Mental Health, Social Inclusion and Arts

developing the evidence base

Final Report

The Anglia Ruskin/UCLan Research Team

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We also to wish to thank the Project Advisory Group for their assistance throughout the study and the many people who have kept in touch with us out of interest over the past two years.

We hope our research will help to sustain participatory arts and mental health work for the benefit of people with mental health needs.

The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Culture, Media and Sport or the Department of Health.

The Anglia Ruskin/ UCLan Research Team

The research team was led by **Jenny Secker**, Professor of Mental Health at Anglia Ruskin University and the South Essex Partnership NHS Foundation Trust. Jenny's research interests centre on social inclusion and mental health and on the use of qualitative methods in health and social research.

Sue Hacking, Research Fellow at the School of Nursing, University of Central Lancashire, took the lead role in the quantitative aspects of the study. Sue's academic career has focused on the development of measures to assess art produced by people with severe and enduring mental health needs, and on the evaluation of wellbeing and social inclusion outcomes.

Helen Spandler, Research Fellow in the Department of Social Work, University of Central Lancashire, took the lead for the qualitative case study work. Helen's research interests include innovative and creative approaches to distress and social exclusion.

Lyn Kent is co-administrator of the South Essex Service User Research Group as well as working with Jenny on other research projects. Lyn played the major role in organising the project and participant surveys and shared the organisation of the case study workshops and interviews with Helen. She also shared the work of data entry and carrying out workshops and interviews with other members of the team.

Jo Shenton is a member of the South Essex Service User Research Group who also works part time for Rethink Graphics, a design and print business that provides employment support to people with mental health problems. Jo combines her paid work with pursuing a career as an artist and has several exhibitions under her belt. For this study, she assisted with survey administration, data entry and transcription, and carried out workshops and interviews with other members of the team. The drawings illustrating this report are Jo's work.

To see more of Jo's work please visit: www.myspace.com/joshenton

Further copies of this report are available at: http://www.socialinclusion.org.uk/resources/index.php?subid=71

More detailed reports of each strand of the study are available from Jenny Secker at:

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Summary

1 Introduction

This report draws together the research carried out for the study Mental health, social inclusion and arts: developing the evidence base. The study was commissioned by the Department for Culture Media and Sport and the Department of Health following publication of the report Mental Health and Social Exclusion by the Social Exclusion Unit.

The aims of the study were to identify appropriate indicators and measures of mental health and social inclusion outcomes, and to develop and implement an evaluation framework based on those indicators and measures.

The study focused on participatory arts projects in England for people aged 16 to 65 with mental health needs and did not therefore include the specific discipline of art therapy. It comprised five strands of work:

1. A survey of arts and mental health projects in England to ascertain the scale and scope of participatory arts work and explore current approaches to evaluation.

2. A retrospective analysis of outcomes data shared with us by two projects.

3. Development of indicators and measures for use within an evaluation framework.

4. Implementation of the evaluation framework in an outcomes study measuring levels of mental health and social inclusion amongst arts project participants at the beginning of their involvement with their project (baseline) and six months later (follow-up).

5. Qualitative case studies with workers and participants at six projects aimed at exploring how and in what contexts arts participation benefits people with mental health needs.

This final report provides a summary of four individual reports describing the survey, retrospective analysis, outcomes study and case studies in order to draw conclusions from across the study.

2 Survey of arts and mental health projects

Participatory arts and mental health projects were identified via internet searches using ‘arts’ and ‘mental health’ as keywords, established lists of projects, snowballing and word of mouth. A survey questionnaire was distributed to around 230 projects and 116 responses were received, 102 of which were from projects whose work was relevant for the research.

Participatory arts and mental health activity emerged from the survey as a vibrant sector within the wider mental health economy. Projects were reaching a large number of people and offering a

vast array of art forms with limited resources in terms of funding and staffing levels.

Projects appeared to be accessible and flexible in their approach to participation. Referrals were accepted from a wide range of sources, including self referral. Length of participation was often open-ended, or negotiated individually, depending on project aims and resources.

Projects reported extensive use of participant-led approaches, depending again on project aims. Participant involvement in all aspects of running projects also appeared to be well developed.

Compared with the 2001 population census data, projects reported reaching above average numbers of people from Black and minority ethnic communities.

Almost all the projects surveyed were attempting to evaluate the outcomes of their work, or had done so in the past, but many were struggling with this. Most used participant-completed questionnaires at only one point in time, and projects were reinventing the wheel by developing their own measures for similar outcomes.

Although some projects were evaluating health and/or social inclusion outcomes, this was not common. The most commonly evaluated outcomes were self esteem and confidence. These outcomes could be important in terms of 'distance travelled' towards 'harder' health and social inclusion outcomes. Where social inclusion outcomes were addressed, this tended to relate to future aspirations regarding education or work rather than to actual changes in participants' lives.

3 Retrospective analysis

Two projects that took part in the survey, 'Time Being' on the Isle of Wight and Arts on Prescription in Stockport, had outcomes data suitable for a retrospective statistical analysis. Both projects generously shared their data with us in the form of anonymised questionnaires that had been completed by participants at the start of their involvement with their project and again at the end.

The outcomes measured at 'Time Being' included mood, four symptoms of depression, ten negative feelings or states, self esteem, seven social anxiety situations and ease of talking to people. At follow up participants were invited to respond to four additional open-ended questions about their experience of the project. The project was able to provide data for 53 participants.

Stockport Arts on Prescription had used a variety of outcome measures over a period of time. Sufficient data were available from a measure of social functioning completed by 24 participants and three measures of depression, two completed by ten women experiencing

postnatal depression and the third by 17 other participants. Participants were invited to respond to two additional open-ended questions at follow up about the benefits of the project.

Study samples from both projects were reasonably representative of project participants more generally. The majority of both samples appeared to have mild to moderate mental health difficulties.

Statistical analysis demonstrated significant improvements in 'Time Being' participants' ratings of their mood, self esteem and ease of talking to people. There were also significant improvements in one symptom of depression (difficulty falling asleep) and two negative feelings/states (sadness and anxiety). With very few exceptions, participants' responses to open ended questions included in the follow up questionnaire were positive and identified many benefits, including improvements in mental health and self esteem, the opportunity for social contact, renewed motivation, decreased anxiety and interest in further arts activity.

At Stockport Arts on Prescription there were significant improvements in the levels of depression recorded for all participants, but no improvement in social functioning. Participants' responses to open ended comments were unanimously positive and identified very similar benefits to those identified at 'Time Being'.

Neither project had asked participants to complete their outcomes questionnaire beyond the time of their involvement with the project, but 'Time Being' had sent a qualitative questionnaire to 59 participants six months later. The 22 responses received suggested that for some people benefits could be sustained in the longer term.

4 Development of indicators and outcome measures

Outcomes were identified from a literature review and project survey, as well as through discussion with representatives of arts and mental health projects and members of the Project Advisory Group. In addition to improved mental health and increased social inclusion, 'distance travelled' was included as a third outcome for measurement.

Indicators of improved mental health were identified as increased levels of mental wellbeing, decreased mental distress, reduced levels of primary and secondary care service use, and reduced medication use.

Indicators of increased social inclusion were higher levels of social contact likely to build bonding and bridging social capital, reduced levels of perceived stigma and discrimination, and higher levels of engagement in employment and education.

'Distance travelled' indicators included increased levels of confidence and self esteem, enjoyment of arts participation, learning/skills gained, and pride in work produced.

Two published measures for some of the mental health and 'distance travelled' indicators were identified: the Clinical Outcomes in Routine Evaluation (CORE) measure of mental health and a measure of empowerment that included self worth and other relevant scales. No published measure of social inclusion was available and a measure was therefore developed for the study.

Additional questions were designed to address service and medication use and employment and education. At follow up participants were also asked to rate their enjoyment, learning, skills development and pride in their work.

To assess the part played by arts participation in any changes at follow up, participants were asked to rate the impact of their arts project on the various dimensions covered in the measures and additional questions.

Demographic and background information requested at baseline covered age, gender, ethnicity, educational qualifications and living circumstances. Participants were asked to describe their mental health difficulties in their own words.

The baseline questionnaire was piloted with participants at two projects and with members of a service user research group, resulting in changes to the rating scale used for the empowerment and social inclusion measures.

Responses to the baseline survey were used to test the CORE and empowerment measures for our study population and to develop reliable scales within the social inclusion measure. Testing resulted in some changes to the empowerment measure and the construction of three coherent scales from the social inclusion measure (social isolation, social acceptance and social relations).

5 Baseline study

Projects that had responded to or expressed interest in the survey of arts and mental health projects were invited to assist with the outcomes study by recruiting new project participants to the baseline study. Twenty two projects recruited a total of 88 participants (60 women and 28 men). Twelve people were from Black and minority ethnic groups. Analysis of the 88 questionnaires indicated that:

1. Participants identified as frequent and regular service users had lower levels of empowerment, mental health and social inclusion than other participants.

2. Participants living with other people had higher levels of empowerment,

mental health and social inclusion than people who were living alone.

3. Participants who were occupationally active (doing paid and/or voluntary work) had higher levels of empowerment and mental health than those who were not occupationally active.[1] They also had better social relations scores, one of the three aspects of social inclusion measured.

4. Although there were a few differences on individual scales included in the measures, there were no major differences relating to sex, age, ethnicity, education or type of mental health difficulty.

[1] These results were close to but did not quite reach statistical significance. The other baseline results reported here were all statistically significant.

6 Follow up outcomes study

A follow up questionnaire was sent six months later to the 88 participants who had completed a baseline questionnaire. The aims were to measure changes in medication and service use, occupational activity, empowerment, mental health and social inclusion, and to assess the extent to which changes could be attributed to arts participation. Sixty two people (70%) returned a follow up questionnaire. There were significant improvements in empowerment, mental health and social inclusion. Improvements in empowerment and mental health were greater for participants identified as having 'clinically significant' mental health problems at baseline and those reporting no recent new stress in their lives at follow up than for participants not in these groups.

There was a significant decrease in the proportion of participants identified as frequent and regular service users, but there was no change in medication use or use of specific services, other than a decrease in use of overnight stays. There was no evidence that the decreases found were related to arts participation.

There were no differences in occupational activity or education, but a third of participants did think their involvement with their project had increased their future employment and education opportunities.

'Triangulation' of results from three analyses assessing the part played by arts participation in the improvements identified indicated that the evidence was very strong for empowerment. The evidence was promising, but less strong, for mental health and social inclusion.

7 Case studies:

Exploring the processes, benefits and outcomes of arts participation

This final strand of the study involved qualitative

case studies at six diverse arts and mental health projects. Workshops were held with project workers, followed by individual interviews with project participants. The aim was to complement the quantitative strands of the research by exploring the processes though which projects achieved benefits for participants.

Our analysis of 34 individual interviews revealed a total of eight processes that were associated with a range of primary and secondary outcomes relating to three key aims identified at the project workshops: improving mental wellbeing, decreasing mental distress and reducing social exclusion.

Three processes were important for most participants at all six projects:

1. Getting motivated inspired hope and reduced inactivity, and so improved mental wellbeing and decreased mental distress.
2. Focusing on art provided relaxation and distraction, which again resulted in improved mental wellbeing and decreased mental distress.
3. Connecting with others in a supportive environment decreased social isolation and increased confidence to relate to others, thus combating social exclusion and mental distress.

A further three processes were important at some but not all projects:

1. Self expression promoted catharsis and self acceptance, and provided alternative ways of coping – benefits that decreased mental distress and reduced social exclusion.
2. Connecting with abilities gave a sense of pride and achievement, which improved mental health/wellbeing.
3. Having time out helped alleviate worries and responsibilities, thus decreasing mental distress.

Two processes were important for some participants at all projects:

1. Rebuilding identities was associated with increased self belief, external validation and moving beyond a service user identity, thus combating social exclusion and mental distress.
2. Expanding horizons led to wider aspirations and opportunities and to enhanced self esteem, resulting in reduced social exclusion and improved mental wellbeing.

9 Conclusions

We believe that our results provide sufficient evidence of mental health, social inclusion and in particular empowerment gains to justify support for arts and mental health work.

The case studies demonstrated that arts

provision for people with mental health needs is not a case of 'one size fits all' and this needs to be taken into account in designing projects.

Support for arts and mental health work could usefully be accompanied by the resources to carry out evaluations.

It will be important to consider the intended outcomes and target groups of arts and mental health projects in designing evaluations. For all groups, we believe 'distance travelled' outcomes are important, particularly aspects of empowerment such as self worth and self efficacy.

The 'log frames' approach to project evaluation is based on the 'theories of change' approach used for the case studies and could provide a pragmatic means for projects to identify appropriate outcomes and the means of achieving these. Qualitative work exploring participants' experiences is also essential to address questions outcomes studies cannot address about how and why arts participation works.

Implications for further research

The main implication for further research is the need for longer term studies:

1. To examine outcomes such as occupational and educational activity.

2. To address the question of whether improvements are sustained beyond participation in arts and mental health projects.

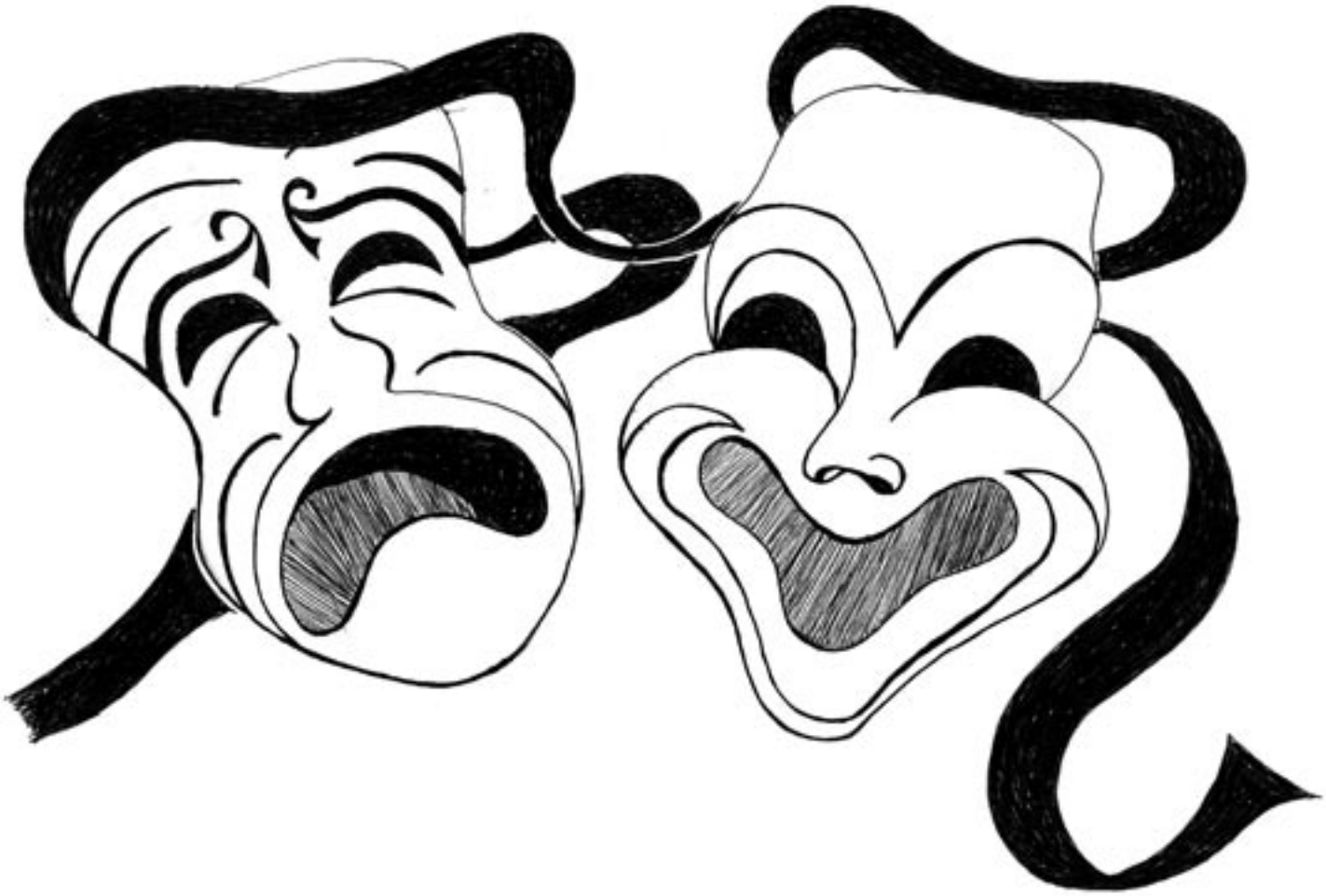
3. To recruit the larger samples required for 'data hungry' analytical methods such as multiple regression.

In any future studies, replicating our question at follow up about new stress in participants' lives would be useful for shedding light on the results, particularly for mental health outcomes.

Our use of participants' impact ratings as a means of attributing change to arts participation is worth further development in a validation study aimed at developing the method for use with the empowerment measure, the CORE and our social inclusion measure.

As for local project evaluation, quantitative methods are only useful in assessing the extent of any change associated with arts participation. To understand how and in what contexts change occurs, qualitative methods are required. This is centrally important if research is to inform service development. A specific question for further qualitative research concerns the benefits for people with mental health needs of arts participation in projects with a broader based membership and focus.

1.Introduction



From a position of relatively low priority until the 1990s, mental health has become an important strand of UK health policy, not least because surveys of psychiatric morbidity in the UK have revealed a considerable burden of ill health (Singleton et al., 2001). In this context, high levels of social exclusion amongst people with mental health needs are of increasing concern. On the one hand, exclusion from participation in community life leads to a downward spiral of increasing isolation and deteriorating mental health. On the other hand, it is now clear that with appropriate support even people with the most severe and enduring problems can and do recover, in some cases in the clinical sense of the absence of symptoms, and in others in the social sense of recovering a fulfilling life in the community regardless of mental health diagnosis (Harding et al., 1987; Secker et al., 2002).

Since social exclusion cannot be tackled by health and social services alone,

the Social Exclusion Unit (SEU), formerly located in the Office of the Deputy Prime Minister (ODPM) and now in the Cabinet Office, is leading work on reducing the exclusion of people with mental health needs. In 2004, the SEU produced a report identifying the causes of exclusion as lying in large part in the stigmatisation of mental ill health and in a focus on medical symptoms at the expense of enabling people to participate in their local communities (ODPM, 2004). Over a third of respondents to the SEU's consultation identified access to recreational activities, including participation in the arts, as essential to promote social inclusion, and promoting access to arts opportunities was amongst the 27 actions identified as part of the SEU's action plan.

Despite the strong belief of those involved in arts and mental health projects that their work does have beneficial effects (Health Development Agency, 2000), two reviews indicated that evidence to support implementation of the SEU action plan regarding participation in the arts was not strong (White and Angus, 2003; Ruiz, 2004). In order to develop a stronger evidence base for arts and mental health work, the Department for Culture, Media and Sport and the Department of Health were therefore jointly charged with commissioning the study presented in this report.

The review carried out by White and Angus (2003) had been commissioned by the SEU to inform the development of further research and was of considerable help to us in designing this study. In particular, the review demonstrated the difficulty of providing evidence that arts and mental health projects have an effect on mental health and social exclusion. The authors concluded that better measurement tools needed to be devised and that these should be sensitive to the aims of arts projects, but also robust enough to delineate outcomes. In addition, they argued that sophisticated assessment of qualitative evidence rather than a short-cut analysis of cost efficiency alone was required.

Accordingly, the aims of the study were to identify appropriate indicators and measures of mental health and social inclusion outcomes, and to develop and implement an evaluation framework based on those indicators and measures, including qualitative work to provide a deeper understanding of the impact of arts participation.

The study focused on participatory arts projects in England for people aged 16 to 65 with mental health needs and did not therefore include the specific discipline of art therapy. It comprised five strands of work:

1. A survey of arts and mental health projects in England to ascertain the scale and scope of participatory arts work and explore current approaches to evaluation.

2. A retrospective analysis

of outcomes data shared with us by two projects.

3. Development of indicators and measures for use within an evaluation framework.

4. Implementation of the evaluation framework in an outcomes study measuring levels of mental health and social inclusion amongst arts project participants at the beginning of their involvement with their project (baseline) and six months later (follow-up).

5. Qualitative case studies with workers and participants at six projects aimed at exploring how and in what contexts arts participation benefits people with mental health needs.

This final report summarises four previous individual reports from the survey, retrospective analysis, outcomes study and case studies in order to draw conclusions from across the study.

Ethics approval was granted by the London Multicentre Research Ethics Committee. Where required, research governance approval was granted by the relevant NHS Trusts.

Terminology

In describing the quantitative strands of research we have used the terms ‘measure’ and ‘scale’. By ‘measure’ we mean a complete instrument for measuring a particular construct such as mental health, for example the Clinical Outcomes in Routine Evaluation (CORE) measure. By ‘scale’ we mean a set of questions within a measure that assess a particular dimension of the overall construct. For example, the CORE is a single measure containing four scales assessing wellbeing, life functioning, problems/ symptoms and risk to self or others. Other measures might consist of only one scale. Questionnaires used to assess outcomes might include one measure or several.

For the qualitative case studies, we have used the term ‘participant’ to refer to the people we interviewed who participated in art at the six projects. While this was not always the preferred term at the projects, which had a number of different ways of referring to people who participated in their project, we have used it as a generic term to aid consistency and avoid confusion. In addition, we have used the term ‘worker’ to refer to the facilitators or staff at the project for similar reasons. We are aware that the distinction between workers and participants is not always clear cut.

2. Survey of arts and mental health projects

Introduction

Participatory arts and mental health projects were identified via internet searches using 'arts' and 'mental health' as keywords, established lists of projects, snowballing and word of mouth. For example, invitations to contact us were published in arts organisations' newsletters or on their websites. An introductory letter was sent to the 245 projects identified, 15 of which told us their work was not relevant for the research.

The survey questionnaire was designed with input from the Advisory Group and piloted with four projects. The questionnaire was distributed to 230 projects and 116 responses were received, 102 of which were from projects whose work was relevant for the research.

Since the main aims of the survey were to map participatory arts and

mental health activity for people aged 16 to 65 in England and to ascertain how projects were currently evaluating their work, the topics covered in the questionnaire included:

- The groups of people with which projects were working
- Their funding and staffing levels
- The art forms used
- The settings in which projects worked
- Referral sources
- Number of participants and frequency and length of participation
- The model of participation adopted
- Intended outcomes
- The data collected about project participants and outcomes, and any evaluation measures used.

Results

Although we had originally thought it might be possible to develop a typology of participatory arts and mental health projects on the basis of the survey results, this was not possible as no single way of categorising projects, for example in terms of funding sources, settings or art forms used, proved watertight. The majority of projects were clearly hybrid in nature, operating flexibly and supported by a variety of funding sources. For this reason the results are presented for all responding projects rather than by project type.

The scale of provision

Participatory arts and mental health activity was evidently a vibrant strand within the wider English mental health economy. The 102 projects were offering an impressive variety of arts activities to almost 4,000 people with mental health needs each week[2]. However, this appeared to be achieved with limited resources, with an estimated national annual spend of £7 million per 100 projects and average staffing levels of 1.5 FTE paid staff members per project. Nevertheless, there was evidence of some stability, in that many projects that responded had been established for eight years or more.

[2] To put this in context, over 900,000 adults in England claim sickness and disability benefits for mental health conditions (ODPM, 2004).

The scope of provision and the models adopted

Health-related activity appeared to predominate. Overall, health service funding sources provided 33% of the total funding for projects. Health services were also the single largest source of referrals to projects, regardless of funding source. However, the range of sources from which referrals were accepted was wide, with self referral second only to specialist mental health services in frequency, suggesting a high degree of accessibility.

Many projects worked with people from the wider community as well as with people with mental health needs, which may well be important in promoting social inclusion. In addition, the projects appeared to be succeeding in areas where other mental health providers struggle:

- They reported reaching above average proportions of people from Black and minority ethnic communities

- Levels of participant involvement in shaping the activities in which they engaged were reported as high, as were levels of service user involvement in the running of projects.

Evaluation methods

Sixty-one percent of projects indicated that they routinely evaluated their work but only two of the 102 projects included in the analysis were using validated outcome measures. However, the majority of projects that were evaluating their work were trying to obtain some kind of standardised information, suggesting that there may be a greater willingness to go down this route than has been suggested (White and Angus, 2003).

The majority of projects used participant-completed questionnaires for evaluation. These are relatively quick and inexpensive to use, but projects up and down the country were ‘reinventing the wheel’ in designing their own ways of measuring similar constructs such as enjoyment or self esteem.

The formats used varied widely from open ended questions that are time consuming to answer and analyse, to tick box or rating scale formats that are less time consuming but can be difficult to design well and can limit the range and depth of responses.

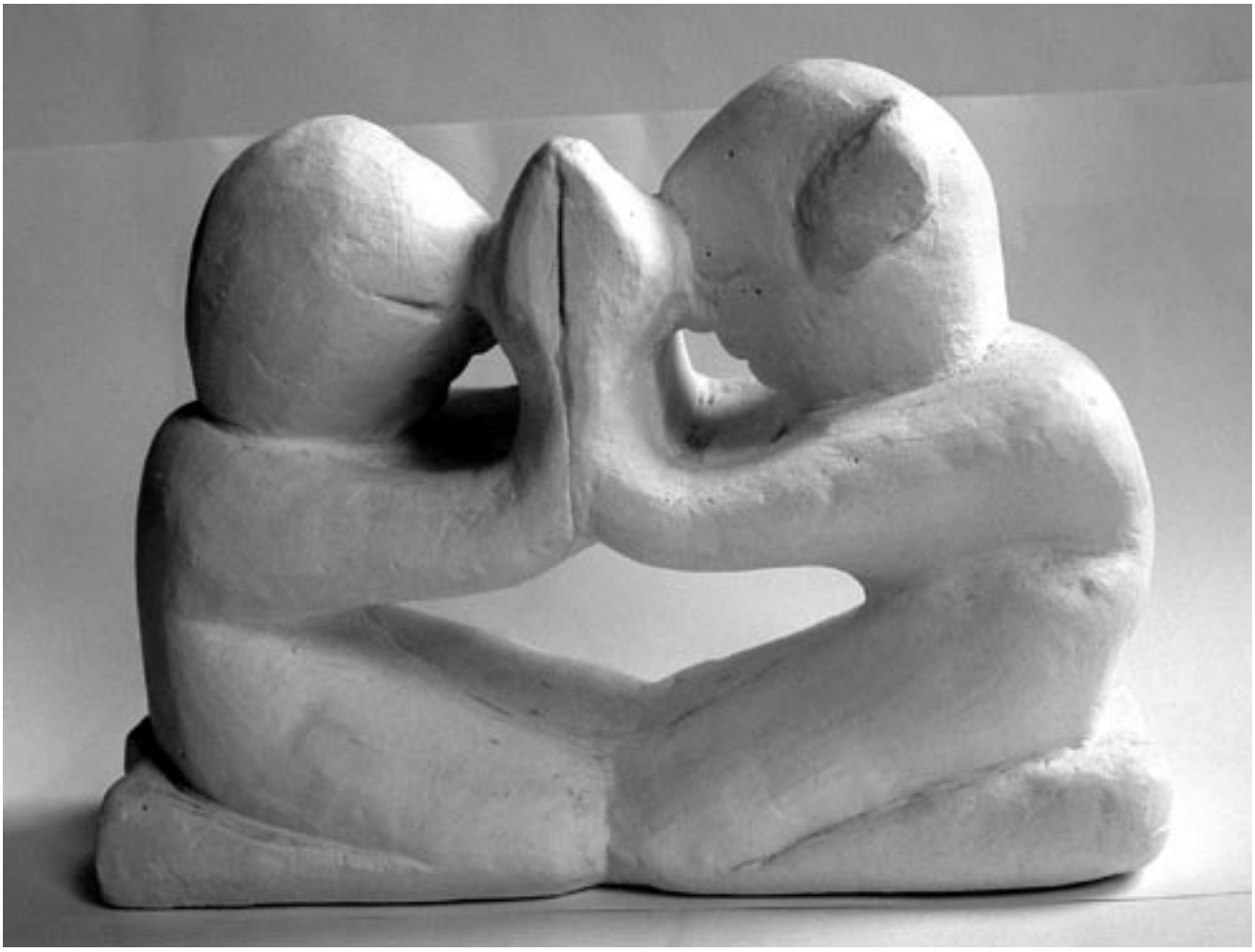
Most projects were evaluating their work at only one point in time, precluding the measurement of change over time. Even where projects were using a pre- and post-intervention design, in most cases it would be difficult to attribute change to the projects' work. However, some projects were directly asking participants at follow up whether the project had contributed to any change.

Evaluation content

Our analysis of the outcomes evaluated by projects indicated that various dimensions of what has been termed 'distance travelled' were both of greatest importance to projects in terms of their intended outcomes, and amongst the outcomes they most frequently evaluated (42 projects). These included enjoyment of arts participation, learning and skills gained, self esteem, confidence and empowerment.

Fewer projects (13) were evaluating outcomes directly related to measurable health outcomes, such as levels of anxiety and depression, or service and medication use. Equally, although 20 projects were attempting to assess dimensions relevant to social inclusion, such as social contact, employment and education, in ten cases this was based on participants' future aspirations rather than actual experience of greater inclusion.

3. Retrospective analysis of project outcomes data



Introduction

Two projects indicated in their Phase 1 survey response that they held outcomes data suitable for retrospective analysis and were willing to share this with the research team.

'Time Being' is an arts and mental health in the community programme provided by Healing Arts for the Isle of Wight Healthcare NHS Trust and Isle of Wight PCT. The project offers a 12-week course to people with a range of mental health and social needs. The outcome measures used at the project comprised scales assessing mood, four symptoms of depression, ten negative feelings or states, self esteem, seven social anxiety situations and ease of talking to people. At follow up participants were invited to respond to four additional open-ended questions about their experience of the project. Baseline (time 1) and follow up (time 2)

measures were available for 53 participants. Demographic information was also available for all project participants over a period of three years.

Stockport Arts on Prescription offers a 15 week course covering a diverse range of art skills and techniques to people with mainly 'mild to moderate' mental health needs (see Section 7 for more information about this project). The project had used a variety of outcome measures over a period of time. Sufficient time 1 and time 2 data were available from a measure of social functioning (SFS, 24 participants) and three measures of depression: the Zung Self rating Depression Scale (ZSDS, 17 participants); the General Health Questionnaire (GHQ, 10 participants); and the Edinburgh Postnatal Depression Scale (EPDS, 10 participants). Participants were invited to respond to two additional open-ended questions at follow up about the benefits of the project. Some demographic information was available for project participants spanning a period of four years.

Demographic information for the study samples was compared with that available for the wider population of project participants. The completed measures provided by the two projects were analysed to generate descriptive data on which statistical tests were performed to assess the significance of differences in scores from time 1 to time 2.

'Time Being' results

The results of our comparison of the 'Time Being' sample with the broader population of project participants indicated that the sample was broadly representative of all 'Time Being' participants. In both groups, most participants were female (81% in the total population, 84% in the study sample) and both groups were similar in terms of age. Only four participants (5%) described themselves as of other than white British ethnicity but this was representative of the area.

Mental health needs

In order to gain some idea of the extent of participants' mental health needs in the absence of the kind of validated measures in use at Arts on Prescription, we developed a measure of the difficulties experienced based on participants' responses to the questions that were asked about symptoms and problems. At time 1, twenty-three participants (almost half) were rated as experiencing more than average difficulty in three or more of the six dimensions measured. At time 2, only 12 participants had more than average difficulty, a decrease of almost half that was statistically significant.

Mood, self esteem and ease of talking to people

Average self esteem ratings were below the middle range at time 1, with average mood ratings around the mid point and average ease of talking to people rated slightly above

the mid point. At time 2, average ratings for all three dimensions had increased significantly, with the largest gain in self esteem.

Symptoms of depression, negative feelings/states and social anxiety

At time 2, participants reported fewer symptoms of anxiety, negative feelings or states and situations in which they experienced social anxiety than at time 1. Across the three measures, four of the changes were statistically significant: difficulty in falling asleep at night, sadness, difficulty concentrating and anxiety.

Open-ended responses

Most of the 53 participants responded to at least one of the four open-ended questions included in the follow up questionnaire. The great majority of comments were positive and only three participants reported that the project had not been of any benefit to them.

Forty-eight people responded to a question about changes and opportunities resulting from their participation. Six of the 48 wrote that they had not experienced any change or new opportunities and two indicated that they had but gave no details. The themes that emerged from the responses of the other participants revolved around improvements in their mental health and wellbeing, recovering valued aspects of themselves that had been lost, the opportunity for social contact, renewed motivation and a developing interest in further arts activity. For example:

I am feeling much more content and able to take one step at a time, without worrying about what might need to be done, what might happen in the future. I think I am concentrating better.

It has made me realise that I can do things other than everyday routine; helped me to use my body and mind in ways I had nearly forgotten about.

Getting to know people and interacting with them and chatting to the staff. I am rather starved for conversation and social interaction.

I looked forward to Friday mornings so general lift in spirits… Given me motivation to try out other new things plus continue with existing projects.

Something I would never have done before also opened up new interest.

Forty-seven people responded to a second question about health improvements. While seven people had not noticed any improvements, the other 40 were able to identify positive changes. Some again commented on increased confidence and concentration or decreased anxiety, while others wrote of the lifting of depression, a renewed sense of joy and interest in life, decreased anxiety, and the health benefits of social contact at the project:

Happier within myself, and with myself am excited about my life

again and looking forward.

I found the sessions cheered me up and made me laugh and relieving the anxiety I have had in recent months.

It has been an improvement for me to attend a programme with other people.

Thirty-seven people responded to a third question about their experience of arts activities at the project and the response was overwhelmingly positive, with many participants writing about how much they had enjoyed the activities. Although some participants had found the activities challenging to begin with, they had clearly been able to overcome their fears:

Have met new people and been put in a situation/ environment I would not put myself in usually.

I would never have done it, embarrassed at first, a challenge, but enjoyable.

Others commented on the support received from staff and on the unpressured approach at the project:

There was no pressure to join in anything if you didn't feel comfortable doing it. You were able to do things at your own pace, with dance I didn't feel comfortable dancing but I was never made to feel left out of the group.

The 46 participants who responded to a final question about the most effective aspect of the project were again overwhelmingly positive. Some people wrote that simply doing something different had been helpful, but the most frequent comments revolved around the benefits of social contact and the support provided by staff, for example:

A great feeling of togetherness, supportive backup to tuition from team project leaders, for each arts activity, encouraged participation to the full and instilled confidence from the start.

The benefits of creative activity itself were also singled out by many people, as these comments illustrate:

I'd never done anything like it.

I've begun to believe in my innate creative ability.

I used to do a lot of writing ... and it dried up while I was working full time - I hope to do more writing now.

Arts on Prescription results

Assessing how representative the Arts on Prescription study sample was of all project participants was difficult due to changes in record keeping at the project. On the basis of what information was available, however, the study sample appears to have been reasonably representative in terms of gender and age. No information was available about participants' ethnicity.

Mental health needs

Information about the mental health needs of the Arts on Prescription sample was available from the time 1 data provided by the project for ten women who completed the EPDS and GHQ, and for 17 people who completed the ZSDS. The authors of both the EPDS and the GHQ have calculated cut off points above which scores indicate 'clinical significance'. Eight of the ten women who completed these measures scored above the cut off points at time 1. Scores on the ZSDS are grouped into four levels of depression: normal range, minimal to mild depression, moderate depression and severe depression. At time 1, 13 of the 17 participants were experiencing moderate or severe depression.

Mental health results

Mean scores on both the EPNDS and the GHQ reduced between time 1 and time 2. Numbers were too small for statistical analysis at this group level and we therefore examined individual changes over time. The results revealed significant decreases in depression on both measures.

On the ZSDS, mean scores had reduced for all levels of depression and the difference was also statistically significant.

Social functioning results

Mean scores for the 24 participants who completed the SFS improved a little on each of the four scales included in the measure, but none of the changes were statistically significant. In addition to analysing mean scores, we again examined changes in individual scores. The results indicate that although there were improvements at time 2 compared with time 1, these were also not statistically significant for any of the four SFS subscales.

Open-ended responses

Twenty-six of those included in the study sample responded to a question about what they would tell a friend about the project. All the responses were positive. Three participants simply wrote that they had enjoyed the arts activities, while two appreciated the time out and break it gave them from their everyday lives. The themes that emerged from the other responses revolved around the social aspects of participation, particularly the group support, mental health benefits, motivation and improved self esteem. For example:

It really helps and you look forward to the next time as everyone is very friendly.

The best thing I have ever done. It was helpful in the process of healing from mental illness and that taught me a way of learning to relax and loving myself.

It gets you out of bed when there's no other reason.

When I am painting I forget everything else. Being part of a group and talking and opening up

with the other members. Realising that I can develop my artistic skills I feel proud of what I have achieved and it has done wonders for my self esteem.

Twenty-two participants responded to a question specifically asking about mental health benefits, and again all their responses were positive. The main themes revolved around improved mood, confidence, concentration and self esteem, and decreased anxiety. For example:

It cheered me up and by the time the lesson had finished was a lot happier than before was happier with my partner and baby.

My confidence has improved and my self image has risen too. I am not as negative as I was.

Ability to concentrate. Since being ill my attention span and ability to concentrate have been almost nil. The turning point was definitely the first part of the scheme, in particular the drawing exercises.

I was able to concentrate on drawing so I forgot my present anxieties.

Longer-term benefits

Neither project had asked participants to complete their follow up questionnaire beyond the end of their involvement with the project, so it is not possible to assess whether the changes reported above were sustained in the longer term. However, 'Time Being' had sent a qualitative questionnaire exploring the perceived benefits of the project to 58 former participants six months after they finished their course. Of the 22 people (38%) who returned a questionnaire:

- 14 made comments indicating that they were experiencing lower levels of depression and anxiety as a result of completing the programme
- 15 noted improvements in their social life
- 14 said their self confidence and self esteem had improved
- 13 reported an improvement in their general health and outlook on life
- 16 said they had been able to further their interest in the arts and intended to continue this.

Because the response rate to the questionnaire was low, due to lack of time and resources at the project to enable more sustained effort to contact people, it is not possible to know whether the views of those who did respond are generalisable to other participants, but amongst these 22 people at least arts participation was seen to have been of lasting benefit.

4. Development of indicators and outcome measures

Introduction

In order to identify indicators and measures for use in our prospective outcomes study, we drew on a review of previous arts in health studies and on the results of the survey described in Section 2. In addition, we discussed our ideas with representatives of arts and mental health projects who attended four regional meetings held for this purpose, as well as with the Project Advisory Group. The process was one of identifying the outcomes regarded as important by the various stakeholders, specifying indicators related to the achievement of those outcomes and identifying or developing measures of their achievement.

Outcomes and indicators

Two outcomes of importance to stakeholders in the research, improved mental health and increased social inclusion, were clearly predetermined, since the benefits of arts participation in these respects were a specified focus of the study. However, our review of previous studies and the clear emphasis of arts projects on the importance of factors indicating 'distance travelled' towards these outcomes enabled us to identify this as a third important outcome. These sources and the views of the project representatives and Advisory Group members were also influential in enabling us to specify indicators for the achievement of the three outcomes, as shown in Table 4.1.

Table 4.1 Outcomes and indicators

Outcome	Indicators
Improved mental health	Increased levels of mental wellbeing Decreased mental distress Decreased levels of primary & secondary care service use Reduced medication use
Increased social inclusion	Higher levels of social contact likely to build bonding & bridging social capital Reduced levels of perceived stigma & discrimination Higher levels of engagement in employment & education Neigbourhood safety and stability of housing tenure
Distance travelled towards improved mental health & increased social inclusion	Increased levels of confidence & self esteem Enjoyment of arts participation Learning/skills gained Pride in work produced

Outcome measures

Since developing valid and reliable measures is complex and time consuming, we were concerned as far as possible to identify published measures for use in our outcomes study. This proved possible for aspects of mental health/mental distress, and for aspects of 'distance travelled' but no published measure of social inclusion was available, meaning that we did have to develop our own. We also needed to find a way of assessing whether any changes we identified could be attributed to the impact of art participation.

Mental health measures

The criteria we used in identifying an appropriate measure of mental health from amongst the many available included:

- A broad mental health focus, as opposed to a focus on a specific diagnosis
- A focus on wellbeing as well as on problems or symptoms.

The Clinical Outcomes in Routine Evaluation (CORE) measure, developed at the University of Leeds (CORE system group, 1998) met both criteria. The CORE contains 34 items grouped into four scales assessing wellbeing, problems/symptoms, life functioning and risk to self or others. The 34 items are expressed as statements about feelings to which participants are asked to respond by indicating how often they had felt that way over the past week (not at all to most /all of the time).

Only one measure of service use, the Client Service Receipt Inventory (Beecham and Knapp, 1992), appeared to have been published and this was too long and detailed for inclusion in our questionnaire. We therefore developed questions of our own asking participants to indicate how frequently they had used primary care, secondary mental health and other voluntary, community or self help mental health services over the previous six months. At baseline we asked how regularly participants took medication for their mental health and at follow up we asked about changes in medication use over the previous six months.

Distance travelled measures

Several measures of factors relevant for 'distance travelled', such as self esteem and self efficacy (belief in one's power to affect things), are widely available, but these were developed for use with different populations. We therefore selected an empowerment measure that was based on published scales but that had been tested for use with mental health service users (Schafer, 2000). The measure comprises 25 items grouped into five scales assessing self worth, trust in experts, desire for community involvement, commitment to mutual aid and self efficacy. The 25 items are expressed as statements with which participants are asked to indicate the level of their agreement on a Likert-type scale (strongly agree to strongly disagree).

To assess levels of enjoyment, learning and skills gained and pride in the work produced, which were of considerable importance to arts and mental health projects, we included questions in the follow up questionnaire asking participants to rate these aspects on a three point scale (a lot, a little, not at all). The follow up version of the questionnaire also asked about further involvement in arts and creativity.

Social inclusion measures

In order to develop a standardised measure of social inclusion we drew on our review of previous arts in health studies and on the approaches used by some respondents to our project survey to identify potentially useful questions relevant to the indicators shown in table 4.1. We also trawled national surveys such as the Labour Force Survey and General Household Survey (www.statistics.gov.uk) for relevant questions. The resulting measure comprised 22 items. These were framed as statements to which participants were asked to respond on the same Likert-type scale as used in the empowerment measure, indicating the extent to which each statement had applied to themselves over the previous three months. Additional questions adapted from the two national surveys asked about paid and voluntary work.

Assessing project impact

Because it was not possible to establish any kind of control or comparison group in the context of a naturalistic study of participation in established arts and mental health projects, for the follow up version of the questionnaire we adopted the approach used by some respondents to the project survey and included questions asking participants to rate project impact on each of the dimensions covered by the various measures and additional questions.

We also included questions about the extent and frequency of involvement in participants' arts projects and about any new stresses experienced in the previous few weeks that might have affected responses to the questionnaire.

Piloting and testing

Members of a service user research group and participants at two arts and mental health projects assisted with piloting the baseline version of the questionnaire. The results indicated that the questions were easily understood and only one minor change to the wording of an item in the social inclusion measure was required. However, participants found the Likert-type scale used for the empowerment measure difficult and this was therefore replaced in both measures with a standard four-point scale that asked participants to indicate the extent to which each statement applied to themselves (not at all to yes definitely).

Although the CORE and empowerment measures had been tested with other populations we used our baseline survey results to retest their reliability for use with our study population. We also needed to establish the reliability of our social inclusion measure. The results relating to each measure are presented below.

CORE

All four CORE scales proved to have good or excellent reliability for our population. Individual items correlated well with the scales to which they related, with the exception of one item from the life functioning scale (I have someone to turn to for support when needed). However, the life functioning scale was otherwise robust. Since it contains a total of 12 items the effect of one item would be minimal and we therefore left the item in. The total scale was also tested. Again, all individual items except the same item from the life functioning scale scored above the accepted level, indicating that all but that item contributed well to the concept of mental health being measured, and the overall reliability of the measure was excellent.

Empowerment measure

The empowerment measure proved somewhat problematic with our population. Only two of the five scales reached good levels of reliability and some of the correlations for items on those scales were rather low. There were also problems with correlations between items and the measure as a whole, in other words with their contribution to the construct of empowerment.

Factor analysis was therefore used to identify more robust correlations between items and the measure was reconstructed accordingly, with one of the original scales, desire for community involvement, reframed as 'positive outlook' to better describe the items now comprising it. Further testing identified five items that were removed because they loaded across most scales, were not reliable or did not relate sufficiently well to the construct of empowerment.

The resulting 20-item measure had better reliability generally but slight problems remained with two scales that corresponded to the original 'mutual aid' and 'trust in experts' scales. Additionally, item correlations with some scales were of variable consistency.

We dealt with this by weighting items based on their contribution to the scale in which they were included. A test was then performed on the reconstructed measure to determine the contribution of the scales to the construct of empowerment. The 'trust in experts' scale did not contribute well and this scale was therefore excluded[3]. The other four scales then contributed to the 'empowerment' construct at high levels of reliability.

The final empowerment measure comprised 17 items grouped into four scales assessing:

- Self worth (4 items)
- Self efficacy (4 (items)
- Mutual aid (4 items)
- Positive outlook (5 items).

[3] We discussed this with the original author who confirmed that this scale had proved problematic in subsequent field trials.

Social inclusion measure

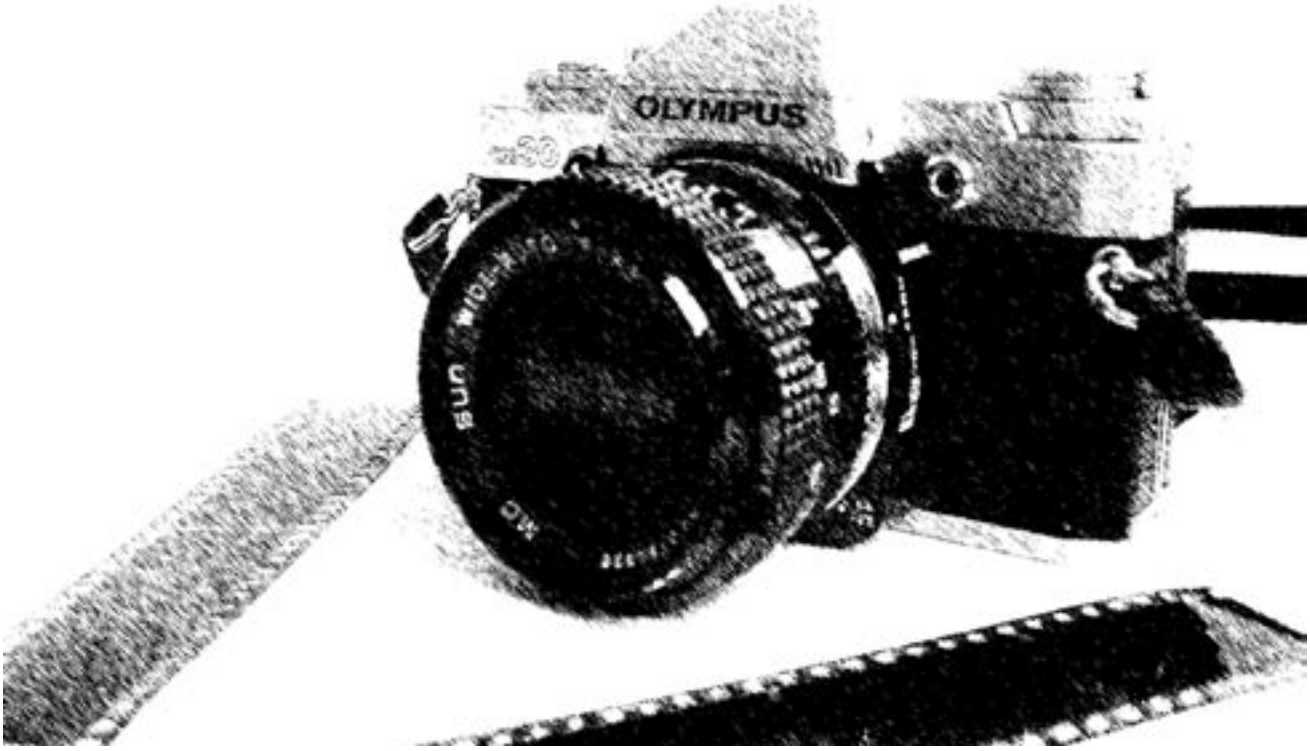
Using a similar process to that used to test the reliability of the empowerment measure, we constructed coherent scales from the questions included in the social inclusion measure. The result was a measure comprising 19 items grouped into three scales assessing:

- Social isolation (5 items)
- Social relations (9 items)
- Social acceptance (5 items).

Three further items from the original measure did not correlate well with any individual scale but they did correlate with the measure as a whole and were therefore included in our analysis of results on the measure as a whole. These related to security of housing tenure, and involvement in sport and charity work.

The final scales had good reliability and also related well to understandings of social devaluation, inclusion and isolation included in previous surveys (Gallie and Paugham, 2002), indicating that at least some of the essential elements of social inclusion appear. However, as a caveat, construct validity cannot be said to be established, because the whole construct of social inclusion may not be fully represented by these dimensions. This therefore remains an issue for further research and theoretical debate.

5. Baseline study



Introduction

As seen in the previous section, the baseline survey questionnaire included three standardised measures: an empowerment measure, the Clinical Outcomes in Routine Evaluation (CORE) measure of mental health and the measure of social inclusion developed for the study. Additional questions relating to mental health and social inclusion addressed medication and service use, employment and education opportunities, and participants' living circumstances.

The questionnaire asked participants to indicate their age group, gender, ethnicity and educational qualifications. Rather than asking for a psychiatric diagnosis, which some people may find inappropriate or offensive, participants were asked to describe their mental health difficulties in their own words. They were also asked about their living circumstances: whether they were living in their own accommodation alone or with other people, or in service accommodation such as a hostel, residential or group home, or a hospital ward.

To assess baseline levels on the three standardised measures, we looked at group averages and total scores by demographic factors, mental health (difficulties and service use), living circumstances and employment and education. For the CORE we also compared those people identified as potentially having a 'clinically significant'

condition, as defined by the authors of the measure, with those who were not. Finally we looked at the relationship between scores on the three measures.

Two members of the research team, one with experience of using mental health services, coded participants' descriptions of their mental health difficulties. In the event, most people used diagnostic terms, such as schizophrenia, depression, anxiety or bi-polar disorder. Although many went on to give further details in their own words, because most people did choose to use diagnostic terms we followed suit in coding the difficulties they described. Where different terms are in use, which was the case with manic depression/ bipolar disorder, we used 'bipolar disorder' because of thirteen people describing this kind of difficulty ten used that term. Following coding of the responses, these were grouped into five categories:

1. Schizophrenia (this term was used by everyone concerned).

2. Bi-polar disorder.

3. Depression, indicated by use of that term or descriptions consistent with experiences usually associated with depression.

4. Anxiety and depression, indicated by the use of the terms stress or anxiety, combined with depression.

5. Other difficulties, including people who used the terms obsessional behaviour or obsessive compulsive disorder, self harm, personality disorder, eating disorder, post traumatic stress, agoraphobia or panic attacks.

There was inevitably overlap between categories. Some people who had used the term schizophrenia also indicated that they were experiencing depression. The depression category itself was very broad, comprising people who wrote 'severe depression' and those who wrote 'mild depression', as well as many who did not qualify the term.

Coding of educational qualifications was based on the categories used for the national Labour Force Survey (Office of National Statistics, 2003).

Projects and participants

Of 51 projects that initially expressed interest in assisting with the study, 22 recruited participants. The main reasons for projects deciding not to take part included doubts about their own capacity to help for funding or staffing reasons, and concerns about the impact of the survey on participants. These concerns focused particularly on the questions about risk to self or others in the CORE, which it was feared could be distressing, on a perceived overemphasis on mental health issues in a context where these were not the focus, and on the length of the questionnaire.

The 22 projects that did assist were fairly evenly distributed across the English regions, although London was under represented. Between them, they recruited 88 participants to the study. Twenty-eight participants were male (32%) and 60 female (68%). Just over half (56%) were aged between 36 and 54. Seventy-five participants (86%) described themselves as from White British or other white backgrounds. Twelve (14%) were from Black and minority ethnic groups.

Education, occupational activity and living circumstances

Twenty six participants (31%) had no formal qualifications and four (4%) did not respond to the question. Of the other 58 participants:

- 17 (20%) had higher education qualifications
- 17 (20%) had 'A' levels or equivalent
- 18 (21%) had GCSEs or equivalent
- 6 (7%) had vocational qualifications.

Sixty-five (76%) of 86 participants who responded to questions about employment were unemployed and ten (12%) were working, for an average of 12 hours per week (range 4 – 25 hours). Seven people (8%) indicated that they were retired, of whom one was also working. Four (5%) were on sick leave from full time jobs.

Twenty-eight (35%) of the 81 people who responded to a question about voluntary work were doing an average of five hours voluntary work per week. People who were occupationally active (doing paid and/or voluntary work) tended to be female, to have GCSE or further education qualifications, to be in the older age groups and to describe their mental health difficulties in terms of depression. They were less likely to be frequent and regular service users, and no one from a Black or minority ethnic background indicated that they were occupationally active.

Forty one participants (48%) were living with other people and 38 (45%) were living alone. Six people (7%) were living in a hostel, residential home or hospital ward.

Mental health

Over half (57, 59%) of participants were experiencing depression and around half of those (22, 28%) were experiencing depression associated with anxiety. Smaller proportions described their difficulties as schizophrenia (8, 10%), bipolar disorder (13, 16%) or 'other difficulties' (12, 15%). Based on their responses to questions about service use, 34 participants (38%) were frequent and regular users of services (medication, mental health, primary care, voluntary sector and other services).

Empowerment results

Higher scores on the empowerment measure indicate higher levels of empowerment.

Gender, age and ethnicity

Mean scores for three of the empowerment scales, commitment to mutual aid, self worth and positive outlook, were above the mid point for both men and women. Self efficacy scores were below the mid point for both men and women.

There were no statistically significant differences on any scale between age groups although there was considerable variation. When participants were distributed across two similar sized groups, younger people (19-45) scored slightly higher on most scales and the difference for self efficacy was statistically significant.

The overall empowerment scores of participants from Black and minority ethnic backgrounds were higher than those of other participants and the difference was close to significance. The results for self worth were statistically significant.

Mental health

People who described their mental health difficulties as schizophrenia or depression had the lowest overall empowerment scores but the differences were not statistically significant.

The 34 participants identified as frequent and regular service users scored significantly lower than other participants on the self worth scale. There were also trends towards lower scores for positive outlook and mutual aid that contributed to a significantly lower score for overall empowerment.

Living circumstances

Participants living with others in their own home scored significantly higher than people living alone on self efficacy, positive outlook, mutual aid and overall empowerment.

The six people living in service accommodation scored lower on all four empowerment scales, particularly commitment to mutual aid and self efficacy (numbers were too small for statistical testing).

Education and occupational activity

Differences in the scores of participants with different levels of educational qualification were small and none were significant.

The overall empowerment scores of participants who were occupationally active (doing paid and/or voluntary work) were higher than those of other participants and the difference was close to significance.

CORE results

Higher scores on the CORE indicate greater mental health difficulties. Fifty nine participants (65%) reached the cut off point on the CORE indicating clinically significant mental health difficulties.

Gender, age and ethnicity

The proportions of men and women above the cut off point were similar. Although women's mean scores were slightly higher than men's on all scales except life functioning, the differences were not significant.

The youngest participants (19-25) scored highest on all scales and this was significant for wellbeing. When the age groups were collapsed to two equal sized groups the mean scores for the younger group (19-45) were significantly higher for risk to self or others but there were no differences for wellbeing.

The mean scores of participants from Black and minority ethnic groups were slightly higher for all four scales but the differences were not statistically significant. There were also no significant differences between people from Black and minority ethnic backgrounds and other participants scoring above the clinical significance cut off point. Mean scores for the Black and minority ethnic group were lower on the wellbeing scale, indicating fewer problems, and this did approach significance.

Mental health

The majority of participants describing their mental health difficulties as schizophrenia, depression, depression with anxiety or the 'other difficulties' scored above the cut off point for clinical significance on the whole measure. The highest proportions were amongst those describing the 'other difficulties' (82%) and those describing their difficulties as schizophrenia (75%). Proportions for depression and depression with anxiety were 61% and 64% respectively. In contrast, only 38% of people describing their difficulties as bipolar disorder scored above the cut off.

The 34 frequent and regular service users scored significantly higher than other participants overall and on three of the four scales: life functioning, problems/symptoms and wellbeing. The scores of 79% of this group reached clinical significance compared to the scores of 55% of other participants and this difference was also significant.

Living circumstances

Participants living alone in their own home scored significantly higher than participants living with other people on the problems/symptoms scale. There was also a trend for those living alone to score higher on the life functioning scale. These two results contributed to a significant difference on the overall measure.

A significantly higher proportion of people living alone also scored above the clinical cut-off for life functioning and there were non-significant trends

for people living on their own to score higher on problems/symptoms and risk to self or others. These results contributed to a significantly higher overall score for people living alone.

The six participants living in service accommodation had lower scores than those living in their own home for wellbeing and life functioning but higher scores for problems/ symptoms. Mean scores for risk to self or others were considerably lower for this group and only two people scored above the cut off point for clinical significance on the risk scale. Four people scored above the cut off for wellbeing and five scored above the cut off for life functioning and problems/symptoms. Five scored above the clinically significant cut off point over the whole measure.

Education and occupational activity

Differences in CORE scores relating to educational qualifications were again small and non-significant. However, 76% of participants with university level qualifications did score over the cut off for clinical significance, compared with 56% of those with vocational or no formal qualifications.

Occupationally active participants scored significantly better on the wellbeing scale of the CORE and there were indications of trends towards better scores on the overall measure.

Social inclusion results

Higher scores on the social inclusion measure indicate higher levels of inclusion. Participants' mean scores on all three scales were below the mid point, particularly for social relations. On the overall measure, mean scores were 0.4 points below the mid point suggesting that most people felt excluded to some extent from ordinary life.

Gender, age and ethnicity

On all three scales, men scored slightly lower than women. The differences were not statistically significant, but there was a trend towards significance for social relations.

There were no statistically significant differences between age groups. People aged 46-55 reported the highest overall levels of inclusion, although their scores were only marginally higher than those of the youngest age group. When we compared two equal sized groups (19-45 years and 46 years

or older), there were no significant differences between the groups.

There were also no statistically significant differences relating to ethnicity.

Mental health

There were no significant differences between the scores of people describing each of the five types of mental health difficulty.

The 34 frequent and regular service users had significantly lower overall scores than other participants. They also scored lower on the social relations scale and this difference came close to reaching statistical significance.

Living circumstances

People living alone in their own home had significantly lower scores for social isolation and social acceptance. The difference in overall scores was also highly significant.

The scores of the six people living in service accommodation were marginally lower than those of people living in the community.

Education and occupational activity

As on the other measures, participants' level of education had little impact on their mean social inclusion scores and there were no statistically significant differences, although those with university level qualifications scored slightly lower overall.

Participants who were occupationally active had significantly higher scores for social relations than participants who were not occupied, but there were no differences for social isolation or social acceptance.

Relationships between scores on the three measures

There was a clear correlation between scores on the three measures. This was clearest for the relationship between mental health, as measured by the CORE, and empowerment. As scores on the CORE increased (i.e. worsened) feelings of empowerment decreased. Social inclusion also decreased overall as scores for mental health and empowerment worsened, but the social inclusion scores of some people with poor mental health as measured by the CORE were nevertheless relatively high. Conversely, the social inclusion scores of some people with higher levels of empowerment were relatively low.

6. Follow up outcomes study

Introduction

The outcomes study was designed to ascertain the extent of any change amongst participants who had completed a baseline questionnaire. A further important question concerned the extent to which positive change could be attributed to arts participation.

To address these questions, a follow up questionnaire was sent to all 88 participants in the baseline study around six months after they had returned the baseline questionnaire. The follow up version included the same standardised measures used for the baseline study (the empowerment, CORE and social inclusion measures), together with the same measures of medication and service use, living circumstances and occupational activity. Additional questions at follow up asked participants how long and how frequently they had been involved with their project, whether their involvement in arts had extended beyond their project, and to rate aspects of their experience of arts participation (enjoyment, pride and learning). At the end of the questionnaire they were also asked about any new stress in the

previous few weeks that might have had an impact on their response to the preceding questions.

Since establishing a control group was not possible in the context of a naturalistic study, we needed to find another way of assessing whether any change after six months could be attributed to arts participation. Further questions at the end of each of the measures therefore asked participants to rate the impact of their involvement with their project in relation to the issues addressed using a four-point scale (a lot, a little, not at all, unsure). Space was left for any additional comments and explanations participants wished to add.

To check whether participants who completed the follow up questionnaire differed from the baseline sample in some way that might bias the results, we compared the two groups in terms of the geographical location of their projects and their age, gender, ethnicity, mental health difficulties and educational level. We also compared their baseline scores on the three standardised measures.

To assess overall change on each of the three standardised measures between baseline and follow up, we compared mean scores for each measure and scale at time 1 and time 2 using a paired samples t-test. Since differences in the extent of change within different groups of participants were also potentially important, we performed repeated measures factorial analyses of variance for each measure. Dependent variables were scores on each measure as a whole. Independent variables were the groups of participants shown in Box 1.

Including the arts participation variables shown in Box 1 in the analyses of variance yielded some information about the extent to which changes could be attributed to arts participation. However, this within-group comparison of mean scores was not in itself sufficient and we therefore carried out two further statistical analyses:

1. We used a block entry multiple regression to identify what predicted change in overall mean scores on the measures. In addition to the three blocks of variables shown in Box 1, this analysis included participants' time 1 scores on the measures, as these could be expected to predict a proportion of the change.

2. We also examined the extent of correlation between individual participants' ratings of the impact of their involvement in arts and actual changes in their individual scores on each of the three measures.

Box 1 Sub group categories and classifications

Participant characteristics and circumstances
Demographic variables (gender, age and ethnicity) **Occupational activity (doing paid and/or voluntary work at baseline)** **Living circumstances (living alone or with other people at baseline)** **Educational qualifications**
Mental health and service use
Type of mental health difficulty **Clinical significance on the CORE at baseline** **Reported new stress at follow up** **Frequent and regular service use** **Change in medication** **Change in use of primary care services** **Change in use of mental health services** **Change in use of voluntary sector and other services**
Arts participation
Ratings of the enjoyment, pride and learning gained from arts participation **Extent of arts participation** **Prior expectations of arts participation** **Participants' ratings of the impact of arts participation** **Participants' reports of further involvement in arts outside their project**

Participants' open ended responses were analysed thematically in four stages: reading through all responses to each question; devising provisional categories to describe the responses and coding them within categories; refining the categories and recoding them; and synthesising categories where this was meaningful. For clarity, only the results of direct relevance to the outcomes analysis are reported here.

Results

Sixty two people (70%) from 20 projects returned a follow up questionnaire. There were no significant differences between the baseline and follow up samples in terms of background characteristics and other variables, or in terms of scores on the measures at baseline. This suggests the follow up sample was representative of participants who completed a baseline questionnaire.

Arts participation

In keeping with the Phase 1 survey data indicating that projects offered a wide range of art forms, participants in the outcomes study reported taking part in a wide range of activities. These are categorised in Table 6.1, with selected examples from participants' responses. Most participants reported at least two activities and several reported as many as six or seven.

Table 6.1 Participants' arts activities

Type of activity	Number of participants
Fine art e.g. painting, drawing, sculpture	**52**
Decorative design and handicraft e.g. ceramics, textiles, mosaics	**39**
Performance arts e.g. drama, dance, music	**15**
Creative writing e.g. story writing, poetry	**13**
Other (photography, animation)	**12**

Over three quarters of participants (79%) were still involved in their project after six months. Forty two (68%) had participated in their project for up to four hours a week, while 20 (32%) had participated for five or more hours per week. This information enabled us to compare the outcomes of a 'lower participation' group with those of a 'higher participation' group.

Sixty-one participants responded to the question about enjoyment of their arts involvement and all 62 responded to the other three questions asking them to rate their pride in their work and their learning/skills development. The great majority of participants enjoyed being involved with their project 'a lot' and no one reported not enjoying it at all. A slightly smaller proportion, but still between two thirds and three quarters, reported 'a lot' of pride in their creative activity and felt they had learnt a lot. Where skills development was concerned, views were more evenly divided between those who felt

their skills had developed a lot and a little.

In order to examine the effect of reported enjoyment, pride and learning on outcomes, we allocated a 'positive experience' point to responses of 'a lot' to any of the four questions. We then compared the outcomes for 37 participants (60%) who gave three or more responses of 'a lot' with those of 25 participants (40%) who gave fewer than three responses of 'a lot'.

One person did not respond to the question about further involvement in art. Of the other 61 participants, only ten (16%) indicated they had not developed their involvement further. Nine explained their only interest had been in their project, two adding that they did not want to get more involved. The tenth explained that although he had not become more involved in arts, he did want to develop a career related to mental health such as counselling or befriending.

The majority of participants (51, 82%) indicated that they had become more involved in art in at least one of five ways suggested on the questionnaire. Thirty four people (56%) had developed their involvement in just one or two ways, most commonly buying arts materials for their own use, while 17 (29%) had expanded their interest in a wider variety of ways. For our sub group analysis we compared participants who reported no further involvement with those reporting one or two further activities and those reporting three or more, in order to understand whether this had any bearing on changes on the three standardised measures.

Empowerment results

Mean scores improved significantly across the whole sample on the empowerment measure as a whole and on individual scales measuring self efficacy and positive outlook. Improvements in self worth scores were also close to statistical significance. There was very little difference in mutual aid scores but the baseline scores had been at quite a high level already.

There were no statistically significant differences relating to participants' characteristics or circumstances. However, analysis of the mental health and arts participation variables found three significant differences:

1. The empowerment scores of participants who had scored above the cut off for clinical significance on the CORE at baseline improved more compared with those scoring below the cut off at baseline.

2. The scores of participants who did not identify a new stress in their lives at follow up improved more compared with those who did identify a new stress.

3. The scores of participants who rated the impact of arts participation very positively improved more than those of other participants.

CORE results

Mean scores improved significantly across the whole sample on the measure as a whole and on individual scales measuring problems/symptoms and wellbeing. Improvements for risk to self or others and life functioning were close to significance and could be important. The proportion of participants scoring above the cut off point for clinical significance on the overall measure also decreased significantly, from 63% at baseline to 50% at follow up.

There were no statistically significant differences relating to participants' characteristics and circumstances, or to any of the arts participation variables. The analysis of mental health variables did find three significant differences:

1. The scores of participants who had scored above the cut off for clinical significance at baseline improved more compared with those scoring below the cut off at baseline.

2. The scores of participants reporting a new stress at follow up deteriorated slightly by 2%, compared with an improvement of 40% for participants who reported no new stress.

3. Improvements for participants whose use of mental health services decreased were significantly greater than for those whose service use increased or did not change.

Social inclusion results

Mean scores increased significantly across the whole sample on the whole measure and on all three individual scales.

There were again no differences relating to participants' characteristics or circumstances. There were also no differences relating to any of the mental health or service use variables examined. The only significant difference found within groups related to participants' ratings of the impact of arts participation, where the scores of those who gave very positive ratings increased by 7%, compared with a decrease of 2% amongst other participants.

Medication and service use

At follow up, the proportion of participants who were frequent and regular service users decreased significantly from 31% to 18%. However, there was no evidence from participants' impact ratings that this was related to

arts participation and use of three specific types of service (primary care, mental health and voluntary sector/other services) did not change significantly. Use of overnight stays in hospital and crisis centres did decrease significantly, but again participants did not attribute this to arts participation. Medication use was unchanged and there were no significant differences within groups.

Occupational activity and education

There were no significant differences in the proportion of participants doing paid and/or voluntary work. Average hours paid work per week decreased from 19 hours at baseline to 15 hours at follow up, mainly due to retirement. The difference was non-significant, but the numbers in paid work were rather low for statistical analysis. Average hours of voluntary work remained stable at five hours per week.

Unsurprisingly, given the six month follow up period, no one reported gaining formal educational qualifications, but seven people indicated that they had completed or were close to completing classes in computing, English or creative writing, and one person was studying poetry and philosophy on her own. Of 56 people who responded to questions about current courses and future plans, eight were currently working towards a qualification and ten were planning to do so.

Sixty people responded to a question about whether they thought their involvement with their arts project had improved their employment and education opportunities. Responses were almost evenly divided between those who thought it had (21, 35%), those who thought it had not (20, 33%) and those who were unsure (19, 32%). Three participants who thought their arts involvement had improved their opportunities added comments indicating that they had actually gained employment and a fourth had started college.

Regression analysis results

The aim of the regression analysis was to develop indicative models that might explain the greatest amount of improvement in scores on the three measures with the smallest possible number of variables (model fit). The analysis can only be seen as exploratory because our sample size was too small to enter each variable into the analysis in the stepwise process recommended. As a compromise, we entered the variables in three blocks, as shown in Box 1 (page 41) but this process is not so robust and a larger sample would be required to draw firm conclusions.

Our exploratory findings were:

1. Improvements on the empowerment measure were predicted by:
   - Participants' empowerment scores at baseline
   - Positive ratings of arts participation impact at follow up.

2. Improvements on the CORE were predicted by:
   - Participants' CORE scores at baseline
   - No new reported stress at follow up
   - Positive ratings of arts participation impact at follow up.

3. Improvements on the social inclusion measure were predicted by:
   - Participants' social inclusion scores at baseline
   - Changes in voluntary sector/other service use
   - No new reported stress at follow up
   - Positive ratings of arts participation impact at follow up.

The variables identified predicted 52% of the improvement in empowerment scores, 43% of the improvement in CORE scores and 30% of the improvement in social inclusion scores.

Taking into account the number of variables found to predict improvement on each measure and the proportion of improvement they predicted, these results suggest that arts participation contributed significantly to the improvement in scores. The contribution was considerable for empowerment and moderate for the CORE. Although still significant, the contribution was smaller for social inclusion, where it appeared that unmeasured variables contributed more to the improvement in scores.

Correlation analysis results

Whereas the regression analysis focused on what best predicted change in overall mean scores on the measures, the correlation analysis focused on whether participants' ratings of the impact of their involvement in arts correlated with changes in their own individual scores. The results indicated that:

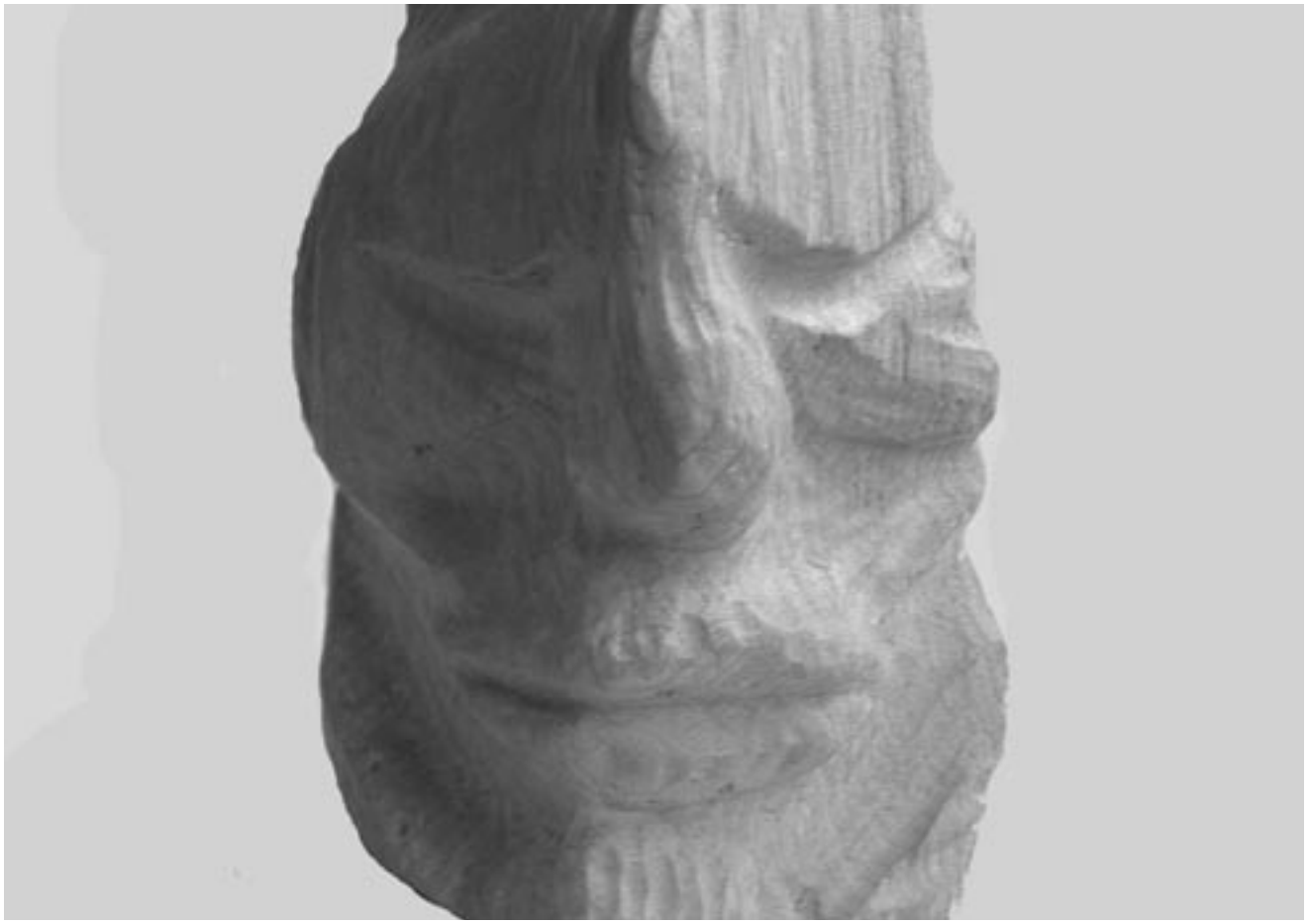
1. There was a significant relationship between participants' ratings of the impact of arts participation and improvement in their empowerment scores.

2. There was no significant relationship between participants' ratings of the impact of arts participation and improvement in their CORE and social inclusion scores.

We consider the implications of the results reported here in the final section of the report, drawing also on the evidence from the case studies reported in the following section.

7. Case studies

exploring the processes, benefits and outcomes of arts participation



Introduction

The final strand of work carried out for this study was a series of in-depth case studies with workers and participants from six projects. The aim was to complement the quantitative strands of the research by exploring the ways in which arts and mental health projects achieve benefits for their participants. The six projects were chosen to reflect a diverse range in terms of location, target group and working methods.

We based the case studies broadly on a 'theories of change' approach to project evaluation. This can be described as developing theory to explain how initiatives work through a systematic and cumulative study of the links between their activities, outcomes and contexts (Weiss 1995).

The case studies were carried out in two stages. In the first stage two members of the research team facilitated six workshops with representatives from each of the projects exploring how projects facilitated benefits – their

'theories of change'. For the second stage we asked each project to invite around six participants to take part in an in-depth interview, basing their selection on obtaining a reasonably representative range of participants and ensuring that they had been involved with their project for sufficient time to benefit. Projects usually identified a minimum period of six months for participants to have benefited. The interviews lasted about an hour and covered participants' expectations of their project, what they saw as the benefits and how these had come about. A total of 34 interviews were included in the analysis.

Overview of projects and participants

The six projects included a mixture of urban/city and rural/town locations. Three of the projects were based in the south of England, two in the north and one in the midlands. A thumbnail sketch of the projects and interview participants is provided below.

Stockport Arts on Prescription (AoP)

Context
The project is located within a health promotion service funded by the Primary Care Trust. It is aimed at people with mild to moderate mental health needs. Most participants are women over 30 years old. The project provides activities in an art room in a local community centre.

Workers and working methods
The project employs two sessional artists who teach painting and drawing skills and techniques, and a part time mental health worker who co-ordinates the project and offers support to individual participants. A 15 week basic skills course is followed by a further more advanced 15 week course. Participants who have completed both can join a self managed 'move on' group to which support is offered by the mental health worker.

Interview participants
Five women and one man aged between 45 and 63 years who described their mental health difficulties as depression and/or anxiety. Most had used the project for between four months and a year.

Studio Upstairs, Bristol (StUp)

Context
The project is located in an open art studio space within a wider area of urban regeneration. It is aimed at people with severe and enduring mental health needs, or drug and alcohol related difficulties.

Workers and working methods
The project employs part time practising artists, who are also trained as art therapists, as well as volunteers and students. They use a combination of art education and therapeutic community practice. Activities usually involve visual arts but also include creative writing and poetry. The project supports participants to exhibit their art work in a variety of settings and to develop their own independent art practice.

Interview participants
Three men and three women aged 35 to 45 who had experienced a wide range of long term, serious mental health issues often related to experiences of past abuse. They had been using the project for between seven months and five years.

Borderland Voices, Staffordshire (BV)

Context
The project is located in a small town in a former shop rented from the local council. It is aimed at a wide range of people, including mental health service users, older people and other vulnerable and marginalised groups who may be at risk of mental ill health. Many participants live in villages and isolated rural areas. The majority are women.

Workers and working methods
The project employs local artists, often with personal experience of the importance of art in recovery, to facilitate workshops and projects. Activities take place in the town and in surrounding rural areas as well as at the project's premises. They include visual arts, crafts, writing, drama, music and dance.

Interview participants
Four women and one man aged between 23 and 63 with complex, long-term and serious mental health problems. Many were socially isolated due to the rural location in which they lived, but also due to mental health issues and family circumstances.

Roshni Ghar, West Yorkshire (RG)

Context
The project is located in Keighley, a former mill town in West Yorkshire. It is part of an Asian women's mental health organisation which provides a range of culturally relevant opportunities for Asian women to gain support from each other. Most of the women who attend the art project are over 30 years old and have a range of mental health needs. The majority do not speak English as their first language and many spend most of their time looking after family members.

Workers and working methods
The project employs project workers augmented by sessional arts workers from Kala Sangam, a local arts and health organisation. Art is one of a range of activities offered at the centre, which also include outings, cooking and massage. Arts activities include Islamic arts, silk printing and crafts that are often part of the women's culture and religion and are therefore seen as acceptable within their communities.

Interview participants
Five women aged between 36 and 55, four interviewed with the aid of an interpreter. All the women described profound social isolation alongside significant family pressures and caring responsibilities, and all had experienced depression over several years. Most had used the project for at least three years.

Mind Day Centre, Worthing and Littlehampton (MDC)

Context
The project is located within an activity focused day centre, run as one aspect of the work of the local Mind organisation. The project engages people through creative activities, providing a structure for developing social interaction with others. It is aimed at all adults with severe mental health needs, including people over 65. Most are aged over 40 years.

Workers and working methods
The project employs two full time and two part time mental health workers who also have skills in arts and crafts. Art is part of a range of activities offered. Participants are supported to try out different arts and crafts activities and develop personal projects. Outings are organised to exhibitions, galleries and other places relevant to participants' current activities.

Interview participants
Three women and three men aged 38 to 78 with a wide range of mental health problems. All used secondary mental health services and most had been involved with the project for at least three years.

Centre for Foundation Studies, Cornwall College (CFS)

Context
The project is located in the town of Camborne within Cornwall College, a further and higher education institution. It offers flexible arts based courses for people with mental health needs at the college and in local mental health facilities, including an acute in-patient unit. The aims are to enable people to adapt to or overcome difficulties that inhibit learning, to help them to achieve their potential and to provide access to further and adult education. Students are adults of working age with severe and enduring mental health needs. Slightly more are male than female.

Workers and working methods
Teaching staff are provided by the college. Informal and flexible learning methods are adapted specifically for people with mental health needs. Classes comprise between six and 12 students. Provision involves teaching art skills and a wide range of creative opportunities with a variety of art forms and media. There is a focus on producing high standards of artwork and opportunities are sought for students to exhibit and sell their work.

Interview participants
Two men and four women aged between 35 and 59. All had recently experienced severe mental health problems and most had been using the project for less than a year.

Data analysis

We were not able to elucidate generic understandings of arts projects' 'theories of change' due to the varied nature of the projects and because the workshop data suggested that project

workers had a wide range of complex understandings of how their project benefited participants. We therefore developed ways of explaining how projects benefited participants by looking at the ways in which participants themselves described these changes. We worked across the interview data from all six projects to develop an explanatory account of 'what worked' for participants, how this happened and the outcomes that resulted. After much refining, we identified eight distinct, but interrelated, processes that appeared important in achieving change. Processes were viewed as the different means through which participants were able to use the opportunities to engage in arts activities provided by the projects to achieve change.

The processes identified do not exist in isolation from each other but are interdependent, and need to be viewed in relation to the projects' work as a whole. The importance of the eight processes varied across projects, depending on the projects' context, the participants they aimed to reach and their particular approach. To take account of this, we weighted the frequency with which particular processes were highlighted by participants and the importance they accorded them. In weighting frequency, we considered whether there appeared to be general evidence across projects for the processes described or whether the evidence was particularly strong in some projects. We assessed importance to participants in terms of:

- The vividness of their description of different processes, since the more vivid and animated the participant became while discussing a process the more likely it was of specific importance to them
- The extent to which participants specifically linked individual processes to benefits.

Based on this weighting we divided the processes identified into three categories:

1. Processes that were commonly reported across all projects and were viewed by most participants as being very important in achieving benefits.
2. Processes that were seen to be very important in achieving benefits by most participants in some projects.
3. Processes that were reported across all projects and viewed by some participants as being important in achieving benefits.

The three groups of processes are presented in turn below. Where possible we highlight which participants seemed to benefit, and draw out the outcomes of each process in relation to mental wellbeing, decreased mental distress and combating social exclusion.

Processes that were very important across all projects

Three processes were described as very

important by the majority of participants across the six projects:

- Getting motivated
- Focusing
- Connecting with others.

Getting motivated

It helps that creative bit and that motivation bit, because the motivation with depression is obviously another symptom…It's given me something to motivate me, to a better quality of life than just being ill. (MDC5)

There was substantial evidence that the creative opportunities provided for participants increased motivation. The outcomes described by the majority of participants related to mental wellbeing and many also described outcomes associated with decreasing mental distress.

Participants linked increased motivation to developing inspiration and pride in their art work. This seemed to give a renewed sense of purpose and meaning in their lives:

I feel when I come that I have got some purpose... Coming here gives me impetus to make the rest of my time more important. (CFS1)

For many participants, increased motivation enhanced their ability to engage in other aspects of their lives. For example, some had been able to turn art into an activity that they could pursue outside their project.

Significantly, a number of participants made explicit links between increased motivation and decreased mental distress, especially lessened depression:

It's an ignition, it's a spark…What happens is when they've ignited me a little bit here I go home and I stay on that creation. If you are creating things you don't get depressed. (BV2)

For some this had a direct impact in terms of combating feelings of hopelessness. Regaining hope is often seen as a crucial aspect of an individual's recovery journey and this was therefore a further potentially important outcome in relation to decreasing mental distress. As a vivid example, at Studio Upstairs all six participants enthusiastically described their growing motivation to develop their art work, which was the more striking as they had all spoken of how pessimistic they had been before they started attending the project:

It's actually given me back in my life some ambition to do something. Which is something that had been absent for a very long time. (StUp3)

Focusing

The one thing I can say about art, as opposed to other things, it starts this mystical, magical quality, or it seems like it has, it draws you into it, it absorbs you like nothing else. It does me anyway. (BV6)

There was substantial evidence that in attending arts projects, participants were able to develop a

focus on arts activity and that this had a wide range of mental health benefits. Being able to concentrate on something absorbing outside of themselves enhanced their ability to relax and provided them with a way of dealing with, or a distraction from, their mental health difficulties. By focusing in this way they found ways to alleviate some of the emotions associated with their difficulties, thereby decreasing distress and promoting wellbeing. For example, focusing on art was particularly highly valued by the six participants at Arts on Prescription, all of whom had relatively recent experiences of depression and/or anxiety following difficult life events and circumstances:

It's just blocking your mind so that the thoughts don't come in…If I was to say what my problem was it's negative thoughts coming in and them getting hold…it's getting your mind to focus on the outer world and distracting. Those pain and troubles might still be there, they might always be there, but it's feeling you can do something to help. (AoP2)

In addition, a few participants across different projects described how concentrating on art helped reduce the distressing impact of voices or visions:

Doing it keeps me active more than anything…It's something to do because sometimes the pressure and power in my head gets too much and I find myself pacing …It takes the edge off any bad visions and leaves me to concentrate on the pleasurable side of things… Without it I would be lying in front of the TV crying and drinking cider, with pain in my head, pacing. (CFS5)

A number of participants also reported that their focus on art had a positive impact in relation to their self harm. For example, one participant was able to use art at home to help him cope with the distress of hearing voices, which in the past he had coped with through self harm:

I used to be distracted by voices. Even though I was on medication to stop it sometimes they'd still come through and distract my days or bring me just right down to the point where I'd cut [myself]. Now, as a distraction, if I feel I'm getting like that, I'll try and draw what I'm feeling on paper so that I can actually visualise it and see it, and then I'll set fire to it and then I've got rid of it. (MDC2)

Most participants saw focusing on art as giving them a break from their mental health difficulties whilst at their project. For some people, that effect lasted beyond the art sessions themselves. This was linked for several people with the 'portability' of their art and was particularly the case for people who were beginning to use art at home:

I do it at home as well and I've got something to do to keep my mind off one thing and another [otherwise] I'd be sitting thinking and getting more and more depressed. (BV6)

A less common but important outcome of the relaxing effect of focusing on art was described by a few participants who were able to reduce their medication:

If you have anxiety you are tight in your body…in a relaxed mental state you can manage your pain and put less pills in. (BV2)

In relation to enhancing mental wellbeing, a number of participants reported that focusing on art could result in improved concentration and kept their minds active, qualities often adversely affected by mental health problems and the use of medication.

Connecting with others

It's taught me a lot that I can interact with people… I've had friends and family saying to me that they've seen the differences. I'm responding to the world differently…I wouldn't have touched a course in the community, it's still a barrier to me but I'm making the circle bigger so it's positive… it's making the safety zone bigger. (BV5)

There was considerable evidence that projects enabled participants to connect with others and that this stimulated social interaction, which in turn decreased social isolation and increased confidence. It was difficult to discern the extent to which these benefits could be specifically attributed to arts participation rather than just being part of a supportive mental health project. However, there was some evidence that participants were able to use art as a way to facilitate communication, since it was often through learning together and discussion about each other's art work that social interaction occurred.

Participants spoke of the value of projects providing a supportive and non-competitive environment in which they could practice or develop art skills at their own pace. Almost all of the participants thought it important that the project was specifically mental health focused, because it was felt that the experience of mental health problems created a 'common bond' and usually made people more sensitive to others.

Many participants contrasted the safe, non-judgmental environment provided by their project with their perceptions of more formal art education courses. For these participants, small numbers, a lack of pressure and being able to work at their own pace, was the key difference. Unsurprisingly, project workers played a central part in creating a sense of safety.

While few participants reported developing new relationships outside their project, their growing sense of self worth meant many felt more confident about developing relationships with others. This was often made possible through shared interests in learning or developing their art work:

I just needed to go somewhere where I could do an activity that I enjoyed and be supported

in that, and just build up my confidence in order to be able to make friends, and sort of take those friendships outside of the studio, which is what's happened over the years...initial conversation is usually around people's art work. (StUp3)

A number of participants described how their involvement in their arts project had helped combat a profound social isolation and loneliness that often accompanied their mental health difficulties. In particular, participants at Roshni Ghar described experiencing extreme isolation, and talking and learning with other women who had similar problems was especially important to them in alleviating depression.

Processes that were very important at some projects

Although they were not described across all projects, the following processes were seen as very important in achieving benefits at some projects:

- Self expression
- Connecting with abilities
- Having time out.

Self expression

I quite like the art because it's a good way of expressing yourself…I think it helps…I can draw things, sometimes, what you fear in your mind, you can express in your paintings… I think that's a good thing too. (MDC6)

For many participants, art provided a means of self expression which could alleviate mental distress. It also helped some participants begin to tackle social exclusion through self acceptance and increased communication. The process varied in importance for participants across projects. For example, it was of central importance to all six participants at Studio Upstairs and of less importance to participants at Arts on Prescription or Roshni Ghar. Self expression seemed to be particularly beneficial for individuals who were experiencing complex mental health issues, people who were struggling with difficult past experiences (such as abuse and bullying) and especially people who self harmed. For these participants, the self expression facilitated by their arts project was in sharp contrast to experiences of repression or feeling controlled by others.

There was clear evidence from participants, particularly those at Studio Upstairs, that the self expression afforded by art enabled them to re-channel emotions associated with their mental health difficulties and evolve a different relationship with feelings or memories that could make these more bearable:

Doing my artwork actually means that I clear out enough stuff inside me to actually then be able to maybe have something else. (StUp6)

Self expression most commonly alleviated feelings associated with self harm. Many participants talked about

how art enabled them to 'externalise' their feelings onto their art work rather than taking it out on themselves:

It's a lot safer, a lot better, and more satisfying… rather than directing it at yourself you're directing it onto something else…It's helped me a lot because I haven't self harmed now in a good two to three years... before that I was doing it quite often…most weeks. (StUp4)

Self expression was also implicated in reducing medication, alleviating depression, coping with suicidal feelings and dealing with voices and visions:

I use art as a creative outlet for anything I might see or any visions I might have. Those can be either from dreams or from day time…Our imagination has just been given free reign so, if I have a vision like that, I can put it straight into my artwork, so a lot of the things I am seeing or experiencing are coming out in my painting …So I have found it easier to deal with the things I'm seeing… It has given me an emotional visualistic and creative outlet…It takes the edge off any bad visions. (CFS5)

The centrality of this process for participants at Studio Upstairs was related to the high levels of emotional support offered at the project and also to the libertarian environment, where there was acceptance of emotional disturbance and the active exploration of distress through art. In expressing themselves in this way participants began to value the art they created, and the person who created it. This was a further important facet of art as self expression in that it enabled them to begin to discover and accept themselves for who they were, a benefit also described at other projects:

It doesn't matter if your leaf or a flower doesn't look like a leaf or a flower, it's your leaf and your flower and it's your expression of what's inside you… We can all get better by truly saying to ourselves, 'well this is where I am, this is what I've been through, this is where I'll start and I can do something with my life'. (AoP2)

The self expression involved in art work also enabled participants to connect with others by making themselves and their experiences visible. This had important consequences for combating feelings of exclusion by enabling people to be seen differently and accepted by others:

People see me differently – a flamboyant character, and I think that was a compliment…There's parts of me I didn't know were there but other people are noticing it. (BV6)

For a number of participants self acceptance was closely bound up with their development as an artist:

My own means of painting and expression has been incredibly

important …accepting that I do paint in this style…and alongside that has gone my acceptance of myself. (StUp1)

Connecting with abilities

It's opened my eyes to my abilities and the fact that there's more out there to learn and it's been very inspiring. (MDC5)

There was evidence that learning something new at their arts projects helped many participants to connect with their latent abilities. This gave feelings of pride and satisfaction and enabled them to feel worthwhile, thus improving mental wellbeing. In turn, this challenged negative self images often associated with mental health difficulties and had some impact on decreasing distress.

Projects enabled participants to connect with their abilities in two ways, either by focusing on learning new art skills or by providing a range of activities, including, but not exclusively, art related activities.

This process seemed particularly important for participants who had little or no experience of art before joining their project and who were therefore able to gain specific benefits from connecting with abilities or potential they had not realised they had. Participants at Arts on Prescription and Roshni Ghar in particular recalled how learning new techniques had helped them feel more worthwhile and capable:

It's all about learning something new, it helps you feel better about yourself and who you are. I would say the most important thing is about self satisfaction. (RG7)

Participants at the Mind Day Centre and Roshni Ghar appreciated the range of different activities (including art), which encouraged them to connect with their abilities by learning new skills and led to an increased interest in other pursuits. While it was often the range of activities that was important at these projects, there was also an important art specific element that stemmed from the sensory and visual 'feel' of learning art. This seemed to enhance participants' awareness of their surroundings and was especially important for participants at Arts on Prescription, where the focus was on teaching participants to access different abilities through learning basic art skills. Several participants explained that the classes had enabled them to 'see the world differently' by increasing their perception and appreciation of colour and texture. This awareness of colour often transferred to a greater pleasure in their surroundings outside the project.

Although connecting with perceptual abilities was rarely linked explicitly with reducing mental distress, a few participants did suggest the process could help alleviate depression by enabling them to develop a broader perspective:

One of the things about anxiety and depression is your mind is closed to the

world. So you can see a scene that other people might say is wonderful but you're not really looking at it…but I've learned to really look at things. (AoP2)

Several participants also described how connecting with their abilities had challenged negative thoughts they held about being 'useless' or 'incapable', which often resulted from the stigma attached to having long term mental health problems.

Having time out

We don't do anything for ourselves and when we did this, it's like a different feeling, that I have done something for myself. [It's] like leaving everybody behind, the children, husband, everything, so it's just for myself. (RG1)

For some people, arts participation provided a space away from pressure in their lives, giving them valuable 'time out' which enabled them to cope better with stressful situations, alleviating distress and contributing to wellbeing. Although this might seem little different from the breathing space provided by other types of mental health project, there was some evidence that doing art itself provided time out.

The process was similar to focusing on art, but merited separate consideration because it came into play in specific contexts. These related partly to pressures in participants' current lives and to projects offering time-limited and contained art sessions that participants could fit into busy lives. In addition, time out seemed especially important for women who were experiencing anxiety and/or depression and for those who had ongoing caring responsibilities. It was particularly important at Arts on Prescription and Roshni Ghar. For these women, arts participation provided a valuable time during which they could forget about the stresses in their lives:

I think it's because my life is so restricted now… Because I feel like my life is controlled through no fault of my own, so much that to suddenly have that freedom, it just released something inside of me... That two hours is quite a long time for me you know…I think the most important thing is it made me forget. (AoP4)

Although time out was most important at the two projects cited, it was also important for some women at other projects. There was some evidence that time out, combined with the benefits of focusing on art, relieved pressure on some women in their families, making them less irritable with family members at home. As is evident from the above description, this was clearly important for their mental wellbeing.

Processes that were important for some participants at all projects

Two processes were described across all six projects, but emerged as

important for the benefits that ensued from the accounts of only some participants at each project:

- Rebuilding identities
- Expanding horizons.

Both were closely related to processes described above, but were sufficiently distinctive to be separated out and explored in their own right.

Rebuilding identities

Oh yeah and furthermore I am an artist! (StUp2)

Arts participation was related for some participants at all projects with the process of rediscovering or rebuilding an identity beyond that of someone with mental health difficulties – again an important element of the journey towards recovery. Because building identities is in large part a social process, involving internalisation of the perceptions of others (Howarth, 2003), the process was especially associated with opportunities to create and display art work. This had an important impact on combating exclusion and for some was also implicated in helping to alleviate distress.

Three aspects of the process emerged from the interviews. Firstly, creating a finished work of art made participants' achievements visible to themselves, enabling them to see themselves as someone who could achieve something. This was a consistent theme at most projects. Secondly, participants at some projects described how creating art work had led to other people viewing them differently, enhancing their self esteem and enabling them to see themselves differently:

I showed my children… my children were really pleased…they are so happy now, they are telling mothers that our mum is the greatest. (RG1)

Thirdly, some participants described an even more profound change. Eight participants, including three who also spoke of other people seeing them differently, described how producing works of art had contributed to a new or alternative sense of themselves as artists, challenging their identity as defined by their mental ill-health. These participants tended to be people who were long term service users with a range of complex and serious mental health difficulties, in other words people whose identities were likely to have been especially compromised by the experience of mental health difficulties. They usually had a previous interest and involvement in art and through participation in their arts project were able to return to those interests and make them central to their sense of self.

Building a new, artistic identity for presentation to others was especially important for some participants, given a social context in which we are so often defined by the work we do:

If people ask me what I do, I don't say 'oh I'm

mentally ill, I go to a day centre', I can say 'well, I do art, I practice art'. (MDC3)

In keeping with the project's emphasis on members' artistic development, finding a renewed identity as an artist was a particularly strong theme at Studio Upstairs. A number of participants in other projects also went on to make explicit links between this kind of realignment of self image and decreasing mental distress. For example:

I was always attempting suicide and stuff like that because I hated myself so much whereas now that doesn't happen because I've found something that I actually enjoy doing and that I get feedback from. (MDC2)

Expanding horizons

This art project I must admit has inspired me to think that perhaps I could do something in textiles or things like that. It does spur you on to consider that. (MDC5)

For participants across all projects, arts participation had expanded their horizons, enabling many to widen their aspirations. A few had already taken up new opportunities as a result. Widening aspirations emerged as important for mental wellbeing and taking up new opportunities as important in combating social exclusion.

The aspirations described by participants revolved around the world of art, work and education. Six participants specifically referred to aspirations to develop their art to a higher level, by becoming a professional artist, exhibiting and/or selling their work. Other participants spoke of wanting to engage in further education, in art or other subjects, as a result of attending their arts project. Not surprisingly, this was particularly significant at Cornwall College:

Before this I wouldn't have even dreamed about doing like any other qualifications whereas now I would really like to go and do the HND which but I know I will really struggle…I would like to continue, definitely, whereas before I would never have dreamt of doing it. (CFS3)

Across all projects, eight participants were hoping to obtain paid work in the future and attributed this in large part to the impact of their arts participation:

Gradually, it's through this, I'm starting to get back into the big wide world again. I don't find it so scary... I don't know what it is, it gives you something. It gives you a reason to get up on the morning, it makes you think, 'well if I can do this two days a week, maybe I can do a job'. (StUp2)

In terms of actually taking up new opportunities, none of the participants reported taking up paid work as a result of their arts participation, but five people from different projects had starting doing voluntary work outside their project. Another five, again from different projects, had developed their art

work and had either had exhibitions outside their arts project or sold some of their work. All of these participants clearly related this to the impact of the project:

I have got to admit this place has made a hell of a big difference… I wouldn't be doing the voluntary work that I do at the moment. And there are a number of other things I am looking into working on at the moment… I don't think I would have been able to move on to those things if I hadn't have come here. (StUp5)

The location of the Centre for Foundation Studies within a mainstream college setting was important in enabling participants to gain access to other learning opportunities and resources, in addition to the opportunities to exhibit and sell their work. Other participants had also begun to access art related facilities or heritage sites in the community:

Now I actually can go over to galleries in Brighton and talk to artists there to find out what their inspirations are and everything which I wouldn't have dreamt of doing years ago but now I feel confident enough in my art to actually be able to go and do that. Whereas when I first came here I couldn't do that at all. (MDC2)

Summary of processes, benefits and outcomes

Table 7.1 lists the key processes identified, the activities and contexts that set these processes in motion and their benefits and outcomes. In the table, outcomes reported by most participants for whom a process was important are termed primary outcomes, while outcomes reported by smaller numbers of participants are described as secondary outcomes.

Table 7.1 Processes, benefits and outcomes

Process	Activities and Contexts	Benefits	Outcomes
Getting motivated	Important in all project contexts	Inspiration, purpose meaning and hope Engagement with other aspects of life Reduced inactivity	Primary: Mental wellbeing Secondary: Decreasing distress
Focusing	Important in all project contexts	Relaxation Concentration Distraction	Primary: Decreasing distress Secondary: Mental wellbeing
Connecting with others	Important in all project contexts Mutual support and understanding in mental health specific environment	Decreased social isolation Increased confidence to relate to others Communication	Primary: Combating social exclusion Secondary: Decreasing distress
Self expression	Contexts with high levels of support and artistic freedom Long term service users with severe and enduring mental distress	Evacuation/catharsis Alternative means of coping with distress Self acceptance	Primary: Decreasing distress Secondary: Combating exclusion
Connecting with abilities	Contexts in which participants with little experience of art can learn basic art skills and try out new activities	Achievement, pride and satisfaction Sensory perception and awareness	Primary: Mental wellbeing Secondary: Decreasing distress
Having time out	Time-limited, manageable sessions Women with current pressures and responsibilities	Alleviating worries and responsibilities	Primary: Decreasing distress Secondary: Mental wellbeing
Rebuilding identities	All projects, especially those encouraging a high level of creative expression Particularly important for long term service users Producing art work, opportunities to display or exhibit work	Moving beyond a service user identity Self belief and confidence External validation	Primary: Combating exclusion Secondary: Decreasing distress
Expanding horizons	Important at all projects, especially for participants with a previous interest in art	Confidence, assertiveness and self esteem Widening aspirations and opportunities	Primary: Mental wellbeing Secondary: Combating exclusion

8. Discussion

This section discusses the results and implications of the various strands of *Mental Health, arts and social inclusion: developing the evidence base*. Our conclusions follow in Section 9.

Project survey and retrospective analysis of project data

Our survey of arts and mental health projects in England demonstrated that participatory arts provision is a vibrant strand within the wider English mental health economy, offering a wide range of activities with limited resources. Projects were reaching above average numbers of people from Black and minority ethnic communities and levels of participant involvement in shaping the activities in which they engaged were high, as were levels of involvement in the running of projects. The importance of these achievements cannot be underestimated in the context of major policy thrusts in relation to both Black and minority ethnic mental health (Department of Health, 2005a) and service user involvement in shaping their care and delivering services (Department of Health, 2005b).

Health service funding sources provided the largest single source of funding for projects in the survey. Given that evidence of effectiveness is often regarded as essential for health services, it was perhaps surprising that evaluation of outcomes did not appear to be built into project planning and budgets in many cases. As Jermyn (2004) points out, evaluation is easier when it is an integral part of project planning. Although the majority of projects did carry out some form of evaluation the methods used were not sufficiently rigorous to provide good quality evidence and many appeared to have had little support with this. Whereas the impression from the arts and mental health literature (e.g. Smith 2003) is that the use of standardised outcome measures may be antithetical to arts projects' aims and objectives, most were trying to obtain some kind of standardised information, suggesting that there may be a greater willingness to go down this route than might be thought. It may be that the perceived resistance relates to the measurement of outcomes not seen as relevant to projects' or participants' aims, rather than to standardised measurement per se.

Projects were using evaluation methods that demonstrated considerable effort and ingenuity, but only three projects were using standardised measures at more than one point in time. Most were 'reinventing the wheel' in designing questions to assess outcomes such as self esteem for which published measures do exist. In addition, evaluations carried out at only one point in time cannot give any reliable indication of whether change occurs over time.

The retrospective analysis of outcomes data shared with us by two projects that had evaluated their work using standardised measures at two points of time highlighted a further problem: that of attributing any change to arts participation in contexts where establishing 'control' groups is not feasible. Nevertheless, the results from the retrospective analysis were promising, in that they showed improvements in mental health at both projects, though not in relation to social factors. The results from the qualitative questionnaire returned by 22 'Time Being' participants six months after their involvement with the project suggested that for some people at least the benefits were maintained in the longer term.

Developing indicators and outcome measures

Together with a review of previous arts and health studies, the survey of arts and mental health projects proved useful in developing indicators and outcome measures for use in our own baseline and follow up studies. In particular, the survey highlighted the importance for arts and mental health projects of 'distance travelled' outcomes such as increased levels of self esteem and enjoyment

of arts participation. The approach taken at one project to the problem of attributing change to arts participation – directly asking participants about the impact of participation – also provided us with a way forward in tackling this problem.

Using the baseline study results we were able to construct a social inclusion measure with three robust scales measuring social isolation, social relations and social acceptance. The measure does require further testing to firmly establish reliability. In addition it measures a limited range of constructs. Recent work by Peter Huxley and colleagues (personal communication) indicates that the three constructs measured relate to individual and subjective, almost exclusively participatory or emotional aspects of inclusion. While Huxley and colleagues conclude that the measure may be very suitable for use in a limited range of settings, their own far more extensive review identified a wider range of constructs, together with objective indicators such as housing quality, social contacts and income levels.

Although we did include one of the most frequently cited objective indicators, paid employment, in a separate question, we would not claim to have comprehensively measured social inclusion. On the other hand, our Phase 1 survey does give grounds for believing that the constructs we measured are those of most concern to arts projects.

Outcomes study

Although we were only able to encompass a six month follow up period, to our knowledge this was the first systematic outcomes study in the UK involving a substantial number of arts participants with mental health needs. As a naturalistic study, it was not designed to obtain a representative sample of arts participants, but our baseline sample compared reasonably well with what projects told us about their participants in response to the Phase 1 survey and there were no significant differences between the baseline and follow up samples.

In breaking new ground, the study both yielded results of considerable interest, and also highlighted a number of methodological issues, not least in relation to attributing improvements to arts participation. We discuss this further below after considering the results themselves.

As reported in Section 6, we found significant improvements on all three standardised measures at six month follow up. The proportion of participants scoring above the cut off point for clinical significance on the CORE also decreased significantly from 63% at baseline to 50% at follow up, a further indication of improvements in mental health.

The improvements were accounted for in the main by small improvements in almost all the sub groups we looked at and there were no statistically significant differences in improvement within any of the demographic

subgroups. Factors that might have been thought likely to influence the results, such as type of mental health difficulty, extent of arts participation, prior expectations and enjoyment, pride and learning were not found to significantly affect the results. However, numbers in many groups were very small and further research with more evenly distributed groups might find more differences. Small numbers within groups also meant we were only able to compare rather crudely divided sub groups in order to obtain samples of a reasonable size for analysis. With a larger sample giving scope for greater distinction between sub groups, more differences might have emerged.

It seemed particularly surprising that the extent of arts participation was not significant, but participants' open ended comments indicated that many had some previous arts involvement. Our criterion for inclusion in the study was that participants should be new to that specific arts and mental health project. Had we specified no prior involvement in arts at all, the extent of participation may have emerged as significant, but it is unlikely we would have obtained a sample of sufficient size, since we discovered in undertaking the case studies that a prior interest in art is one of the requirements for participation in some arts and mental health projects.

The significant differences we did find were:

1. On the empowerment measure and the CORE, improvements were greater for participants who scored above the CORE cut off at baseline and for those who did not report a new stress in their lives at follow up than for participants not in these groups.
2. On the CORE, improvements were greater for participants whose use of mental health services decreased than for those whose service use increased or stayed the same.

Where the differences relating to CORE scores at baseline were concerned, this most likely reflected the greater scope for improvement amongst participants with the poorest mental health at baseline. Our baseline analysis indicated that the scope for improvement in empowerment amongst this group was also greater than for participants with better CORE scores at baseline, since there was a strong correlation between scores on the two measures: those scoring poorly on the CORE also tended to score poorly for empowerment. To the extent that improvements on the measures can be attributed to arts participation (see page 69 under heading 'Attributing improvements to arts participation'), these results indicate that arts and mental health projects can benefit people with a range of mental health needs, including people with significant mental health difficulties. The results from our case studies support that view, in that we were able to identify three processes, getting

motivated, focusing and connecting with others, that were of benefit to all participants regardless of their mental health difficulties. Moreover, some processes, such as self expression and rebuilding identities, were particularly important for people experiencing severe and enduring mental distress.

The difference relating to new stress reported at follow up indicates that recent experience of a stressful event could mediate improvements in empowerment and mental health. Including a question about recent stress in the follow up questionnaire therefore proved useful in shedding light on the empowerment and CORE results.

An analysis of variance is not designed to determine direction of causality, but it seems reasonable to suggest that the relationship between improved CORE scores and decreased use of mental health services reflected a decreased need for services stemming from improved mental health, rather than to conclude that decreased use of services improved mental health.

In our baseline study we identified two groups of participants, frequent and regular service users and those living alone, in whose outcomes we were particularly interested because they consistently scored lower on all three standardised measures. However, the analysis of variance found no difference at follow up in terms of extent of improvement on any measure. Although the scores of participants who had been frequent and regular service users did improve more on all three measures than those of other participants, by five or more percentage points depending on the measure, the differences did not reach significance. The scores of participants who had been living alone at baseline also improved more than those of participants who had been living with others, but only by five or fewer percentage points.

Our retrospective analysis of outcomes data held by two projects highlighted the need to follow up participants beyond their involvement with arts and mental health projects in order to ascertain whether improvements are sustained in the longer term. We had hoped to be able to address this issue in the outcomes study, but in the event only 13 of the 61 participants who responded to the question were no longer involved with their project at follow up. This suggests that a longer period of follow up, beyond the six months we were able to manage, would be required to address the question.

Turning to the other results, there was a significant decrease in the proportion of participants falling into our frequent and regular service user group, but we found no change in medication use or in the use of specific services, other than use of overnight stays, and there was no evidence that the differences we did find were related to arts participation.

In the light of our experience with the outcomes study we think it was probably a mistake to attempt to measure change on these dimensions. One reason is that assigning value to any change would be fraught with difficulty: in some contexts decreased use of medication and services might be seen as a positive outcome, but in other contexts increased use might equally well be positive. Change may also relate to a change in type of medication, or in intensity but not frequency of service use, making it difficult to assess these differences simply in terms of increases and decreases. In addition, in our project survey changes in medication and service use were amongst the lowest ranked intended outcomes for projects and it is arguable that it is not reasonable to evaluate projects on dimensions they are not intended to address.

We also found no significant differences relating to occupational activity or education. This may seem disappointing, but our results are far from conclusive for two reasons. Firstly, it is probably unrealistic to expect that many participants would move into work within six months, and it is highly unlikely that they could gain a new educational qualification in that period of time. It has been argued that 'hard' outcomes such as returning to work are unlikely to be achieved in the short term (Dewson et al., 2000) and longer term studies would therefore be required to detect these outcomes. In the shorter term, 'distance travelled' outcomes may be important indicators of project effectiveness and the improvements in empowerment we found are an example of such outcomes. In particular, the highly significant increase in self efficacy may be important in the longer term, since high levels of self efficacy have consistently been identified as one of the best predictors of returning to work for people with mental health needs (Grove and Membrey, 2005). That a third of participants thought arts participation had improved their future employment and education opportunities lends support to this view, as do the open ended comments indicating that for a few people participation had already led to getting back to work or starting college. The widening aspirations documented in the case studies and the opportunities already taken up by a few participants provide a further indication of potential future benefits.

Secondly, around a quarter of our sample were aged 55 or over and almost half were over 45. People in the older age groups are known to face discrimination in returning to work (Department of Trade and Industry, 2004), and may also see themselves as too close to retirement to consider doing so. This age factor compounds the employment discrimination faced by people of any age experiencing mental distress (Dunn, 1999), who may well also have been advised not to contemplate returning to work by mental health professionals whose low expectations contribute to low employment rates

amongst this group (Perkins and Rinaldi, 2005).

Attributing improvements to arts participation

Because it was not feasible to establish control or comparison groups in order to establish whether improvements on the standardised measures could be attributed to arts participation, we included questions after each measure asking participants to rate the extent to which involvement in arts had impacted positively on the various dimensions encompassed within the measures and their constituent scales.

Our assessment is that this method holds promise, but needs further refinement and testing in future studies before firmer conclusions can be drawn. One issue highlighted by our experience is that on the whole participants' ratings tended to be positive, making it difficult to construct clearly defined groups for comparison. With hindsight, in developing our rating scales we erred on the side of offering a scale that we thought would be easier for participants to respond to (a lot, a little, not at all, unsure) and would not add too much to the length of the follow up questionnaire, at the expense of using a more extended scale that might have proved more sensitive to different views about impact. This was an issue in relation to all three measures, but particularly to the CORE, where responses were so positive that only seven participants gave fewer than three positive responses to the five questions asked.

A further issue was the extent to which the questions we asked about impact really reflected the dimensions measured by the scales. For the empowerment and CORE measures we tried to frame the questions to reflect what each constituent scale was measuring but were unable to pilot or field test the questions before sending out the follow up questionnaire. Because we were unable to construct scales from the social inclusion measure before sending out the questionnaire, the questions for this measure related to the concepts on which the measure was originally based, rather than to the three scales eventually constructed. The results relating to this measure are therefore open to greater doubt.

In short, a full scale validation study would be required to develop both a more sensitive impact rating scale and questions proven to reflect the dimensions measured. However, we were able to carry out three analyses of the impact ratings that together shed some light on the question of attribution, since each analysis addressed the question from a different angle, as outlined below.

1. The analysis of variance allowed us to compare changes over time in the scores of participants who rated the impact of arts participation positively and those who gave less positive ratings.

2. The multiple regression enabled us to tentatively explore the extent to which positive impact ratings predicted improvement in scores. It is important to reiterate that the multiple block entry method was not methodologically strong, but was used as an exploratory device to identify variables for the final analysis.
3. The correlation analysis established the extent to which participants who gave more positive impact ratings were those whose scores on the measures did improve.

No one analysis was conclusive in itself, for intrinsic methodological reasons coupled with the impact rating issues discussed above, but it seems reasonable to propose that where all three support an effect for arts participation, this can be taken as sufficient evidence of an effect. Evaluation methodologists have argued that where traditional controlled study designs are not feasible, the judicial standard of 'beyond reasonable doubt' provides a practical way forward for policy makers and practitioners (Davidson, 2000). We suggest that this standard is appropriate in the context of arts and mental health evaluation. Box 2 therefore draws together the information from the three analyses, allowing us to 'triangulate' the results.

When triangulated in this way, the results of the three analyses indicate beyond reasonable doubt that arts and mental health projects did improve participants' levels of empowerment. As noted above, this 'distance travelled' outcome could also be important for future outcomes relating to employment and education. The evidence is promising but less secure for mental health and social inclusion. In each case there was an element of support for an arts participation effect, suggesting that this merits further research, taking into account the methodological issues we have raised.

Box 2. Evidence for an arts participation effect

Analysis	Empowerment	Mental health (CORE)	Social inclusion
Analysis of variance	More improvement when impact ratings positive	No significant difference	More improvement when impact ratings positive
Multiple regression	Positive impact ratings a good predictor of improvement	Positive impact ratings a good predictor of improvement when not combined with recent stress	Positive impact ratings a weak predictor of improvement in combination with other elements
Correlation analysis	Significant correlation with positive impact ratings	No significant correlation with positive impact ratings	No significant correlation with positive impact ratings

Case studies – exploring processes, benefits and outcomes

The case studies reported in Section 7 lend additional support to the view that arts projects do benefit their participants. For example, several of the benefits associated by case study participants with improved mental wellbeing, such as increased self esteem and meaning in their lives, can be seen as relating to attributes assessed by the self worth and positive outlook scales included in our empowerment measure, and to the wellbeing scale of the CORE. Similarly, benefits associated by participants with decreasing mental distress, such as reduced anxiety and depression, can be seen to relate to the attributes assessed by the problems/symptoms scale of the CORE, while the benefits associated by participants with combating social exclusion, such as decreased isolation and increased confidence to relate to others reflect the scales included in our social inclusion measure. However, the case studies provided a more holistic perspective on the ways in which different benefits and outcomes interrelate.

The Health Development Agency's report into arts in health (Health Development Agency, 2000) noted a lack of established principles and protocols for evaluating outcomes, assessing the processes by which outcomes are achieved, and disseminating recommendations for good practice. Our study was not large enough to generate a systematic understanding of what type of arts project works best for which participants and in what circumstances. Nevertheless, the study has made a contribution by identifying some of the important processes that arts projects set in motion to achieve benefits for participants, generating a deeper and broader understanding of the multiple ways in which projects can benefit people with mental health difficulties.

Although some of the benefits reported might seem little different from those provided by other types of mental health project, there was good evidence that it was not just going to a supportive project, but engaging in art activities that facilitated benefits.

The most frequently described benefits related to mental wellbeing. These are best described as the development of attributes and experiences that are usually seen as important and even necessary for all of us, regardless of mental health difficulties. However, they are attributes that can be adversely affected by mental ill-health and experiences of social exclusion.

Engaging in creative activities, learning new art related skills and developing their creativity enabled many participants to connect, or reconnect, with their abilities and potential. This gave a sense of pleasure, achievement, pride and satisfaction, and resulted in reported improvements in confidence and self esteem. In turn, this had an important effect on participants' growing motivation by creating additional interest, purpose and meaning in their lives. In particular, learning and focusing on art seemed to help individuals relax and improved their concentration. For some this also increased their awareness and perception of both themselves and their surroundings.

As in the outcomes study, there was no extensive evidence for reducing medication or use of services, but there was evidence of a few people beginning to cope without medication while participating in the arts projects. There was also considerable evidence that the arts projects were able to support participants to begin to use art as a multi purpose 'tool', which they could deploy in different circumstances to alleviate mental distress and cope better with mental health difficulties or past or present life experiences. For most participants these effects were confined to their involvement in the project. However, some people were beginning to transfer them into other aspects of their lives outside their project, partly due to the 'portability' of art, which meant they were able to use art at home to achieve some of the same benefits they experienced at their project.

In addition to promoting mental wellbeing, many of the processes described were implicated in reducing mental distress. Time out, self expression and focusing on art could all be important at different times, depending on the individual, the project and the context. Time out was important in alleviating stress associated with pressures and responsibilities, while focusing on art was often important as a distraction from intruding negative thoughts and feelings. In some projects participants were able to express previously unacknowledged aspects of themselves and this had direct benefits in providing relief from difficult thoughts, feelings and memories, especially in relation to hearing voices, self harm and coping with past experiences of abuse. These processes were often closely interrelated. Sometimes one process seemed to be necessary to enable the others to take effect. For example, individuals who had high levels of past and current emotional disturbance often had to express their feelings in their art before they could gain other benefits from their project, such as those gained through connecting with abilities or focusing on their artwork.

While participants' accounts clearly illustrated the various ways they were able to use art as a creative means of coping with distress, indicating that arts participation could be 'therapeutic' in reducing mental distress, art was not merely used as a form of 'therapy'. Rather, participants were often able to use their experiences creatively and the resulting art work was valued in itself, as well as the person who created it.

For outcomes relating to social inclusion we looked at the ways in which participants referred to specific processes that seemed to enable them to combat feelings of isolation and social exclusion. The pride and sense of achievement that stemmed from engaging in creative activities and learning something new was related for some participants at all projects with the rediscovery or rebuilding of an identity beyond that of someone with mental health difficulties, an important element of the journey towards recovery. In addition, engaging in creative activities helped to reverse an enduring sense of hopelessness, despair and futility about the future which can be common in people who are long term users of mental health services.

The social contact and mutual support provided by projects was highly valued by participants and there was evidence that this helped decrease isolation, improve social skills and increase confidence in relating to others. The projects were often seen as an important link to the outside world. However, there was less evidence that the benefits of social interaction extended beyond the projects, although some participants did describe improved family relationships or making new friends. Similarly, while all the arts projects facilitated access to other art activities in the community, for most participants this did not translate into accessing other arts activities independently. This appears to support the view that arts projects are more likely to build 'bonding' rather than 'bridging' social capital (White and Angus, 2003), but caution is required about this for several reasons.

In the first place, our case study sample was necessarily small, involving only 34 participants at six projects, and it is not possible to draw conclusions about the benefits of arts projects more generally. In addition, most of the projects worked primarily with people with mental health needs rather than being 'mainstream' community arts projects. This raises questions as to the possible additional or alternative benefits of participation in more generic arts provision. However, the mutual support and safety offered by the mental health specific projects was of particular importance to all of the participants interviewed in our case studies. Further research is therefore needed to explore whether similar or different benefits could stem from participation in arts projects with a broader based membership and focus.

In addition, developing art skills and an appreciation of art did enable a significant minority of participants to access other arts facilities in the community independently of their arts project. This opened up new opportunities for these participants to relate to others and become more involved in their local communities, doing voluntary work, talking to other artists, visiting galleries, exhibiting and selling their art work.

Having said that, we need to be careful not to assume that inclusion in mainstream activities was necessarily lacking for or desired by the majority of participants. Some participants, particularly those with 'mild to moderate' difficulties, appeared less socially isolated than others, and for these participants social contact had been a less important motivation to join their arts project. Other participants described experiences of stigma and discrimination in the outside world that certainly raise questions about the desirability of engaging with that world. As Wallcraft (2001) points out, people with mental health difficulties do not necessarily want to be part of a mainstream society that has rejected them, and many participants reported difficult experiences of mainstream or formal arts courses.

Some participants did appear to be in the process of establishing a confident renewed identity that did not involve subscribing to mainstream social norms, but enabled them to accept and value themselves for who they were. In those projects that worked with people with severe and long term mental health problems, whose exclusion was likely to be more evident, some participants were able to make quite profound challenges to their exclusion. In projects that tended to work with people with less severe and long term mental health difficulties, whose experiences of exclusion may be less evident, this was less important. Some participants, such as the Asian women involved in one project, experienced quite profound social isolation relating to complex ethnic, gender and cultural dynamics that are unlikely to be addressed by an arts initiative.

In any case, as noted above, participants' involvement in the arts projects had considerably widened their aspirations and hopes for the future. Although most had yet to achieve their aspirations, the significance of widening aspirations should not be underestimated because a broadening of the horizons of people's lives beyond the world of mental health services is such an important aspect of the journey towards recovery.

Arts participation had also begun to impact on many participants' sense of themselves through increased self belief and confidence. For most participants this was about gaining new interests or reconnecting with previous interests, developing a new skill or being able to express themselves through their art. Some had begun to develop or consolidate a renewed identity in relation to their new skills and abilities as artists, moving away from being primarily defined by their mental ill-health. In turn this further widened their aspirations and opportunities in relation to the world outside mental health.

Finally, projects had different ways of attempting to combat social exclusion or promote social inclusion and some of these were still in the early stage of development. For example, Borderland Voices was beginning to open its project activities to other local people in order to promote a wider understanding of the benefits of arts to the wider community and to challenge stigma and discrimination. Equally, Studio Upstairs was moving towards developing closer relationships with other art organisations and creating opportunities for individual and group exhibitions outside the project.

These examples are not about a narrow vision of social inclusion that tries to 'slot individuals back into society' without challenging the ways in which society excludes people (Bates and Davis, 2004). Rather, they seek to develop an important role for people with mental health needs to challenge and change the social world, at least in small ways, through art and creativity.

9. Conclusions

Drawing from across the different strands of *Mental health, social inclusion and arts: developing the evidence base*, but primarily from the outcomes study and case studies, the conclusions from this research and the implications for future arts and mental health research are presented here.

Conclusions from this research

Notwithstanding the need for further research, we believe that our results provide sufficient evidence of mental health, social inclusion and in particular empowerment gains to justify support for arts and mental health work. Our outcomes study demonstrated beyond reasonable doubt that arts participation improved levels of empowerment, and the evidence for improvements in mental health, as measured by the CORE, was promising. These results were supported by the case studies, where the most frequently reported outcomes related to mental wellbeing, and where outcomes relating to decreased mental distress were also evident. Although there was little evidence of the kind of benefits associated with savings in health service costs, such as reductions in medication and service use, the value of these, other than in cost terms, depends on the individual context. However, increased empowerment is an important element in the journey to recovery from mental ill health, as are many of the benefits identified through the case studies.

Where social inclusion is concerned, the evidence from the outcomes study was also promising, and the case studies vividly illustrated the ways in which arts participation could decrease social isolation and improve social relations. Self expression that facilitated self acceptance, rebuilding a positive identity and expanding horizons that widened participants' aspirations and opportunities were the key processes involved. Although neither strand of the research identified increases in occupational activity as a major benefit for participants, widening aspirations and opportunities are important in this respect, and the increase in self efficacy revealed by the outcomes study could be particularly important in relation to employment. A few participants in both strands of the study did report obtaining voluntary or paid work, and it may be that longer term research would yield more positive results in relation to occupational activity. However, it is important to recognise that social inclusion, in terms of integration in mainstream society, may not be lacking for some arts participants, and may not be desired by others.

The case studies demonstrated that arts provision for people with mental health needs is not a case of 'one size fits all' and this needs to be taken into account in designing projects. For example, structured provision that participants can readily accommodate in busy lives may be particularly beneficial for women with caring and other family responsibilities, while projects with the capacity to provide high levels of support and to tolerate high levels of disturbance may be particularly important for people with long term experience of severe distress. It was precisely in these latter projects that more profound changes in

relation both to combating social exclusion and decreasing mental distress were evident. One feature was important for all groups, that of providing arts activity in a safe, supporting, unthreatening environment.

The results of our project survey concur with findings elsewhere suggesting that support for arts and mental health work could usefully include resources for projects to evaluate their work. Ensuring sustained activity and stability in order that long term evidence of effects can accrue is important in this respect (White and Angus, 2003). However, as our case studies highlighted, projects had evolved a range of innovative means through which arts participation benefited people with mental health needs. We therefore agree with White and Angus that increased evaluation should not lead to bureaucratised service provision that could stifle creativity and inappropriately shape projects according to predetermined outcomes and requirements.

Although quantitative evaluation provides important information for funders and projects, it can only answer questions about the extent of any change, leaving crucial questions about how and why change occurs unanswered. To answer those questions, qualitative methods are needed. In-depth qualitative research of the kind we carried out would be unlikely to be practical for many arts and mental health projects, but a version of the theories of change approach, termed logical framework analysis, or log frames, has been developed for pragmatic use in practice contexts. Log frames were used by Everitt and Hamilton (2003) for their study of arts in health projects and might prove helpful for arts and mental health projects. White (2005) provides a useful summary, available on line (see reference list). Qualitative work exploring participants' experiences is also essential to address questions outcomes studies cannot address about how and why arts participation works.

Implications for further research

Our main conclusion regarding further research is the need for longer term outcome studies than we were able to carry out. As noted above, a longer time frame is needed to examine outcomes such as occupational and educational activity, and to address the question of whether improvements are sustained beyond participation in arts and mental health projects. In a longer term study it would also be possible to recruit larger numbers of new arts project participants. Although the arts projects that worked with us were able to recruit a substantial number of participants, the sample size was not large enough to carry out a fully robust regression analysis. This is a powerful means of discovering what predicts improvement on standardised measures, but it is 'data hungry' in that the more variables examined, the greater the sample size required. Based on our experience, a three year period of study allowing for a year's recruitment and a year's follow up would be a useful time frame.

Including a question at follow up about any new stress in participants' lives proved useful for shedding light on the outcome study results, particularly for mental health outcomes, and we recommend that future studies include this question. We also believe our use of participants' impact ratings as a means of attributing change to arts participation is worth further development. A validation study aimed at developing the method for use with the empowerment measure, the CORE and our social inclusion measure would be required, taking account of the need to test out the sensitivity of the rating scale used.

As noted above, however, quantitative evaluation methods can only answer questions about the extent of any change associated with arts participation. Understanding how and in what contexts change occurs is equally important if evaluation is to inform service development, and we therefore recommend that quantitative methods are not used alone but are combined with qualitative methods addressing those key questions. A specific question raised by our case studies concerns the benefits for people with mental health needs of participating in arts projects with a broader based membership and focus.

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Appendix

Arts and mental health project contacts

We are aware this appendix is not an exhaustive list of projects and organisations involved in arts and mental health work in England. Projects start up all the time and there are bound to be many we do not know of. Some projects are also short term and we have not been able to get in touch with several we were in contact with in the earlier stages of the research to ask permission to publish their contact information. We hope the list will nevertheless provide a useful resource for people interested in arts and mental health work. The information varies in detail and is as provided by the projects and organisations.

Project/ Organisation	Contact details
AIM (Artists in Mind)	Turnbridge Mill Quay Street Huddersfield HD1 6QT 01484 345223 www.artists-in-mind.org.uk www.myspace.com/artists_in_mind
Anchor Project, Falmouth	Julie Acton Julie.Acton@cpt.cornwall.nhs.uk
Art for Arts, Portsmouth	Martin Dunning Martin.Dunning@ports.nhs.uk
Art for Surgeries Art for Change Ltd, Plymouth	Marianne Sturtridge msturtridge@blueyonder.co.uk
Art Matters, Surrey	www.artmatters.nhs.uk
Artery (Mental Health) Amber Valley Borough Council	Rosemarie Reed Arts & Health Officer Town Hall Ripley Derbyshire DE5 3TU 01773 570222 Ex2549 rosemarie.reed@ambervalley.gov.uk
Artlink West Yorkshire	01132 431005
Arts on Prescription, Stockport	Alex Barton /Gwenwyn Nelson Stockport Centre for Health Promotion 2nd floor Regent House Heaton Lane Stockport SK4 1BS 0161 426 5095 gwenwyn.nelson@stockport-pct.nhs.uk
Artscape Directory	www.artscape.org.uk
Arty-Folks, Coventry	Lorella Medici 02476 633203 lorella.medici@ntlworld.com
BAND Bolton Association and Network of Drop-ins, Bolton	01204521673 admin@band.org.uk
Bedford Creative Arts	Bedford Creative Arts Community Education & Outreach Team The Gatehouse Foster Hill Road Bedford MK41 7TD www.bedfordcreativearts.org

Project/ Organisation	Contact details
Bethlem Arts and Gallery/ South London and Maudsley NHS Trust	Karen Risby, Art Co-ordinator Bethlem Gallery, Bethlem Royal Hospital, Monks Orchard Road, Beckenham Kent BR 3 3BX 02032 284182 Karen.Risby@slam.nhs.uk Peter.O'Hare@slam.nhs.uk www.bethlemgallery.com
Borderland Voices	Sheena Barnes 55, Queens Drive Haregate Leek Staffordshire ST13 6QF 01538 384142 info@borderlandvoices.org.uk enquiries@steppingstonesarts.co.uk www.borderlandvoices.org.uk
Bridges to Education Interact	InterAct Moulsham Mill Parkway Chelmsford CM2 7PX 08452 579159
Castle Arts	c/o Castle Day Centre Hampton St. SE1 6SN 02075 253477 castlearts1@hotmail.com
Centrepieces, Kent	01322 521162
Challenging Stigma and Promoting Social Inclusion through the Performing Arts East Surrey PCT	Maya Twardzicki Senior Health Promotion Specialist (Mental Health) 01737 214823 Maya.Twardzicki@EASTSURREY-PCT.NHS.UK
Community Arts Project Group South West London and St George's Mental Health NHS Trust	The Community Arts Project Group The Access Team Roselands Resource Centre 163b Kingston Road New Malden Surrey KT33NN Facilitators Beck Phillips and Jamila Fuller
Community Music East	189 King Street Norwich NR1 2DF 01603 628367 enquiries@cme.org.uk www.cme.org.uk
Connected (Oldham Arts and Mental Health Network)	Linda Boyles Connected Co-ordinator The Beeches 5 Waterloo Street Oldham OL1 1SP 01619 098060 linda.boyles@nhs.net
Cooltan Arts	Cooltan Arts Unit B, 237 Walworth Road London SE17 1RL 0207 7012696 info@cooltanarts.org.uk www.cooltanarts.org.uk www.afunnyfarm.org.uk
Cornwall College Department for Foundation Studies	Steve Phillips c/o Trevithick Court Department for Foundation Studies Cornwall College, Camborne Pool, Redruth TR14 8QQ 01209 611611 ex 3489 steve.phillips@camborne.ac.uk
Creativity & Healing APCMH	Sue Albery APCMH Cornerstone House Willis Road Croydon CRO 2XX 0208 6656718 www.croydon-apcmh.co.uk
CREDO	Creative Ceramic Designs Anchor House Station Road Orpington Kent BR6 ORZ 01689 878225 / 07753 244743 credoceramics@onetel.com www.credoceramics.org
Expressions Art	Expressions Art c/o Matrix Project Cedar Lodge Summerlands 56 Preston Road Yeovil BA20 2BX 07725 955035

Project/ Organisation	Contact details
Footsteps Arts Group	17 Beechwood Avenue Greenwood Middlesex UB6 9UA 0208 5787707 footsteps@freeuk.com www.footsteps-arts.com
Hartlepool Art Studio Ltd	120a Park Road Hartlepool TS26 9HU 01429 867775 info@hartlepoolartstudio.org.uk www.hartlepoolartstudio.org.uk
Hastings Resource Centre, Together	Hastings Resource Centre Carisbrooke House Stockleigh Road St Leonards-on-Sea East Sussex TN380JP 01424 434886 hastingsrc@together-uk.org together@together-uk.org
Havering Mind	Harrow Lodge House Hornchurch RM11 1JU 01708 457040
Healing Arts	Guy Eades, Arts Director Healing Arts Isle of Wight Healthcare NHS Trust St. Mary's, Parkhurst Road Newport Isle of Wight PO30 5TG 01983 534253 healingarts@iow.nhs.uk
Indigo Brave, Nottingham	www.indigobrave.com
Insider Art	PO Box 272 St Thomas Exeter EX2 9ZL insiderart@blueyonder.co.uk www.insiderart.org.uk
Inspire	Lorraine von Gehlen Artistic Director Inspire - wellbeing through arts Wysing Arts Centre Fox Road Bourn Cambridge CB3 7TX 01954 718181 lorraine@inspire.org.uk
Islington Music Forum	0207 5614150 imf@candi.nhs.uk www.imfmusic.org
Kwan Wai (Mental Health) Project	Wai Yin Chinese Women Society Kwan Wai (Mental Health) Project 1st Floor, 61 Mosley Street Manchester M2 3HZ 0161 375908 www.waiyin.org.uk
Landscape Tockwell-Villandry Ass.	Anne Tockwell Tockwell-Villandry Ass. 01189 845554 a.tockwell-v@clara.co.uk www.duckeggorg/tockwellV
Lincoln Theatre of the Oppressed / Converse Theatre	mail@converse.info john. bowtell@lpt.nhs.uk
LSO Discovery London Symphony Orchestra	Paul Broadhurst Disability Projects Manager London Symphony Orchestra Barbican Centre London EC2Y 8DS 0207 5881116 0207 3822526(direct) paul.broadhurst@lso.co.uk www.lso.co.uk
Magic Carpet	The Scrapstore Gordon Road Exeter EX1 2DH 01392 422938 magic.carpet@tesco.net www.magiccarpet-arts.org.uk
Mental Health Programme Workers Educational Association	Helen Widdowson Organiser for Harrogate & Craven Worker's Educational Association hwiddowson@wea.org.uk www.wea.org.uk
Millennium Arts Project Friends of Fulbourn Hospital & the Community	Friends of Fulbourn Hospital & the Community Christina Rowland-Jones, Chairman 01223 881267 fofhc.org.uk
Worthing and Littlehamptom Day Centre, Mind	Lou Hastings MIND Day Centre 8-10 Durrington Lane Worthing West Sussex BN13 2QG 01903 693047 lou.hastings@worthingmind.co.uk www.worthingmind.co.uk

Project/ Organisation	Contact details
Mind Games Dead Earnest Theatre, Sheffield	Dead Earnest Theatre www.deadearnest.co.uk.
Mind in Dacorum Education and Leisure Groups, Hemel Hempstead	Mind in Dacorum www.mindindacorum.org.uk
Music for Life-Barrow Mind / Annie Mawson's Sunbeams Music Trust	Annie Mawson Sunbeams Music Trust 1, Greystoke Castle Estate Greystoke Cumbria CA11 0TG 017684 83035 annie@sunbeamsmusic.org www.sunbeamsmusic.org
North Street Day Service Northampton & District Mind	Northampton & District Mind North Street Day Service North street Daventry NN11 4GH
North Tyneside Art Studio	North Tyneside Art Studio Ltd Linskill Centre Linskill Terrace North Shields Tyne & Wear NE30 2AY 0191 296 1156 ntc.artstudio@connectfree.co.uk www.artstudio.cc
Open Link Art Yeovil College	www.yeovil.ac.uk
Partial Hospital Department Newcastle, North Tyneside and Northumberland MH NHS Trust	Louise Merridew Head Occupational Therapist Acute Day Service Collingwood Court St Nicholas Hospital NE3 3XT 0191 2130151
Partnership working with Lancashire College West Lancashire PCT	Stacey Roddie Stacey.Roddie@westlancspct.nhs.uk
Pass It On Humber Mental Health Teaching Trust	Elaine Burke Arts and Health Manager Victoria House Park Street Hull HU2 8TD 01482 617821 elaine.burke@humber.nhs.uk
Pathways / LIME	Brian Chapman, Director Lime Saint Mary's Hospital Hathersage Road Manchester M13 OJH 0161 256 4389 lime@limeart.org brian@limeart.org www.limeart.org
Phoenix Art Group Tees Valley Arts Middlesburgh	phoenixartgroup1@hotmail.com
Pool Arts & St Lukes Art Projects	c/o St Lukes Guidepost Square Longsight Manchester M13 9EA alison.sl-arts@good.co.uk poolarts@googlemail.com
REACH (Reducing Exclusion And Changing Hope), Bradford	Sarah.Hall2@bradford.nhs.uk
Reality Matters / Common Ground	Moira Blackwell Moirablackwell@aol.com Professor David Kingdon University of Southampton, Department of Psychiatry Royal South Hants Hospital
Roshni Ghar	Sasha Bhat Manager 13 Scott Street Keighley West Yorkshire BD21 2JH 01535 691758/ 07918622897 info@roshnighar.org.uk www.roshnighar.org.uk www.elysiumproject.org

Project/ Organisation	Contact details
Safe'n'sound Soft Touch Community Arts	Christina Wigmore Soft Touch Arts 120a Hartopp Road Leicester LE2 1WF 0116 2702706 info@soft-touch.org.uk www.soft-touch.org.uk
Salamanda Tandem	Lisa Craddock, Company Manager Salamanda Tandem 0115 9420706 info@salamanda-tandem.org www.salamanda-tandem.org
Sample This Music Project South West London and St George's Mental Health Trust	David Heasman Occupational Therapy South West London and St. George's Mental Health Trust
Sharing Voices Lifecraft Singers	Bev Sedley 97 Hills Road Cambridge CB2 1PG 01223 368845 bev@naturalvoice.net
Shift Dance Xchange	DanceXchange Birmingham Hippodrome Thorp Street Birmingham B5 4TB 0121 6893169 www.dancexchange.org.uk
Shine Community Action Furness, Barrow-in-Furness	01229 430429 www.communityactionfurness.org.uk
Shoestring Theatre Company, Shipley, West Yorks	07899 772903 shoestringtheatre@hotmail.com www.shoestringtheatre.org.uk
Sing Your Heart Out, Norfolk	01603 421491 Tracy.Morefield@nwmhp.nhs.uk
Solent Social Clubs Solent Mind, Southampton	02380 222394 gmunoz@solentmind.org.uk dhannam@solentmind.org.uk
Sound Minds	20-22 York Road London SW11 3QA 0207 2071786 www.soundminds.co.uk
Spinning Yarns Prism Arts	Prism Arts, Unit 1, Brampton Business Centre Union Lane, Brampton CA8 1BX 01697 745011 office@prismarts.fsnet.co.uk www.prismarts.co.uk
St George's Eating Disorders Service Creative Options Groups	Laura Lock Head Occupational Therapist St George's Eating Disorders Service, Avalon Ward Springfield University Hospital 61 Glenburnie Road London SW17 7DJ 0208 6826468 www.swlstg-tr.nhs.uk follow links: Services/Speciality/Eating Disorders
Start in Manchester	Wendy Teall, Start Lead Artist Start in Manchester High Elms, Upper Park Road Victoria Park Manchester, M14 5RU Tel: 0161 257 0675 wendy.teall@mhsc.nhs.uk www.startmc.org.uk
Start in Salford	Bernadette Conlon Project Manager Brunswick House 62 Broad Street Salford M6 5BZ 0161 3516000 www.startinsalford.co.uk
Studio One, Manchester	01614 366949 matthew@studioone.wanadoo.co.uk
Studio Upstairs	Studio Upstairs Units 1 & 2 Albion Dockside Hanover Place Bristol BS1 6UT 0117 9300314 bristolstudio@studioupstairs.org.uk www.studioupstairs.org.uk
Survivors Poetry	Dr Simon Jenner, Director simon@survivorspoetry.org.uk

Project/ Organisation	Contact details
Sydenham Green Health Centre Art and Craft Group Sydenham Garden	Sydenham Garden 0207 7714613 info@sydenhamgarden.org.uk www.sydenhamgarden.org.uk
The Art Studio	1-3 Hind Street Sunderland SR1 3QD 01912 961156 theartstudio@btconnect.com www.artstudio.cc
The Arts Development Group Nottingham-shire Healthcare NHS Trust	Penny.Coulson@nottshc.nhs.uk
The Arts Project	Brian Scott, Arts Project Manager Northumberland, Tyne & Wear NHS Trust Northgate Hospital Morpeth Northumberland, NE61 3BP 01670 394174 Brian.Scott@nap.nhs.uk
The Bridge Project Saturday Clubs The Bridge Project	The Bridge Project Bridge House Trowbridge BA14 9AE 01225 358564 mail@thebridgeproject.org.uk www.thebridgeproject.org.uk
The Old Parcels Office Arts Centre Hull & East Yorkshire Mind	Perrie White Arts Manager for Mental Health 01262 400000 oldparcels@mindhey.co.uk
The Project Group	The Project Group (Oswestry)Ltd 17a Cross St Oswestry Shropshire SY11 2NF
The Tate Experience Pentreath Ltd, Cornwall	Pentreath Ltd pentreath@pentreath.co.uk
Theatre Resource, Ongar	www.theatre-resource.org.uk
Trust Arts Project (TAP) South London and Maudsley NHS Trust	Trust Art Project Arts and Health Services Rehab, Lambeth Hospital Landor Road London SW9 9NT 020 7411 6145 Trustartproject@slam.nhs.uk
Venture Arts, Manchester	venture.arts@btinternet.com
Waddington Street Centre	Waddington Centre 3 Waddington Street Durham DH1 4BG 0191 3860702 Fax: 0191 3755140
Wear Purple Age Concern Cheshire	Wear Purple Arts Project Age Concern Cheshire 314 Chester Road, Hartford Cheshire CW8 2AB 01606 881662 wearpurple314@hotmail.com
Zion Art Paintbox (ZAP)	Zion Art Paintbox Zion Centre 01612 265412

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