capital and information capital including skills, training, organisational culture, leadership, systems and databases.

Given the global financial crisis and the considerable, consequent fiscal constraints on the present availability of resources for public health, it seems that arts and health professionals will increasingly need, alongside utilising and developing further the evidence base in support of their work, to understand and adopt this sort of fiscal modelling in the design of their programmes and projects and in exploring their utility worth. Depending on local community factors, the model has advantages in that different customer, learning and growth, and social and environmental impact factors can be built into it.

In exploring possible links between the Balanced Scorecard Approach and the development of Social Impact Bonds, they can, among public health professionals, be usefully considered together and in the context of Integrated Reporting.

5.4.2.3 Integrated Reporting is a requirement incumbent now on many companies and associated with Balanced Scorecards and Social Impact Bonds. It includes the concept of *'Social and Relationship Capital'* as one of the key elements of reporting for businesses and enterprises. The term Integrated Reporting refers to an integrated strategy to achieve financial results and create lasting value for a successful company, its stakeholders and society. In this approach it is reasoned that the value created by such a company cannot be expressed by isolated financial and sustainability reports with no single clear links between the three traditional 'single bottom line' pillars of people, planet and profitability. Coming from it, an integrated report is a concise communication about how an organisation's strategy, governance, performance and prospects lead to the creation of value for all stakeholders over the short, medium and long-term (http://en.wikipedia.org/wiki/Integrated_reporting).

A framework for Integrated Reporting has evolved rapidly since 2009, when HRH The Prince of Wales convened a high-level meeting of investors, standard setters, companies, accounting bodies, and UN representatives, including The Prince's Accounting for Sustainability Project, the International Federation of Accountants, and the Global Reporting Initiative, to establish a body to oversee the creation of a globally accepted Integrated Reporting framework. This body is the International Integrated Reporting Council (IIRC) and is there to aid businesses and investors as they begin to adopt it. The IIRC was launched in 2010 by HRH The Prince of Wales with international partners and the Prince's Accounting for Sustainability Project (A4S) acted as its Secretariat until January 2012.

The IIRC is being seen as a global coalition of regulators, investors, companies, standard setters, the accounting profession and non-governmental organisations. Together, this coalition shares the view that communication and businesses' value creation should be the next step in the evolution of corporate reporting. Its mission is to create a globally accepted International Framework. Public health professionals will, it is anticipated, be interested to learn that among more than 90 businesses in its Pilot Programme Business Network, companies such as Unilever, Coca-Cola, Microsoft, China Light and Power, Hyundai, HSBC, Deutsche Bank, Goldman Sachs and Hermes are included. The programme reasons that following the onset of the banking crisis in 2007, the western model of capitalism needs to adopt a more resilient framework and that sustainability is an essential ingredient if a company is to survive (http://en.wikipedia.org/wiki/Integrated_reporting).

As well as fiscal viability, companies engaging with the Pilot Programme are required to communicate in a transparent market and regulated environment the sustainability of their overall business value. It includes value to the business of the wellbeing of staff, the community, and the environment; standards being developed must be in the public interest. For companies such as those listed on the South Africa Stock Exchange, Integrated Reporting is being increasingly encouraged (Diplock, 2013).

To help further evolution of the arts and health movement, public health professionals with interests in sustainability, and the strengthening of social and cultural capital, may wish to respond during the present consultation period 16 April-15 July 2013 to the IIRC Consultation Draft of the Integrated Reporting Framework. It seeks comments and feedback from all stakeholders on all its aspects of its work (q.v. www.theiirc.org/consultationdraft2013).

The developments described in this section of the report are part of what is being seen as a need for improved innovation and motivation, described as “a move towards citizen-respecting market economies” and in which the aim is to “foster enterprise and creativity within the culture of mutual it respect and dignity” (BBC, 2013).

5.4.3 Introducing New Arts and Health Programmes and Projects into a Community

A co-ordinated approach to research development and information sharing of published research through for example, freely accessible, widely known, electronically linked archives, could enable improved programme development, evaluation, comparisons of effectiveness and efficiency and improved sustainability.

A comprehensive framework for economic appraisal of a proposed local programme or project needs to consider the cost of preventive measures, and balance them against costs incurred by the community from the problem(s), the cost of dealing with them when and where they occur, and opportunity costs of using limited resources elsewhere.

In the balanced scorecard approach, there is an art to developing relevant implementation plans. They need to include information about aspects of the proposed programme or project such as:

- relevant international, national and local research knowledge;
- applicability of the research to the community being considered;
- asset mapping, being the process of intentionally identifying the human, material, financial, entrepreneurial and other resources in the community and using it as a basis for exploring needs, gaps and opportunities in services provision;
- cultural sensitivities;
- central, local and organisational political expediency;
- social capital of communities such as their networks, institutions, relationships and social cohesion that will / could enable synergy and active participation in programmes and initiatives;
- the overall economic, environmental, cultural and social wellbeing of the community;
- cost-benefit analysis including cost-effectiveness and efficiency and in which the costs of doing nothing and allowing a problem or situation to continue are compared with the costs of introducing, conducting and evaluating a programme or other intervention; and
- opportunity costs.

To be successful, this arts-linked approach requires involvement of as many different stakeholders as possible, multidisciplinary partnerships and shared ownership. If too, the community has high stocks of social capital, it can be reasoned that the programme or project is more likely to be successful and sustainable.

Towards this aim, in his book: Bowling Alone, Robert Putnam used 14 principal indicators of community networks and social trust. By way of summarising them, Jonathan Porritt has reported that a community or society is said to have high stocks of social capital if it has:

- high levels of trust between people;
- high membership of civic organisations;
- high levels of volunteering and charitable giving;
- high levels of participation in politics, including membership of political parties;
- high levels of participation in religious groups; and
- high levels of informal socialising (Porritt, 2005).

To help support themselves better and improve their local opportunities for a framework of sustainable economic, social, cultural and environmental wellbeing, many local communities utilise the above framework. In doing so, they include widespread consideration by their local residents of values, valuing and value systems, what they seek from community cohesion, and how these aspirations relate to their own personal physical, psychological, emotional and spiritual wellbeing.

Three interesting, informative and illustrative examples of this arts, health and wellbeing approach to adding value, with very clearly set out websites of what can be achieved by local communities for their sustainable development, are:

- **Victoria Park Action Group, Bristol, UK** (www.vpag.org.uk). It is a committed and active local-user voluntary group started by people living near their park who wanted to preserve and improve its facilities and utilisation of them. The many, diverse activities taking place there as a direct consequence of their actions are, with photographs, beautifully described on the website.
- **The Bearpit, Bristol, UK** (www.the-bear-pit.org.uk). Starting out initially as a small group of volunteers, partnerships have evolved to transform a sunken paved area formed by an inner-city roundabout, into a meeting place with sociable seating that includes good food trading and eating opportunities, art and notice boards for local artists to showcase their work and add colour and interest to the subways, busking platforms and outdoor play opportunities for adults and children.
- **The Guardians of Pauatahanui Inlet, New Zealand** (www.gopi.org.nz). This coastal Inlet is well-recognised for its high ecological, aesthetic, recreational and cultural values. It is a Site of Special Wildlife and an area of significant conservation value. The voluntary group was formed to, among its activities, inform and educate the public about the Inlet, consult with the diverse communities around it, provide opportunities for the public to share in celebrating and caring for it, and promote research and monitoring that helps to ensure its qualities are sustained for the wellbeing of the community.

These examples illustrate recent news about the growing evidence linking green spaces to human wellbeing and how it can help strengthen the case for conservation (www.bbc.co.uk/news/science-environment-20713185), and the value to wellbeing and quality of life of parks, gardens and green spaces for people living in urban areas (www.bbc.co.uk/news/health-22214070).

5.4.4 Volunteering, Citizenship and Helping to Overcome Social Isolation

Volunteering is a key element in the above examples of what can be achieved from an arts, health and wellbeing approach to sustainable development. Citizenship education is a core component of the model. It has been described as being focused on enabling people to make their own decisions and to take responsibility for their own lives and communities, requiring an understanding of the political, legal and economic functions of adult society, and with this the social and moral awareness to thrive on it (www.citizenshipfoundation.org.uk).

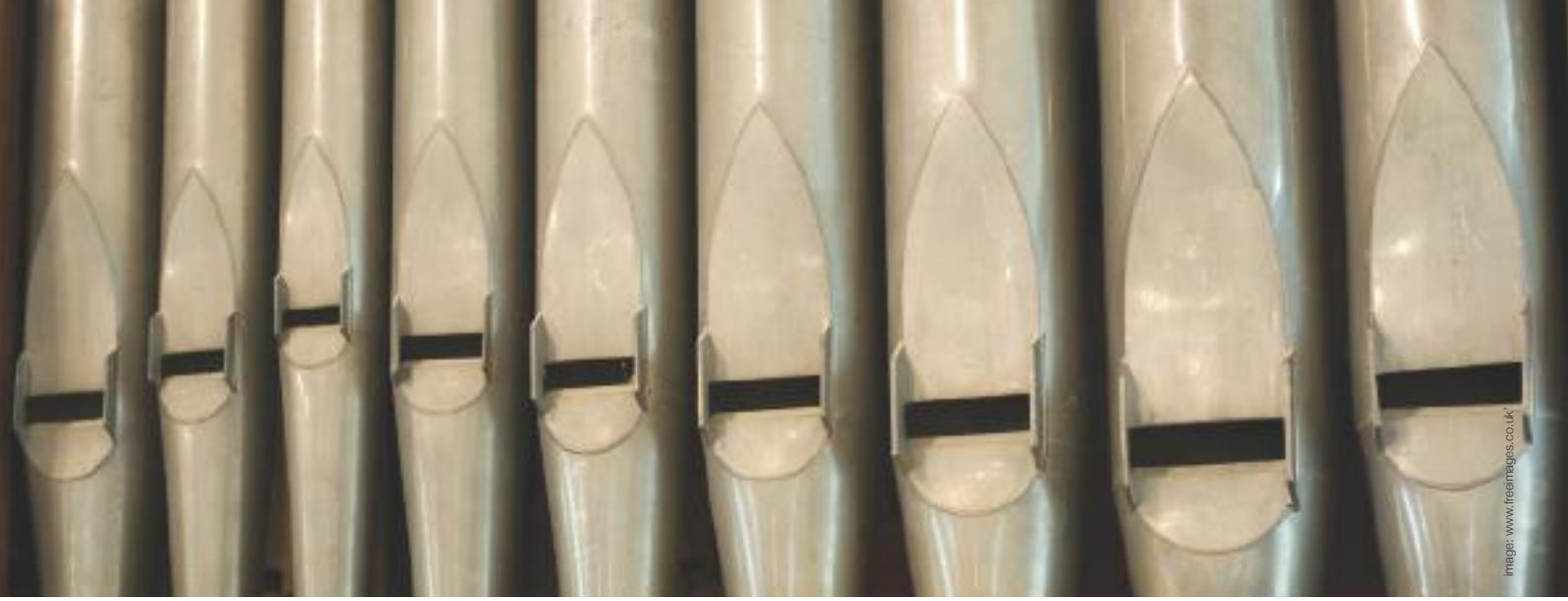
Citizenship can therefore be considered as something that has to be learned and needs to be lifelong and inclusive of everyone regardless of their ability or background.

It could therefore, in citizenship education, be worthwhile to consider further the suggestions of linking philosophy, values, valuing and value systems set out in **Sections 5.4.1** and **5.4.2** above.

If this framework can be further developed for educational purposes and the strengthening of human capital, it is worth noting too what the aphorism: '*You get out of something what you put into it'*, implies. For example, to help us feel part of what goes on rather than apart from it, there is much to be said for becoming involved. It is an essential ingredient of social and cultural capital and the concept is well-recognised by psychologists.

In considering aspects of the model, Abraham Maslow set out a hierarchy of needs in the shape of a pyramid with the largest, most fundamental levels of needs at the bottom and the need for self-actualisation at the top. His model noted that the hierarchies are interrelated and that self-actualisation included morality, creativity, spontaneity, problem solving, lack of prejudice, and acceptance of facts (http://en.wikipedia.org/wiki/maslow's_hierarchy_of-needs).

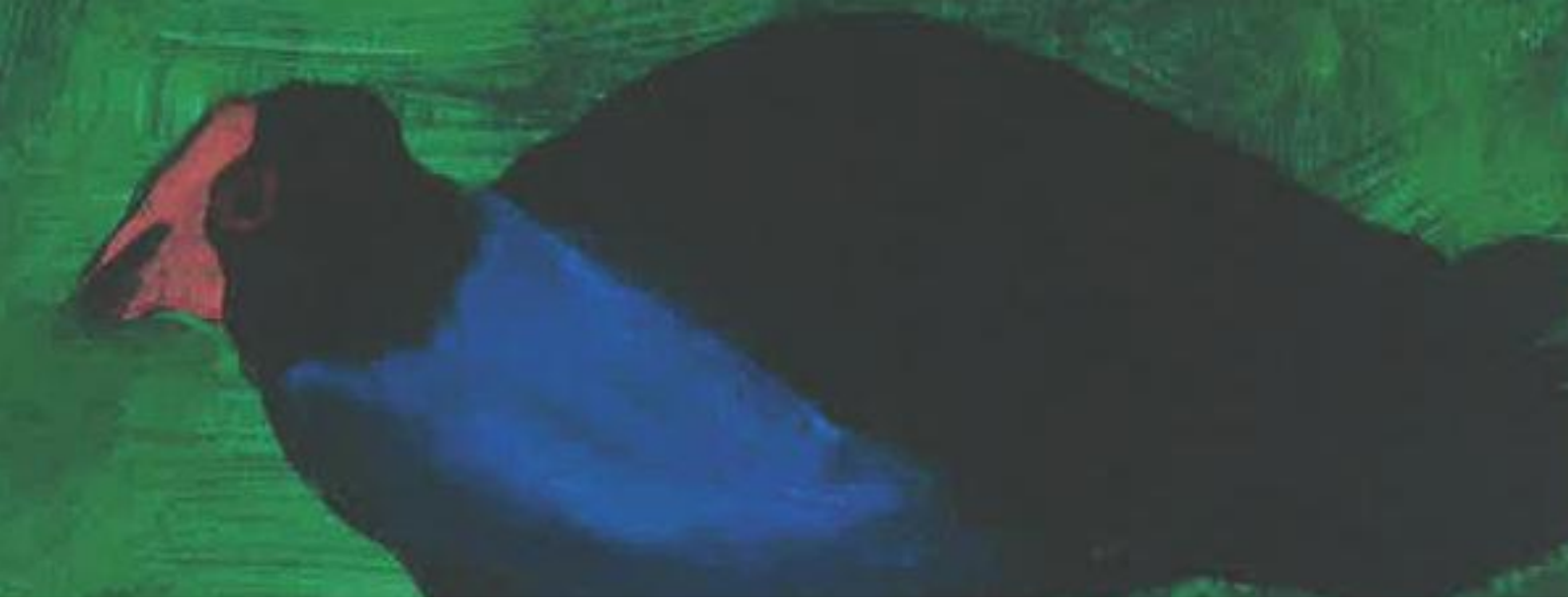
Maslow noted that the characteristics of a self-actualizer include the feeling of having: *"fellowship with humanity"* (http://en.wikipedia.org/wiki/Self-actualization). This feeling was referred to in the two earlier Nuffield Trust Reports, *Humanities in Medicine: beyond the Millennium*, and *Arts Health and Well-Being,* where the medical humanities were defined as: "*compassionate concern for the welfare of mankind*", and the key role was also noted of arts and health professionals being able to help people to fulfil their needs and achieve self-actualisation.



In considering self-actualisation further, the effects of the present global financial crisis need to be considered. Due to them, there is an increasing need and expectation in society for more volunteering, benefaction, philanthropy and charitable work. It can therefore be noted that reaching out to other people, supporting and helping them and their communities, and in doing so offering one's skills, expertise, warmth and friendship, is in itself an art and that from reaching out to others there are reciprocal gains for one's wellbeing through taking part in it. The values to oneself are, however, not always immediately obvious to many people. Accordingly, to help with these and other related health needs, programmes have evolved such as Training Solutions, offered by the RSPH (www.rsph.org.uk/trainingsolutions). They are intended to help develop for example, 'Health Champions in the Community'.

Community Health Champions are people who, with training and support, voluntarily bring their ability to relate to people and their own life experience to transform health and wellbeing in their communities. Within their families, communities and workplaces they empower and motivate people to get involved in healthy social activities, create groups to meet local needs and signpost people to relevant support and services. In this way they help others enjoy healthier lives by raising awareness of health and healthy choices, sharing health messages, removing barriers and creating supportive networks and environments (www.altogetherbetter.org.uk/community-health-champions).

Given these points it should be noted that central organisations such as the National Institute for Health and Care Excellence (NICE), UK, are seeking ways of overcoming barriers to implementing public health guidance for communities such as workplaces and of sharing the successes (NICE, 2012). See: http://www.healthandwellbeing.nhslocal.nhs.uk/training-toolkits/sample-strategic-framework/implementing-nice-public-health-guidance-workplace. In the interests of local communities and individuals it seems therefore worthwhile to explore further ways in which volunteering and citizenship can be utilised to help strengthen both human capital, the aesthetic quality of the built and natural environment, and the additional problems associated with loneliness (www.campaigntoendloneliness.org.uk). Community Health Champions and Arts and health professionals among them have roles to play in helping people to become more aware of and understand better the wellbeing-related values to themselves of actively engaging, contributing to and participating in what is going on in their community, and in being able to demonstrate resultant social, cultural, economic and environmental gains to the broader wellbeing of their society. Within this framework, one model that is valued and continues to evolve is social prescribing for complex social problems through arts on prescription schemes (Stickley and Hui, 2012).



5.4.5 Social Cohesion and a Place and Role for Cultural Barometers

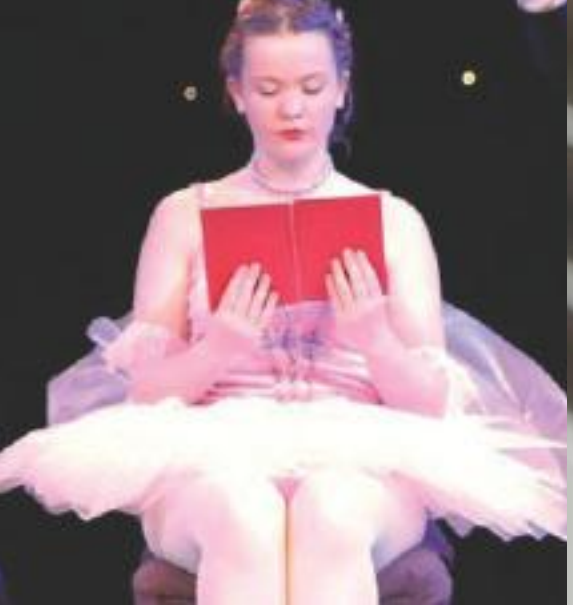
In their roles of using the arts in health and in the art of fostering wellbeing, the arts and health community could perhaps give additional, coordinated support to ongoing steps being taken to improve social cohesion, the sense of citizenship and of belonging to a community. The suggestions in **Sections 5.1 – 5.4** of the report that could be taken forward include contributions to the philosophical framework, values and valuing systems, cost-benefit analyses and economic modelling, strengthening of social and cultural capital, and restoration of a sense of 'hope' among individuals.

In seeking models to adopt and building on points in **Section 2.6.1** of this report, at least in the UK newly-emerged links of the Public Health National Outcomes Framework, the Adult Social Care Outcomes Framework, and the NHS Outcomes Framework, give a useful networked structure that could be utilized. If so, it would help to address priority areas for Public Health England. They include the need to:

- *"develop a national programme on mental health in public health that supports 'No Health Without Mental Heath', prioritising the promotion of wellbeing, prevention of mental health problems and the prevention of suicide, along with improving the wellbeing of those living with and recovering from mental illness; and*
- *encourage more widespread adoption of the Responsibility Deal commitment on mental health adjustments in the workplace, and develop a greater understanding of the workplace's potential for improving and sustaining good mental health, resilience and wellbeing"* (Public Health England, 2013).

For these are areas to be taken forward within a sustainable development framework, it can be suggested that cooperation and coordination with a transparent, auditable, interdisciplinary approach is needed. As NICE has noted, (q.v. **Section 5.4.4** above), there are barriers that need to be overcome and for which they are seeking ways forward, particularly when exploring how best to implement public health guidance within communities such as workplaces (NICE, 2012). The concept of *'Cultural Barometers'* identifies possible ways that arts and health professionals could contribute to the identified need.

Within organisations, the recently-published Francis Report in the UK, in 2013, into the Mid-Staffordshire Hospitals NHS Foundation Trust has given renewed impetus to Cultural Barometers. It identified the need within organisations for a common culture and for compassionate care, shared by all and in which there is accurate, useful and relevant information, noted to be vital in an open, transparent and candid culture (http://www.midstaffsinquiry.com/pressrelease.html). Ways are now being sought to achieve a widespread



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culture of dignity, compassion and respect through improved leadership (Hawkins, 2013). It has been reported that they include consideration of actions to achieve commonly shared values such as inclusion, equity, equality, accessibility, reciprocity, social solidarity, effectiveness, efficiency, appropriateness, responsiveness, and outcomes for individuals and communities, and leadership founded on integrity and respect for others and the Seven Principles of Public Life (Hands, 2013). These principles were promulgated at the request of the Prime Minister, UK, in the Nolan Committee's First Report on Standards in Public Life (http://deni.gov.uk/appendix_2_principles.pdf).

Is there an art to taking these needs forward? If so, what next steps are being taken, or could be taken, and can arts and health professionals contribute to the process?

The NHS Commissioning Board for England has set out its vision in the document, *'Compassion in Practice'* (http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-prctice.pdf). The report notes that in the health-based context a Cultural Barometer aims to help managers, leaders and staff at the front line to reflect on the culture of their organisation, department or team, or indeed themselves. Embedded in the barometer are six values and behaviours: care; compassion; competence; communication; courage; and commitment. Arts and health professionals may therefore wish to consider ways in which these six principles, together with the suggested actions outlined above (Hands, 2013), and those outlined in **Section 5.4.2** above of this report can perhaps become further incorporated into their work.

One practical way step that could be taken with a more integrated approach to help strengthen the contributions arts and health professionals make to society, communities and individuals, is to consider strengthening the role of focus groups in exploring, shaping, agreeing and sharing culture, particularly if all stakeholder groups are included and a sense of common ownership can be fostered. For example, it has been suggested that in the 'new' public sector a Public Sector Cultural Barometer explores the relationships and simplicity of communication rather than undertaking complex paperwork, and that it should collate 'the voice of the people' and be about collaborating and working with internal knowledge instead of buying in expensive external consultants/facilitators and continuing to work in silos (https://knowledgehub.local.gov.uk/web/heidi.dewolf/blog/-/blogs/public-sector-cultural-barometer).

5.4.6 Utilising Statistics and their Information Yield

Earlier in this report:

- empirical evidence for the benefits of arts in health was discussed in **Section 2.4**;
- research work was outlined in **Section 3.1.2**;
- dissemination of research findings and aspects of best practice were explained in **Section 3.1.6**;
- known recent literature reviews were cited in **Section 3.3.5**; and
- examples of evaluation research were given in **Section 3.3.6**.

In addition, often at a national level, relevant arts, cultural and living standards statistics are published. The following websites and summary of relevant material published by the New Zealand Government are examples that researchers may find useful:

http://www.mch.govt.nz/research-publications/cultural-statistics

This website includes information about cultural indicators, employment in the cultural sector, government and household spending on culture, views of the public on the importance of culture and time spent by them on cultural activities. The research reports include studies of cultural philanthropy, cultural tourism and ways of enhancing cultural visitor experiences, cultural and heritage tourism strategy, government policy for the management of historic heritage, sponsorship of cultural events, organisations and activities, and the supply of cultural skills and training.

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http://www.treasury.govt.nz/abouttreasury/higherlivingstandards

This website outlines information about key living standard dimensions including managing risks, economic growth, sustainability for the future, increasing equity, and social infrastructure.

http://cera.govt.nz/recovery-strategy-cultural

Following the two recent devastating earthquakes, the website of the Canterbury Earthquake Recovery Authority outlines the strategy, framework and approaches to renewing the greater Christchurch's unique identity and its vitality expressed through sport, recreation, art, history, heritage and tradition.

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http://www.creativenz.govt.nz/en/arts-development-and-resources/research-and-arts-sector-resources

The reports on this website include information about attitudes to, attendances at and participation in the arts, the building of audience capital, strengthening private sector support for the arts, and an Audience Atlas giving a detailed survey of cultural audiences covering 39 art forms and leisure activities and 640 individual arts, culture and heritage venues throughout the country. It measures lapsed, current and potential markets to provide detailed insight into New Zealand audiences.

5.5 Conclusion: we can and perhaps should each take responsibility for the next steps

In this report we have attempted as best we can, to bring together and update what is going on in the broad area of arts and health. Considerable progress has been achieved since publication in 1999 and 2002 of the two Nuffield Trust Reports. They are both readily accessible and freely downloadable from the Nuffield Trust website:

- http://nuffieldtrust.org.uk/publications/humanities-medicine-beyond-millennium
- http://nuffieldtrust.org.uk/publications/arts-health-and-well-being

Members of the Working Group in the Royal Society for Public Health who prepared this present report hope there is something of interest in it for everyone.

In caring about what goes on in the world and how we can contribute constructively to it, and considering areas of the United Nations Agenda outlined in **Section 5.4.1** of this report, the WHO slogan: *'Think globally; act locally'* is a useful reminder that what we each do in and for the arts and health and how we go about it adds up to something much bigger. In doing so we help to make something happen whether this is based on a practical, strategic, research policy or other approach.

If we want to see changes and further steps taken in this area of public health, then as Mahatma Ghandhi said: *"Be the change you want to see in the world"*. There is much that we can each and collectively do. The viewpoint can be summarised as:

Of This We Can Be Certain

Our world may be uncertain
Insecure, unsafe, and unsure
Yet there is much we can each do
To give it help so that it can better be
More certain, secure, safe and sure;

If we could each think not just of ourselves
We would and surely this is for sure
Reach out less hesitantly to help make it safe
For a future more comfortable, connected for all
One that's sustainable, sincere, settled, secure.

R. Philipp

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This report is freely available to read and download at www.rsph.org.uk/artsandhealth

Links to the two Nuffield Trust reports referred to in this report, along with other relevant reports and information, are also available at www.rsph.org.uk/artsandhealth

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The RSPH is very grateful to the Philipp Family Foundation, whose support has made publication of this report possible. It was established in 2006 in New Zealand to support research, education, programme development and services support for health and wellbeing. In 2010, a Memorandum of Understanding was put in place between the RSPH and the Philipp Family Foundation.

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