Mental health, social inclusion and arts: developing the evidence base

Final report from Phase 1:

The state of the art in England

The APU/UCLAN Research Team

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Executive summary

1. Introduction

This report presents the work carried out for Phase 1 of *Mental health, social inclusion and arts: developing the evidence base*, a study commissioned by the Department for Culture Media and Sport and the Department of Health following publication of *Mental Health and Social Exclusion* by the Social Exclusion Unit (ODPM, 2004). The objectives for Phase 1 were:
- To review participatory arts and mental health projects in England in order to map the range of activity, establish what evaluation data projects already collect, and develop indicators and measures for use in Phase 2.

2. Social exclusion/inclusion and health in the context of the arts and mental health

An ongoing review of the literature relevant to the study context indicates that there are grounds for linking the concepts of social inclusion and health in ways that are helpful in relation to our task of developing indicators and measures. Outcomes such as levels of confidence and self esteem may represent progress or 'distance travelled' towards:
- Social inclusion outcomes such as employment or education.
- Mental health outcomes such as lower levels of mental ill health, and reduced use of medication and services.

3. Phase 1 methods

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.

A survey questionnaire was designed with input from the Advisory Group and piloted with four projects. The 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.

4. Survey 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 flexibility 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 is evidently a vibrant strand within the wider English mental health economy. Projects were offering an impressive variety of arts activities to almost 4,000 people with mental health needs each week[1]. However, this appears to be

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

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.

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.

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.

Most 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.

The projects were succeeding in areas where many mental health providers struggle:
- they were 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

61% of projects indicated that they routinely evaluated their work.

Only two projects were using validated outcome measures, the Hospital Anxiety and Depression Scale (HAD) and the Clinical Outcomes in Routine Evaluation (CORE) measure. 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 might be thought.

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, 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 (see Table 7, page 33)

The 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). Fewer projects (13) were evaluating outcomes directly related to measurable health outcomes.

Although 20 projects were attempting to assess dimensions relevant to social inclusion, in 10 cases this was based on participants' future aspirations rather than their actual experience. The other projects had designed their own questions, such as whether participants had made new friends or tried a new activity.

## 5.	Conclusions

A more coordinated approach to evaluation using published, validated measures where possible in a pre- and post-intervention design, would generate a wealth of useful, comparable information.

Evaluation orthodoxy sees the 'control group' or 'comparison group' approach as the way around the problem of attributing change to projects' work. However, establishing a control or comparison group is likely to be impractical for projects without the assistance of external researchers, so we do not recommend this approach as the way forward. We think the way forward lies in the approach taken at some projects, of direct questions at follow-up about the project's impact.

Validated measures are available for two dimensions of 'distance travelled': self esteem and empowerment. We recommend use of the User Empowerment Measure, which measures both and was developed in the UK with input from people with mental health needs.

Some dimensions of 'distance travelled', such as enjoyment or skills gained, can only be measured at follow-up. We suggest that standardised ratings of the impact of participation on these dimensions be included at follow up.

Of the two validated health measures in use at two projects, we think more widespread use of CORE would be useful, because this is a relatively brief measure of general mental health and well-being.

Only one validated measure of service use is available and this is overly complex for use in the context of arts and mental health work because it requires quite complex, detailed information which participants may well struggle to provide with the accuracy necessary for the measure to work reliably. Our suggestion is that the approach in use at some projects of asking about levels of medication and service use at follow-up provides the best way forward.

The development of validated, standardised measures of social inclusion is at an early stage but we found three potential sources of useful questions. Our suggestion is that relevant items from these three sources could be combined in one fairly brief measure of social inclusion and used alongside the CORE and the User Empowerment Measure in a pre- and post-intervention evaluation design.

Table 8 on page 39 summarises the outcomes, indicators and measures identified through this first phase of the study.

1. Introduction

In 2004, the Social Exclusion Unit (SEU) produced a report addressing social exclusion and mental health. The report identified 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 is a key recommendation of the report. However, it was acknowledged that the evidence base for arts participation is currently weak. As part of a 27-point action plan the Department for Culture Media and Sport (DCMS), in partnership with the Department of Health (DH), was therefore charged with undertaking research to establish the health benefits and social outcomes of participation in arts projects and the characteristics of effective local projects.

Mental health, social inclusion and arts: developing the evidence base is the study commissioned by DCMS and DH in fulfilment of that brief. It builds on the comprehensive literature review undertaken by the Centre for Arts and Humanities in Health and Medicine at the University of Durham (White and Angus, 2003). The objectives of the study are to identify appropriate indicators of mental health and social inclusion outcomes, to develop evaluation measures based on those indicators, and to identify the characteristics of effective arts and mental health projects through use of the measures with arts and mental health projects. The study relates to participatory arts and mental health work in England with people with mental health needs aged 16 to 65 and does not therefore include art therapy.

The research is being carried out in two phases. Phase 1, to which this report relates, comprised a review of participatory arts and mental health projects in England to map the range of activity, establish what evaluation data projects already collect, and develop the indicators and measures for use in Phase 2. Originally, Phase 2 was planned to comprise a retrospective analysis of quantitative data held by projects, alongside a mixed methods evaluation with four to six projects, using the measures developed during Phase 1 and in-depth evaluation techniques. However, it was decided at a meeting of the project Advisory Group in July 2005 to extend an invitation to pilot the measures developed during Phase 1 to all projects that had taken part in that phase of the study. The retrospective analysis of quantitative data held by projects and an in-depth evaluation with four to six projects will be carried out alongside this more extensive prospective evaluation.

The following section of this report is based on an ongoing review of the relevant literature and represents our current thinking about the key concepts we are investigating, namely social exclusion/inclusion and health in the context of the arts and mental health. The methods used for Phase 1 of the study are then described, before presenting the results in Section 4. Section 5 comprises a discussion of the results and is followed in section 6 by our conclusions from Phase 1 and recommendations for Phase 2 of the study.

2. Social exclusion/inclusion and health in the context of the arts and mental health

In order to examine the key concepts we are investigating, we start by separating out social exclusion from social inclusion to focus on each in turn before presenting a critique of the concept of social inclusion from two perspectives: that of the relationship between exclusion and inclusion; and that of people with mental health needs. We then turn to look at the

concept of health, drawing on both the health promotion literature and the arts in health literature. Finally, we take a step towards identifying indicators for, and measures of, the benefits of arts participation by considering the links between social inclusion and health.

Social exclusion

Like 'art', ' health' and 'mental health', social exclusion is a highly contested and debated concept. In the UK the SEU was established in December 1997 with a remit to improve government action to reduce social exclusion. The SEU defines social exclusion as:

> … a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown. (Cabinet Office, 2000, cited in Jermyn, 2001)

Social exclusion, according to this definition, is complex and multi-dimensional in nature and can occur when various linked problems are experienced in combination. This view maintains that social exclusion can be experienced at a range of different levels: it can affect individuals, groups, or geographic areas. The concept is viewed as more than merely a product of material conditions or poverty, since it draws attention to people's experiences of being prevented from being full members of society (Community Development Foundation, 2001). It also refers to the idea that there are complex, multi-dimensional problems that create a cycle of disadvantage such as lack of work, lack of opportunities to acquire education and skills, inequalities in health and poor housing (Department of Social Security 2000).

Similarly, a national study from the Joseph Rowntree Foundation (2000) identifies four dimensions to exclusion:

- impoverishment, or exclusion from adequate income or resources
- labour market exclusion
- service exclusion
- exclusion from social relations.

Social exclusion and mental health

So what is 'social exclusion' in relation to people with mental health needs? Two recent key documents shed light on this question: the SEU's *Mental Health and Social Exclusion* report (ODPM, 2004) and Mind's inquiry report into social exclusion and mental health service users (Dunn, 1999).

Not unlike the Joseph Rowntree Foundation report, the SEU report views social exclusion in mental health as encompassing:

- structural dimensions, including unemployment, housing, transport, financial and benefits (poverty trap, debts), insurance, legal and human rights
- problems accessing information and advice in relation to the above
- community/cultural dimensions involving non-inclusive communities and activities that militate against community participation, including arts.
- restrictive social networks/social isolation.

While participation in arts activities may have an indirect or longer-term impact on the structural dimensions of exclusion, a more direct potential impact is seen as '… helping people to integrate into wider society by increasing self-esteem, confidence and social networks.' (ODPM, 2004 p83).

MIND's inquiry report *Creating Accepting Communities* (Dunn, 1999) has been described as the largest ever UK inquiry into social exclusion and mental health service users. It appears to take a 'social model of disability' perspective and while it discusses social exclusion, the key problem it highlights is discrimination. The inquiry panel received strong and consistent evidence of the discrimination people experience as a direct result of their mental health problems and the report argues that this discrimination, which occurs in every area of life, especially in jobs and education, makes mental health service users vulnerable to extreme exclusion from virtually every aspect of society.

This situation is seen to be exacerbated by sensational reporting in the mass media and the inquiry also raised concerns about the impact of the new mental health bill, which may further intensify exclusion by focusing on public safety and compulsory treatment in the community. In addition, the inquiry found that mental health services themselves bear some responsibility for creating and perpetuating exclusion, partly because a psychiatric diagnosis often marks the start of social exclusion, and because psychiatric services can be experienced as ghettoised and stigmatising.

As a result of the strength of their findings regarding discrimination, the report's author argues that any definition of social exclusion that focuses solely on the labour market is misplaced and partial and, equally, any attempt to address mental health problems that does not take into account the material circumstances of service users will be critically undermined. While policy initiatives should focus on addressing the poor material circumstances of service users, the report maintains that they should also work towards creating greater social cohesion or social inclusion, identifying the arts as important in addressing public mental health and countering stigma:

> The arts can play a catalytic role in promoting social inclusion both by virtue of the participatory processes involved and the products created. Whether in drama, visual arts, poetry, or other forms, artistic product can help audiences to grasp truths about mental health. (Dunn, 1999)

Social inclusion

The reports reviewed above indicate that social inclusion in mental health is about ensuring that people with mental health needs can become valued and responsible citizens and take part in 'mainstream' activities alongside people who do not need to use mental health services. Thus social inclusion is a concept that can be used to help ensure that people with mental health needs have greater and fairer access to activities and relationships in society such as jobs, education and other social roles.

The Inclusion Research Network, established to bring together UK researchers working in this field, has outlined three key strands to social inclusion in mental health (Bates, 2005):

1. Access to services that promote:
   - empowerment
   - participation in design and review of services delivered to self and others
   - service user employment in services

2. Standard of living – a fair share of the benefits of modern society:
   - income
   - housing
   - employment
   - education
   - healthcare

3. Relationships – diverse roles, relationships and connections:
   - social networks
   - social capital
   - respect and positive attitudes of others (absence of stigma & discrimination).

As a complex concept of much current interest in its own right, social capital is considered further below.

Social capital

Whereas conceptualisations of 'social inclusion' have a tendency to emphasise the development of specific formal roles in the community (e.g. through work and education) social capital theorists focus more on informal roles, relationships and ties. Definitions frequently refer to the existence of, and participation in, organised networks or groups as well as less tangible and informal ties such as social trust, civic co-operation, mutuality, reciprocity, local democracy and group solidarity. While these latter have often been referred to as 'weak' or 'thin' ties, they are viewed as 'glue' that holds wider and more formal institutions together (World Bank, 2001). However, a more radical conceptualisation of social capital links its possession to discussions of power and inequality (Bourdieu, 1983). Thus 'building social capital' can be viewed as a way of increasing societal cohesion, or as a means of exposing inequality and discrimination and challenging power structures by developing networks of solidarity and local democracies.

Much discussion of social capital refers to the work of Robert Putnam, an American political scientist who has written about the erosion of 'social capital' in modern societies. Putnam (1995) reported that Americans increasingly tend to 'bowl alone' rather than in leagues, a metaphor for disappearing togetherness, as measured by a decline in all types of communal behaviour. Using a measure operationalising social capital in terms of communal behaviour, Putnam demonstrated that communities with high levels of social capital tended to have better health status, education, lower levels of crime and so on. In Britain, Campbell et al. (1998) have used some of this thinking to show that areas with greater social capital (as defined by Putnam) predominately had higher levels of health. In London specifically, Cave and Coutts (2002) have demonstrated that where social support improved over time the mental health of the community also improved.

Two types of social capital identified by Putnam (1995) are of particular interest in relation to our study:
   - bonding capital, described as connection and contact amongst people who share similar characteristics.
   - bridging capital, described as connecting with people unlike ourselves and the wider and communities.

Within the social capital literature the arts are viewed as having the potential to generate both. Putnam and Feldstein (2000) suggest that the enjoyable nature of art makes this the

most promising, if neglected, means of developing social capital, arguing that the participatory nature of art can develop many 'civically valuable dispositions' such as trust, openness, honesty, cooperativeness, tolerance, and respect, which in turn helps to build and nurture social capital. Moreover, engaging in art creates enjoyment, which in turn develops a willingness to connect with others.

Equally, studies of arts participation have indicated that generating social capital is amongst the potential benefits (e.g. Williams, 1997). However, White and Angus (2003) report that arts and health projects are more likely to demonstrate their ability to generate 'bonding' as opposed to 'bridging' forms of social capital. In other words, they create supportive links between people in their target group but may be less successful in linking the group into the wider community. The authors go on to argue that overcoming barriers to integration should become a key aim of arts and mental health projects. On this point, the SEU report (ODPM, 2004) notes that participation in the arts amongst people with mental health needs is often facilitated through mental health specific services such as day centres rather than through support for people to take up arts activities in mainstream settings.

The limitations of social inclusion

Our review thus far would appear to suggest that social inclusion can be universally regarded as a positive aim. However, the review would not be complete without a critique of this position, and there are two grounds for such a critique.

The first concerns the relationship between promoting 'inclusion' and reducing 'exclusion'. On the basis of our review, when ideas relating to social exclusion and social inclusion are compared, it appears that the social inclusion agenda has moved unproblematically from a discussion about social exclusion to imperatives to 'include' people. As a result, the social structures and divisions that lead to exclusion in the first place are often left out of focus. Bates and Davis (2004) argue that social capital concepts are necessary to enrich thinking about social inclusion, since social capital theories have a greater potential to help understand the importance of oppression, discrimination and structural inequalities, and the ties that might help combat this. Not dissimilarly, other commentators maintain that social exclusion can be removed only by fighting the structural conditions that cause it, and that those conditions cannot be removed by benevolent programmes which may merely mitigate the perceptions people have of their own exclusion rather than combat it with genuine structural change and opportunities (Merli, 2000). Arguably, there is a danger that arts and mental health projects come to constitute one of these 'benevolent programmes'. Indeed, concern has been expressed that although the Arts Council (1999) has agreed a similar definition of social exclusion to that put forward by the SEU (Cabinet Office, 2000, cited in Jermyn, 2001), taking low-income areas as its starting point and focusing particularly on poverty, publications from the social inclusion team at the Arts Council England national office rarely mention poverty as an underlying problem. Instead, activity tends to be focused in two key areas: health and criminal justice (Shaw, 2003; Jermyn 2004)

Moreover, there remains a lack of clarity about what might constitute socially inclusive activity or socially inclusive projects. Allin (2000) argues that it is not sufficient for arts projects to be viewed as socially inclusive simply because they increase access to arts activities. Rather, the issue is whether or not such activities contribute to social inclusion and neighbourhood renewal outcomes. Although arts projects are often located in centres within socially excluded neighbourhoods or communities and work with excluded groups, they may not *explicitly* aim to address the problems associated with social exclusion such as health, education, employment and crime. While some may use the arts to address certain problems associated with social exclusion, others may have no such social objectives and be offered

purely as an opportunity to participate in arts activities (Jermyn 2001). Jermyn (2004) recommends that the Arts Council considers offering a clearer definition of social exclusion and also outlines what it counts as 'social inclusion work'.

The second basis for a critique of the concept of social inclusion relates to an assumption that social inclusion will have health benefits. While it seems clear from the literature that social exclusion has a negative impact on health and well-being, it is less clear that the accompanying widespread assumption that inclusion in wider social networks is important for health and well-being is justified (Angus, 2002). Whereas addressing social exclusion can be seen as action to remove vertical barriers to inclusion, promoting social inclusion necessarily involves a radial shift in attitudes towards minoritised groups. Such a shift in attitudes is arguably the key benefit to be attained through social inclusion policies, without which a society that claims to be 'inclusive' may be experienced as intolerant and coercive. For example, is it really the case, as social inclusion theorists suggest, that everyone can feel at home in mainstream society and might such attempts risk focusing on slotting people into society, at the expense of a focus on transforming that society (Bates and Davis 2004).

This is consistent with a measure of disquiet amongst mental health service users and psychiatric survivors about the social inclusion agenda. Although most welcome efforts to identify the extent and impact of social exclusion and discrimination, some are concerned about the imperative to be 'socially included'. While it might be thought that this view would be expressed mainly by people considered to be 'institutionalised', and therefore reluctant about and fearful of change, it is a view shared by some active members of the service user/survivor movement. For example:

> Survivors don't necessarily want to be part of a mainstream society which has rejected them and in which they will never easily fit until society itself redresses its prejudiced attitudes and tunnel vision. Where is the problem located, in the individual who has dropped out or been excluded, or in society, which tries to force people to fit its stereotypes? 'Social inclusion', if we are not careful, can sound rather like 'normalisation', which appeared to mean making people more normal so they would fit in. (Wallcraft, 2001)

Similar critiques are emerging in relation to the arts. For example, on the basis of her survey of a small sample of community arts projects and participants, Jermyn (2004) reported that while arts practitioners were more comfortable with the language of social inclusion than that of social exclusion because it appeared less stigmatising, many raised questions such as 'inclusion in whose culture and whose society?'

Health

As noted earlier, the concept of 'health', and particularly 'mental health', is just as contentious as 'social inclusion'. Writers in the field of health promotion (Research Unit in Health and Behavioural Change, 1989; Ashton and Seymour, 1989) have long argued that health should be viewed as a positive concept, often termed well-being, in line with the World Health Organisation's definition:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (WHO, 1948)

In turn, health promotion is viewed as underpinned by a number of key principles including:
- a clear focus on the promotion of positive health, or well-being, alongside the prevention of ill health

- addressing the structural issues such as discrimination, poverty and unemployment, that affect our health and the choices we make, as well as focusing on the knowledge and behaviour of individuals or groups of people. (WHO, 1986)

Nevertheless, where UK policy is concerned until recently 'health' has tended to be seen as no more than the absence of illness and the focus has been on the prevention of illness in priority areas, including mental health (Department of Health, 1993; 1999a). Equally, the remedies for ill health have been seen as lying primarily in changing individual behaviour rather than in addressing the structural issues that affect health and health behaviour.

Although the most recent public health White Paper (Department of Health, 2004) is set in the context of cross-governmental initiatives to address the structural determinants of health, including initiatives aimed at tackling social exclusion, reviews of the mental health promotion literature (Secker, 1998; 2005) indicate that approaches to the definition and promotion of mental health remain largely illness-centred and focused on the individual.

A more positive approach, at first sight, is the notion of a continuum from mental health to mental illness along which people might move back and forth depending on their life circumstances. From a campaigning perspective this is a useful conceptualisation because it does highlight that anyone can experience mental ill health. But from a health promotion perspective the continuum approach fails to take us very far, because again mental health is seen only as the absence, albeit in this case the relative absence, of mental illness.

During the 1990s, attempts were made to rethink the relationship between mental health and illness, notably by Trent (1992), who proposed a model in which two continua, one representing mental health and the other mental illness, were intertwined like the strands of a cable. While this does allow for the promotion of mental health alongside and separate from the prevention of mental illness, the idea did not take root and Trent himself later appeared to abandon it, proposing instead that shame, guilt, fear and isolation should be the focus for mental health promotion on the grounds that they are precursors of mental illness (Trent, 1994). Thus his attempt to conceptualise mental health as distinct from the absence of illness collapsed back into a negative approach.

What is perhaps most striking about Trent's endeavour to separate mental health and illness is that he was reinventing a wheel that had already been invented by Downie et al. (1990). In this key health promotion text, Downie and his colleagues argued that the relationship between health and illness can be conceptualised in terms of a two-axis model, with high to low levels of positive health represented on a vertical axis and high to low levels of ill health on an intersecting horizontal axis. Transferred to mental health (Figure 1), this model locates people at any point in time in one of four quadrants. Those located in quadrant A would have attained the ideal state of enjoying both low levels of mental ill health and high levels of positive mental health. Those in quadrant B, on the other hand, would have low levels of mental ill health, but also low levels of mental well being, a state many people can probably recognise from their own experience. Moving round to quadrant C, here both high levels of ill health and low levels of positive health would be experienced, a condition that might be thought to characterise those who need to use mental health services. However, quadrant D allows us to think differently about mental health service users: although people who need to use mental health services will by definition be experiencing mental ill health, they can nevertheless achieve and maintain mental well-being, in the same way that someone with a physical impairment can nevertheless aspire to good physical health.

While this might seem counter-intuitive, it accords with recent evidence that challenges clinical notions of recovery from mental ill health as necessarily involving the absence of

symptoms. Instead recovery can be understood as a social process of recovering a fulfilling life regardless of the presence or absence of symptoms (Kruger, 2000). In terms of the health promotion model, then, we may have a diagnosis of 'mental illness' or self defined distress or 'madness' but we can still aspire to all the things that engender a sense of mental well-being: good relationships, a valued role, a reasonable standard of living and so on.

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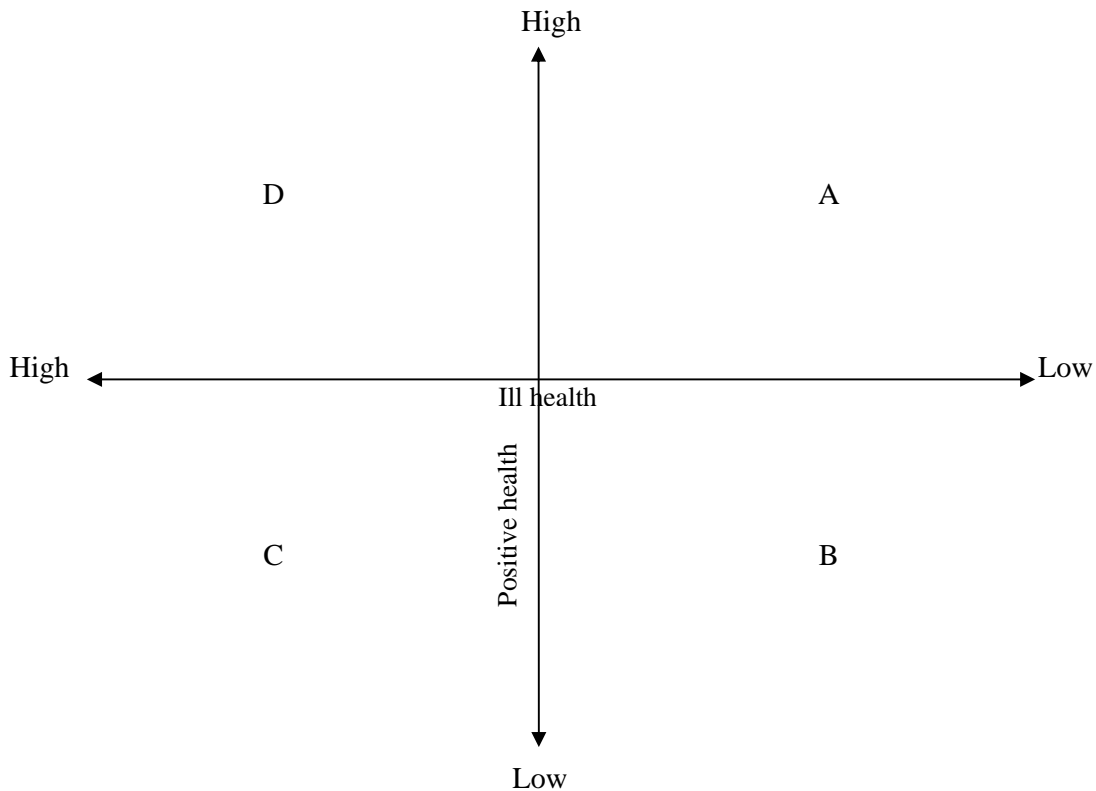
Positive health

Figure 1. A two-axis model of mental health & illness

Recognition that people with mental health needs may nevertheless aspire to mental well-being also has some resonance with notions of 'mad pride' which have recently emerged in the UK psychiatric survivors' movement. Here survivors have sought to celebrate all aspects of their lives, including their aspirations and experiences during periods of madness (Curtis et al., 2000). Interestingly, in view of the focus of our study, Mad Pride (and similar organisations such as Mad Women, Mad Chicks and Survivors Poetry) have tried to forge and celebrate a culture of mad pride predominantly through visual art, poetry and music. Indeed, from a progressive 'social inclusion' perspective, Mad Pride events could be considered the most socially inclusive of all. Organisations formed loosely around the notions of 'Mad Pride' regularly put on cultural events in local music venues, parks, pubs and cafes. Here the challenging music, poetry and art of psychiatric survivors (and others) are celebrated and open to all. These events seem to demonstrate the potential of what White and Angus (2003) argue is the creative energy of art which can push against barriers, boundaries and preconceptions in mental health and really engage with the madness of art and its making.

Turning to health promotion's emphasis on working at structural levels, arguments for approaches that move beyond changing individual behaviour have rarely been translated into action in mental health (Secker, 1998). A striking illustration is provided by a mental health promotion conference held in Vermont in 1981 that focused on political action and social change, the only one of this annual series of conferences to do so. Although a conference

addressing this theme might have been expected to attract papers describing relevant initiatives, rather than addressing structural issues, the initiatives described aimed to assist oppressed groups to cope with the destructive effects of poverty and discrimination. A similar picture emerges from a review of the European literature. For example, a collection of papers from a mental health promotion conference held in England in 1994 included two papers addressing the need for structural change. In the checklist drawn up after the conference to guide commissioning policy, however, no mention was made of activity at this level. Within the field of mental health promotion, then, questions arise about the extent to which individuals are assisted to cope with disadvantage rather than addressing the structural factors involved, just as questions arise about the extent to which 'social inclusion' means helping individuals to fit into a prejudiced, unwelcoming society.

The arts in health

A review of community art for health activity undertaken for the Health Development Agency (2002) reports that surprisingly few arts/health projects explicitly state that their aim is to affect health. Nevertheless, the literature does provide some indication that arts participation may have health benefits, particularly in relation to positive health or well-being. For example, in his study of arts participation, Matarasso (1997) found that participants reported feeling better or happier and more confident. Similarly, Jermyn (2004) reported that participants in her study identified the following benefits (amongst others):

- raised levels of self-esteem and confidence – as a result of projects, participants said they felt proud of what they had achieved, felt more confident and many felt better about themselves
- a greater feeling of self-determination and sense of control – participants felt they had freedom to develop their ideas and generally felt a strong sense of ownership of the final product
- pleasure and enjoyment.

Where people with mental health needs are concerned, however, studies have focused on indicators relating to ill health instead of or in addition to positive health or well-being. The results reported include:

- fewer re-admissions to psychiatric hospital (Colgan et al., 1991)
- lower levels of depression (Huxley, 1997)
- reduced rates of GP consultation (Everitt and Hamilton, 2003)
- Reduced incidence of 'behaviours associated with mental illness' (Malley et al., 2002)

Linking social inclusion and health

So far we have treated social inclusion and health as distinct concepts. However, there are grounds in the relevant literatures for linking these concepts in ways that are helpful in relation to our task of developing indicators for and measures of the benefits of arts participation for people with mental health needs.

The well-being related outcomes described above may represent progress or 'distance travelled' towards social inclusion outcomes such as employment or education, and towards health outcomes such as lower levels of mental ill health. The term 'distance travelled' has been used to refer to the progress that a beneficiary or participant has made towards greater employability as a result of the project intervention (e.g. Dewson et al., 2000). We have therefore used the term to refer to any progress made towards health or social inclusion outcomes.

Where social inclusion is concerned, for example, Hill and Moriarty (2001) note that increases in confidence and self esteem could lead to individuals using arts projects as a stepping stone into prevocational education or into employment. Equally, in designing a model for measuring increases in employability or 'distance travelled' for projects operating under European Social Fund Objective 3, Dewson et al. (2000) note how the acquisition of certain 'soft' outcomes, such as confidence, could represent an immense leap forward for some individuals, and were often seen as vital first step towards social inclusion. In similar vein, the HDA (2000) argue that building self esteem, confidence and social connectedness helps to build social capital, which in turn leads to enhanced individual health and social inclusion outcomes. The literature relating to employment for people with mental health needs provides support for these linkages, in that confidence building emerges from research as a crucial first step in the journey to work (Secker et al., 2002).

In addition, well-being related outcomes can also be viewed as indicators of 'distance travelled' towards mental health outcomes such as reduced use of medication and services. For example, clear links have been demonstrated between mental health problems such as depression and low levels of self-esteem (Emier, 2002; Cheng and Furnham, 2003; Marmot 2003) while the Mental Health Foundation's report *Strategies for Living* (Faulkner and Layzell, 2000) demonstrates the importance of enjoyment and pleasure in the lives of those who experience mental distress.

We return to the potential of the notion of 'distance travelled' for developing outcome indicators and measures in describing the ways in which arts projects currently evaluate their work.

3.   Phase 1 methods

This section describes the strategy used to search for, identify and contact relevant arts projects, the design and piloting of the Phase 1 survey questionnaire, the data collection process and the way in which responses from projects were analysed.

Identifying and contacting projects

A number of methods were used to identify as full a range of relevant projects as possible to invite to participate in the survey. As a first step, Internet searches using 'arts' and 'mental health' as keywords were carried out. These revealed several relevant websites and contact information for projects listed on these was entered on our database. We also followed up various established national and regional networks, mailing lists and databases, 'snowballing' the information we gathered through other projects and 'word of mouth'. The links we made were followed up until there was sufficient overlap in the projects identified for us to be reasonably confident we had exhausted these sources. Once the study went 'live', in March 2005, we sent each project an introductory letter explaining the research, inviting participation and asking them to circulate our letter to other projects of which they were aware. Rather than asking projects to opt into the study, we asked them to contact us if it was clear that it was not relevant for them. Otherwise, we would send them a questionnaire in two weeks time. Of the projects we contacted in this way, 13 let us know that the study was not relevant for them.

At the same time, we contacted a number of 'umbrella' and other organisations to ask for help in publicising the study. These included the National Network for the Arts in Health, Voluntary Arts England, the Disability Arts Forums, Mad for Arts, the National Institute for Mental Health in England (NIMHE) Regional Development Centres, the National Institute of Continuing Adult Education (NIACE), the national mental health voluntary organisations, all mental health NHS trusts in England and all local Mind or associated organisations in England. For these organisations we enclosed a shorter briefing about the study, inviting relevant projects to contact us. We received a great deal of assistance from the organisations we contacted, many of which disseminated our briefing via their websites, newsletters and mailing lists. Members of the project advisory group also provided contact details for relevant projects and organisations and distributed information for us, as did the Regional Arts Councils. Projects contacted in this way were also sent our introductory letter.

A list of all those projects that agree to publication of their contact details will be provided with our final report. Copies of our correspondence with the projects are contained in Appendix 1 of this report.

Design and piloting of the questionnaire

Since the main aims of the Phase 1 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.

Where projects were collecting data about participants, we asked them to let us have copies of the forms they used for this purpose. Similarly, where projects were evaluating their work we asked for copies of the forms and measures used. In addition, we asked if they would be willing to share their evaluation data with us. All respondents were invited to send us any documents they thought relevant, such as leaflets and other literature.

To make the questionnaire as 'user friendly' as possible, most questions could be answered by ticking a box, though space was also included for 'other' responses that did not fit the categories provided, and for comments if projects wished to add to their responses.

Four projects with which we had contact during the process of setting up the study agreed to pilot the questionnaire for us and it was amended in light of their helpful comments and suggestions. Members of the project advisory group then gave comments on the amended version that resulted in further useful changes.

The survey questionnaire is contained in Appendix 3.

Data collection

Electronic and postal versions of the questionnaire were produced and where possible it was mailed electronically. A Freepost address was provided for projects that received the questionnaire electronically but wished to print it and return it by post as well as for projects sent the questionnaire by post. Projects were asked to return the questionnaire within three weeks. At the end of this period a reminder was sent to projects that had not yet responded, followed by a final reminder around one week later. At this stage, projects that had not responded were contacted by phone. Although time consuming, this proved valuable in almost doubling the response rate. In a few cases, the questionnaire was completed with projects over the phone. All projects from which a response was received were sent an acknowledgement and thanked for their assistance. As questionnaires were returned all data, including additional, written comments, were entered on an Access database to facilitate analysis.

Since completing the survey, we have continued to receive expressions of interest in participating in the study and we are continuing to mail questionnaires to these projects. Although their responses cannot be included in this report, we will include them in our final report.

Data analysis

The process of analysing the survey responses involved 'cleaning' the data followed by thematic categorisation. As an example of cleaning, many projects had ticked more than one box on single answer questions and we used this information to add multiple answer categories to those questions. For example if a number of projects ticked two answers to a particular question then we added a category combining the two answers. In addition, some projects gave a range of numbers where a 'best estimate' single number was requested, such as for their income in the previous 12 months. In these cases we used the mid range as the best estimate. As far as possible, we also used existing information to fill in uncompleted boxes. For example, where a project indicated that 95% of participants were from white ethnic backgrounds but did not include figures for any other ethnic groupings, we added 5% for that project in calculating the overall proportion of participants from minority ethnic groups.

In thematically categorising responses, many categories had to be reduced to take account of overlaps and make sense of complex data. For example, funding agencies were reduced to the main funder, and some funding categories were collapsed together because it proved impossible to separate them (see pages 21-22).

Where it was possible, category responses were checked for reliability across a project's responses by triangulation with similar or related questions. For example, when checked against staffing levels some projects' estimate of their annual funding was clearly an underestimate. We therefore used a staffing cost calculation to arrive at a more accurate figure (see pages 19-20).

Where evaluation was concerned, in addition to categorising projects' responses about whether they routinely evaluated their work, we analysed the forms and measures they sent us in order to ascertain the range of methods used and issues covered.

4.   Survey 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 flexibility and supported by a variety of funding sources. For this reason the results are presented for all responding projects rather than by project type.

We first consider the response to the Phase 1 survey in terms of how representative the responses we received were. We then present our analysis of projects' responses under four main headings relating to:
- the scale of arts and mental health provision
- the scope of that provision
- models of provision
- monitoring and evaluation.

The response to the survey

It is not possible to calculate a precise response rate to the survey because some organisations and individuals to whom we sent questionnaires copied it to others so we do not know how many were eventually distributed. Our best estimate is that of around 230 questionnaires distributed 116 were returned, a response rate of 50%, which is more than respectable for a survey of this kind. It has subsequently become apparent that some projects to which questionnaires were sent were not relevant to the study, or that different contact details for the same project meant some projects received more than one questionnaire. Other projects which would have been very relevant had either closed or were not yet running, although some of these did send us useful information.

Of the projects described in the 116 responses received, 102 fit the criteria of offering participatory arts activity to adults between the ages of 16-65 with mental health needs. Our analysis is based on these projects' responses. However, this sample reflects some areas of England better than others. For this reason we have not attempted an analysis by geographical area. Few cities have more than one or two projects represented and for some areas, none at all responded. This is not consistent with existing knowledge and we are aware that smaller projects are particularly under-represented. It is important to bear this in mind when interpreting the findings of the survey. The types of projects that were able to respond to our questionnaire in the relatively short space of time available were likely to be more established and better funded projects. Nevertheless, we are fairly confident that our responding projects offer a representative sample of these more established projects from which to draw some comparisons, although they may not sufficiently represent projects that are less well-funded, not long established, spontaneous and primarily volunteer or user run.

Projects responded from a wide variety of English locations, both large and small and rural and urban. The Greater Manchester (7 projects) and Greater London areas (17 projects) seem to be represented particularly well, but surprisingly, we had no response from projects in the major cities of Liverpool or Birmingham, both areas reported to have very active arts participation. The distribution is shown in Table 1 (*one project had a number of locations in different areas).

Area	No. of Projects
North East	9
North West	20
Yorkshire	9
East Midlands	7
West Midlands	2
East	8
London	17
South East	15
South West	13
Isle of Wight	1
Total *	101

Table 1. Response by area

The 102 projects on which our analysis is based did not all answer every question and the response rate for each question considered in the following sections therefore varies as noted in the text.

The scale of provision

Projects' responses to four questions about funding levels, staffing levels, length of time established and the number of participants projects worked with each week enabled us to gain an impression of the scale of arts and mental health provision in England, at least for the more regularly run projects that comprise our sample.

Funding levels

We asked projects for an estimate of their income for the last 12 months, having assumed that this would be fairly straightforward. In the event, only half of the responding projects were able to provide an estimate. The impression from those that were able to do so is that funding levels varied greatly over time and could depend in part on opportunistic bids, even where a substantial proportion of income came from established sources.

Additionally, it was clear from responses to questions about staffing levels that projects run as part of statutory sector provision, for example within a mental health NHS trust, received not insignificant funding 'in kind', such as staff salaries and administrative support provided by the host organisation, that was not included in their response. In order to develop a more accurate idea of funding levels nationally per 100 projects, we therefore compared projects' stated annual income with the staffing levels they reported. Where there were obvious discrepancies we calculated the in kind support associated with staff salaries and on costs on the fairly low assumption of an average annual salary of £20,000 FTE[2].

Altogether, the declared funding from the 50% of responding projects totalled almost £2m. If these projects are reasonably representative, a funding level nationally of £4m per 100 projects would be assumed. Taking into account our staffing cost calculation, however, we estimate that the funding level is in excess of £7m per 100 projects.

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[2] Based on average weekly earnings for public sector workers (Office for National Statistics 2005, Quarter 1).

Staffing levels

Turning to the staffing level responses themselves, we asked projects how many people worked for their project on a part-time, full time, freelance/sessional and volunteer basis. Only six projects were not able to provide this information. Table 2 shows the total number of paid staff and volunteers across the 96 responding projects.

Not all projects employed paid staff, some were entirely run by volunteers and some by sessional workers. The average number of non-sessional paid staff across the 96 projects was two: one full time and one part time (over 15 hours). The average for sessional workers was five, but here the range was very wide, varying from none or one to as many as 20. For volunteers the average was also five, but again with a range from none or one to as many as 50

	No. staff	No. of projects with each staff category
Full time staff	97	40
Part time staff (over 15 hours)	100	39
Part time staff (under 15 hours)	106	42
Sessional staff	275	54
Volunteers	286	59
Total no. of projects responding	96	96

Table 2. Project staffing

Length of time established

Interestingly, although projects' responses about funding suggest a patchwork of complex arrangements, responses to a question about the length of time they had been operational do indicate a degree of stability. Most projects (92 of 94 that responded to this question) indicated that they had been established for over a year and more than half (54) had been established for over five years. The average was eight years within a range of a few months to as long as 30 years.

Number of participants

Of 97 projects that responded to our question about the number of participants engaged in their project each week, 19 told us they offered a series of sessions or workshops in which participation varied. We therefore calculated the average level of participation in these sessions in order to include them in our estimate. The range was very wide, from as few as five participants each week to as many as 300 at one project, with an average of 40. However, the average figure may be an overestimate since it was not always clear from responses that all participants were involved in the arts component of projects that offered a variety of activities as well as arts. Around a third (30) of the projects reported having ten or fewer participants each week. Most commonly participation ranged between ten and 30 people (36 projects). In total, projects' responses indicate that at least 3,909 people with mental health needs were participating in arts project activity each week.

The scope of provision

Several questions enabled us to map the scope of arts and mental health provision. Questions about projects' funding sources, settings and referral sources provide a broad impression of the extent to which provision relates to healthcare or to other contexts. Questions about the art forms used and about project participants enabled us to assess the range of activity provided and for whom.

There seemed to be no clear relationship between funding sources, project settings and referral sources except within the healthcare setting and even here the relationship is rather complex, because many projects took place in multiple settings. Overall, just over the half the 38 projects that told us they operated in healthcare settings, either exclusively or as well as in other settings, were both funded from and took referrals from health services.

Funding sources

Most projects (93) were able to provide an indication of their main funding sources and some projects were clearly the result of strong community development or NHS programmes and thus had a clear sense of identity as, for instance, an 'arts for health programme'. The majority, however, reported multiple funding sources. To make sense of this complex picture, we grouped projects by a simplified version of their declared funding sources, which were many and varied (see Table 3, column 2), and then into four main areas (Table 3, column 1): health; culture (encompassing the Arts Council and a wide range of charitable institutions); education; and social (encompassing social services and local authority community development and related initiatives).

On this basis, the most common funding sources were culture and health.
However, the 'culture' category is rather imprecise because it was impossible to separate out the overlap between arts and charity funded projects, since many charitable sources were clearly aimed at funding a varied range of cultural activities, including arts.

	Main funding Source	No. of projects
Health	NHS only	21
	NHS mixed	9
Social	Social Services	9
	LA community development	10
Culture	Arts Council full or part	6
	Various, private trust or self funded	21
	Large charitable trust	7
Education	Education/Learning Skills Council	10
	Total	93

Table 3. Funding sources

Project settings

Projects were asked to indicate the setting in which they worked on a list including community, healthcare, social services, integrated (health and social services), education and specialist arts settings. All 102 projects were able to respond to this question. As Figure 2 shows, the most common setting was in the wider community, but healthcare and specialist arts settings were also common.

Figure 2
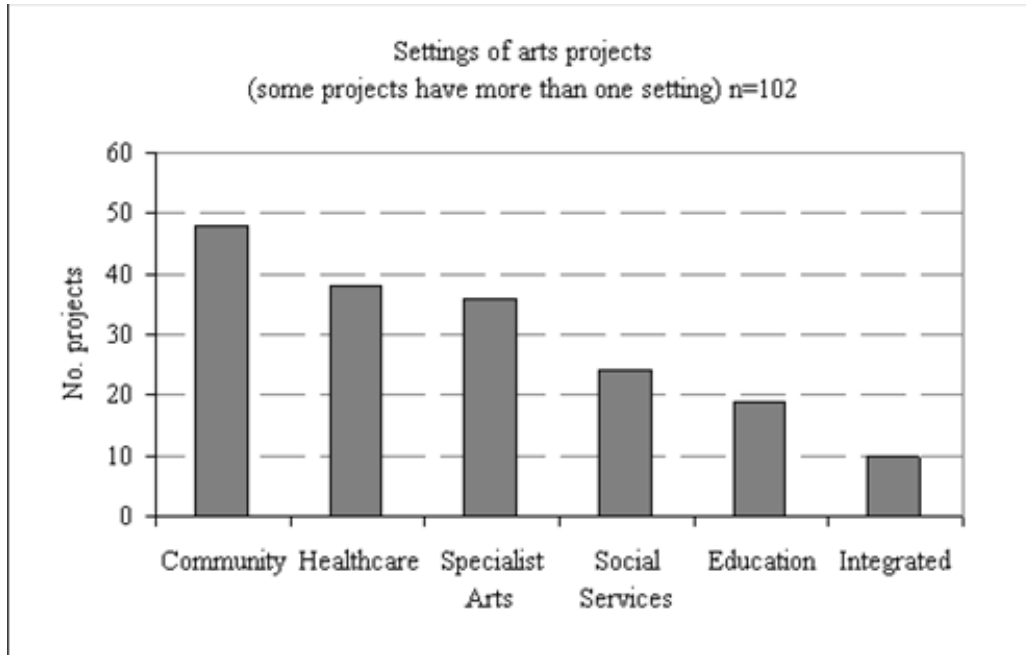
Referral sources

Most of the 100 projects that responded to this question accepted referrals from multiple sources, although 12 accepted referrals only from specialist mental health services and four only from primary care health services. Table 4 shows the number of projects accepting referrals from each source identified. When projects' referral sources were examined in relation to their funding sources it was clear that most referrals to most projects (78%) came from health service sources, regardless of their funding source.

Source	No. of projects
Specialist mental health services	87
Self-referral	75
Primary care services	66
Voluntary & community agencies	57
Social services	59
Informal carers	41

Table 4. Referral sources

Art forms

All 102 projects responded to this question and between them they offered participants a vast range of art activities. As Figure 3 illustrates, the most common were visual arts in the form of drawing and painting (77%), but craft and writing were also very common, as was photography. Most projects offered more than one art activity, with an average of ten and a range from one to 20 or more, although projects offering such an extensive number did not offer them all concurrently.
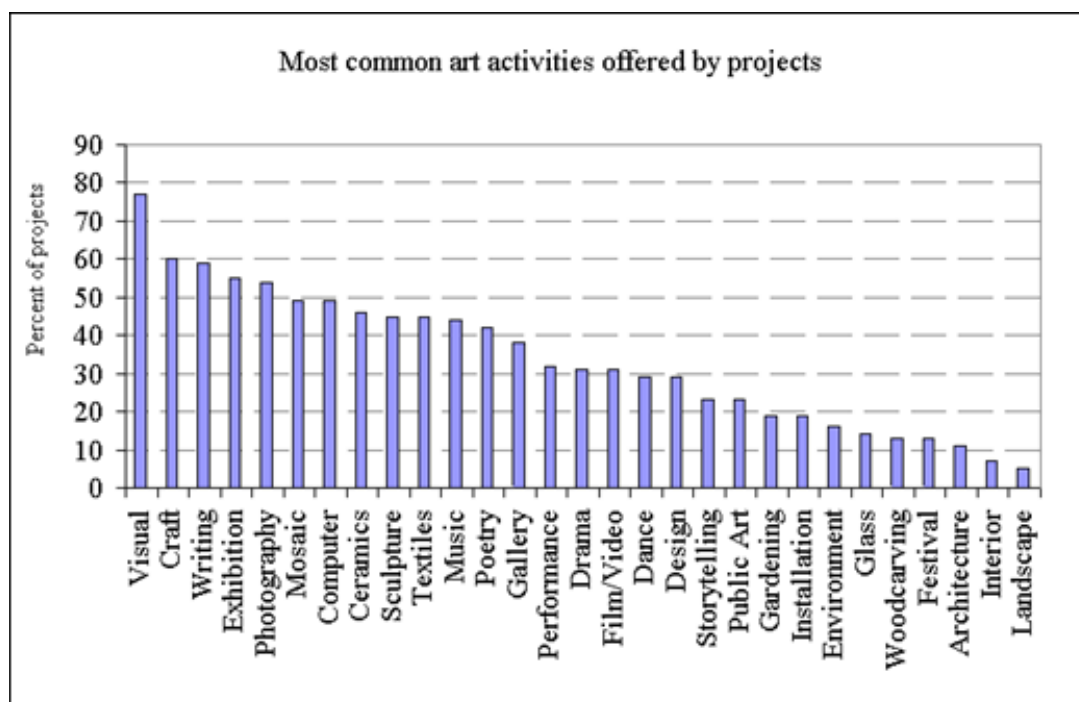
Figure 3.

Project participants

Questions relating to project participants concerned the proportions of male and female participants, their ethnic background and their mental health needs.

Overall, arts and mental health projects appear to be working with slightly more women than men. Across the 95 projects that responded to this question, the average proportion of female participants was 56%. However, the range was very wide, from as low as 2% at one project to one women-only project.

Using the 2001 census categories, projects were asked to indicate the proportion of participants from each of four ethnic groupings. Table 5 compares the responses of the 95 projects with the national population figures from the census. As can be seen, arts and mental health projects appear to be working with above average numbers of people from minority ethnic groups. Sixteen projects specified their main ethnic groups as 'other' and they detailed

very diverse populations, including Spanish speaking, Eastern European, Australian, Iranian, Greek, Jewish and Vietnamese people as well as Travellers.

	Census 2001	Arts Projects (n=95)
White	92.1	85
Asian	4.0	8.6
Black	2.0	12.1
Chinese	0.4	5.4
Other	1.6	4.6
All minority ethnic groups	7.9	16.0

Table 5. Percentage participation by ethnic group

Projects were also asked to indicate which groups of people with mental health needs they worked with and whether they also worked with other groups of people. Of the 80 projects that responded to the question:

- 5% (4 projects) said they worked with people receiving mental health care only from primary care services (mental health services provided by GPs, practice nurses, counsellors etc. in local GP practices)
- 45% (36 projects) said they worked with people using specialist mental health services (community mental health teams, rehabilitation or assertive outreach services and any other services provided by psychiatrists, community psychiatric nurses, mental health social workers or other specialist mental health workers)
- 49% (48 projects) told us they worked with people with specific mental health diagnoses (e.g. schizophrenia, depression, anxiety, bi-polar disorder).

It was clear that not all the 48 projects that reported working with people with specific mental health diagnoses were working exclusively with specific diagnostic groups, as intended in our question, since 22 of these projects described the group with which they worked as 'all mental illness'. The other 26 projects mainly listed diagnoses associated with mental health needs viewed as serious and enduring, such as bipolar disorder, schizophrenia and psychosis. Two projects told us they worked specifically with people with eating disorders and one with people experiencing depression.

Most projects did not work only with people with mental health needs. Over half (45) worked with people from the wider community as well as people with mental health needs. A further 35 projects worked with people with other identified needs, including learning disabilities (17), physical disabilities (12), long term illness (4) and older people (2).

Models of provision

Questions of interest in relation to the models adopted in providing arts and mental health participation for people with mental health needs concerned the models of participation adopted, the intensity of participants' involvement and the extent to which people with experience of using mental health services were involved in running projects.

Models of participation

Projects were asked to select the model adopted for participant involvement in the arts from a list of descriptions adapted from a previous review of arts based projects (Health Development Agency, 1999). The descriptions encompass five models:
- Instruction/education: an artist, instructor or someone in a similar role directs or educates project participants
- Guidance: project participants motivate themselves to produce their own art works, with guidance where necessary
- Collaboration on given project: project participants work together on a project decided by an artist, instructor or someone in a given role
- Collaboration decided by participants: project participants cooperate to decide on a project and work together on it
- Creation of events: professional artists work with a project group to create a festival, pageant or other event.

One hundred projects responded to this question. The responses shown in Figure 4 indicated that directed models were the most common (48 projects represented in columns 1 and 3), with participant-led models in second place (33 projects represented in columns 2 and 4). The creation of festivals and other events (column 5) tended to be used by projects that adopted more than one model (the 18 projects represented in column 6) because they were running different programmes at different times, or several programmes concurrently with different groups.
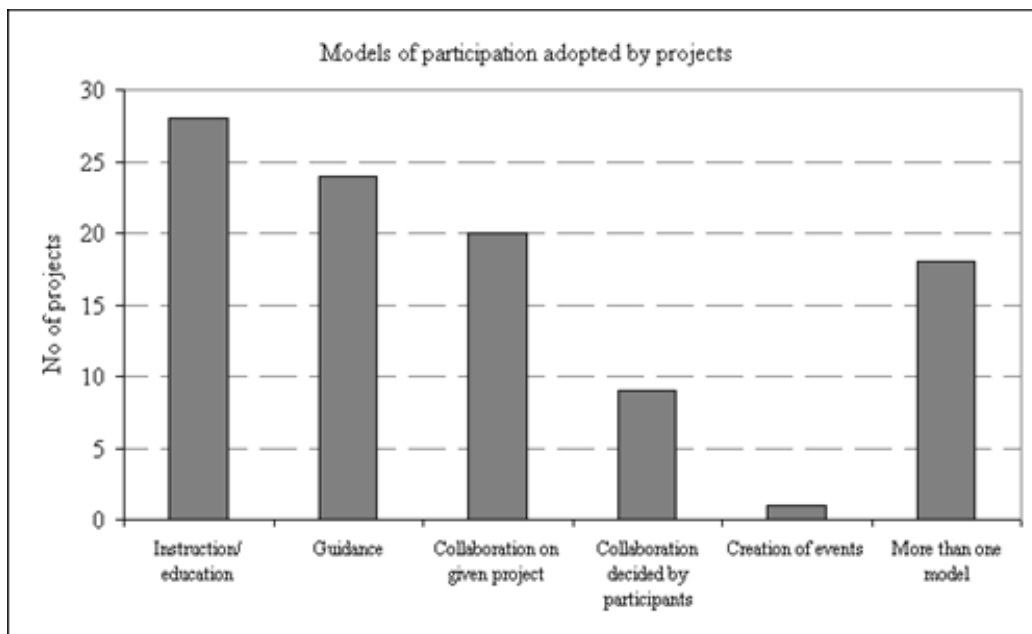
Figure 4.

Intensity of involvement

On the basis of responses from 91 projects, the average time participants spent at a project each week was five hours, with a range of less than three hours (37 projects) to more than three days (two projects). Although participants might not spend much time at a project each week, in just over half the projects (52%) they were able remain involved with the project as long as they wished. In a further quarter of projects, length of involvement was open to

negotiation based on participants' needs and goals. Where involvement was time limited this tended to be because the projects themselves were running for a fixed time period.

Involving people with mental health needs in running projects

Projects were asked whether and how they involved people with experience of using mental health services in running the project. All 102 projects responded and their responses are indicative of high levels of involvement (Figure 5). At over half the projects (57%) current or former service users helped run the project as volunteers. In almost half (44%), they were committee members and in a similar proportion (42%) they were employed as staff members. At one project only one of 80 people involved with running the project had not used mental health services at some time and only 15 projects did not appear to involve people with experience of using services at all. As many projects pointed out in their response, the high levels of involvement reported are consistent with the participant-led models of participation adopted by many projects.
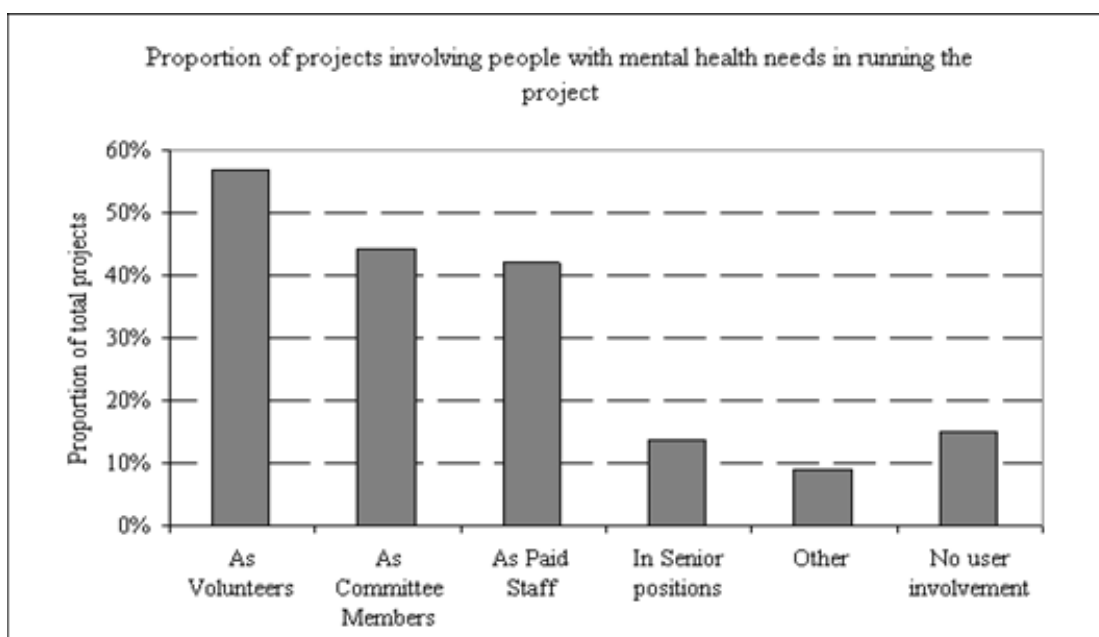
Figure 5

Monitoring and evaluation

In view of our brief to assist in developing the evidence base for arts and mental health activity, we were interested to discover the extent to which projects routinely recorded information about participants' backgrounds and needs, what outcomes they intended their work to have and whether and how they evaluated their work.

Information recording

We asked projects if they recorded any or all of six categories of information about participants:

- age
- sex
- ethnicity
- diagnosis or assessment details
- mental health needs
- participants' goals.

Ninety three projects responded and almost two thirds (65%) said they collected information in three or more of these categories, the most common being sex (73%) and age (68%), with 42% recording mental health needs and only 28% diagnosis. Fifteen projects did not routinely record information about their participants and several of these commented that recording such information would compromise the security and integration of participants.

Intended outcomes

We asked projects to select the outcomes they intended their work to have for participants from a given list and to then rank the three most important (Table 6 overleaf).

Amongst the 101 projects that responded, the most common and most important outcomes, agreed by more than 90% of the projects, were:
- improved self-esteem
- improved quality of life
- personal growth in the sense of a transformation of identity
- increased artistic skill.

Although most projects hoped for and worked towards increased employment opportunities and health related outcomes such as reduced use of services or medication, none ranked these as the most important outcomes. For example, while 77% of respondents stated that reduced mental ill-health symptoms was an intended outcome, only 26% of respondents ranked it as one of the three most important intended outcomes. (We were unable to use the rankings from 26 projects as they ranked more than three and it was unclear which three were most important).

What outcomes do projects intend their work to have? N=102 projects	Intended outcomes (not ranked)	Most important	2nd most	3rd most
Improved self-worth, confidence, self esteem	99%	43%	20%	13%
Improved quality of life	96%	8%	20%	13%
Personal growth/ transformation	91%	8%	13%	14%
Increased artistic skills	93%	9%	8%	9%
Reduced symptoms of mental ill health	77%	7%	9%	3%
Increased social contact with other people with mental health needs	81%	4%	5%	5%
Reduced stigma and discrimination	78%	5%	3%	7%
Increased opportunities for education	73%	3%	8%	3%
Increased social contact with people other than those with mental health needs	73%	3%	4%	5%
Increased opportunities for employment	63%	0%	8%	3%
Increased involvement with the local community	76%	3%	3%	4%
Improved access to mental health services	30%	1%	1%	1%
Reduced use of medication	35%	0%	3%	1%
To be recognised as artists	6%	0%	3%	1%
Reduced use of Primary Mental Health services	37%	0%	3%	0%
Reduced use of Secondary Mental Health services	41%	0%	1%	1%

Table 6. Most common and most important intended outcomes

Evaluation

Ninety-nine projects responded to our question about evaluation. Of these projects, 59 (61%) indicated that they routinely assessed the outcomes of their work. A further 24 projects (25%) had carried out an evaluation in the past, and eight did not routinely assess the outcomes of their work but were currently doing so. Only eight projects had never assessed their outcomes.

Thirty-nine projects sent us examples of the various forms they routinely used to assess outcomes. Based on an analysis of these forms, this section of our report examines the methods being used and the sort of outcomes being evaluated.

Evaluation methods

Like previous reviews of approaches to evaluation (Angus, 2002; White and Angus, 2003; Ruiz, 2004), our analysis suggests that projects are keen to demonstrate the benefits of their work but are struggling in some respects to find ways of doing this. Only two respondents indicated that they used a standardised, validated outcome measure at more than one point in time, in each case alongside 'softer' approaches such as project-designed questionnaires or qualitative approaches. One project used the Hospital Anxiety and Depression Scale (HAD), while the other used the Clinical Outcomes in Routine Evaluation (CORE) mental health measure. A third project used a range of scales that appear to be derived from standardised measures of well-being and self-esteem but were described as 'taken from primary care

mental health teams'. Perhaps unsurprisingly, all three projects were located within or primarily funded by the health sector, where there are stronger traditions of formal evaluation than in other sectors.

Of the other methods in use, the great majority (25) comprised participant-completed questionnaires presumably developed by the projects concerned. In 23 cases, the forms were completed at one point in time: at the end of participants' involvement with the project (14); after each session (7); or as part of an annual monitoring exercise (2). Only two projects asked participants to complete their forms at the beginning of and in later stages of their involvement with the project (a more robust 'pre- and post-intervention' design).

In terms of the formats used for these participant-completed questionnaires:
- 8 questionnaires contained mainly open-ended questions with space for participants to respond in their own words
- 6 used mainly closed questions with yes/no tick boxes (3 projects), rating scales (2 projects) or a combination of the two (1 project) for participants to indicate their response
- 8 used a combination of open-ended and closed questions.

At the remaining three projects, different formats were used at different points in time or with different participant groups.

Other methods used by projects alongside or in addition to participant-completed questionnaires included:
- monitoring forms completed by workers (usually artists) after each session or series of sessions (9 projects)
- qualitative methods such as interviews, group discussions, diaries, observation and case studies (5 projects)
- recording and review of participants' goals (3 projects).

One project had commissioned an innovative arts-based evaluation within which creative techniques were used alongside more conventional evaluation methods in an attempt to elicit and monitor changes in participants' health and well-being. The techniques used included: *Tree People*, where participants choose which of a number of figures depicted in different positions in or around a tree best describes how they are feeling; *Social, Cultural and Role Atoms*, used to enable participants to reflect on these aspects of their lives; and *Lifelines*, where participants use objects of their choice to stand for significant moments and relationships within their lives.

Evaluation content

In order to examine what sort of outcomes projects were evaluating we used three categories derived from our review of the social exclusion/inclusion and health literature to group the content of projects' forms:
- distance travelled outcomes, including confidence, self-esteem, empowerment, enjoyment, learning/skills gained and pride in the work produced.
- health outcomes, including mental health status, service and medication use
- social inclusion outcomes, including bonding and bridging social capital, employment and education outcomes, and future aspirations related to the latter.

Table 7 overleaf shows the number of projects evaluating their work within the three categories (projects might be evaluating more than one dimension within each main category).

In addition to the outcomes listed in the table, 13 projects used a range of formats to assess participants' satisfaction with organisational arrangements and/or content, while nine asked workers (usually artists) to record their perceptions of what was achieved during a session or workshop. Eleven projects asked open-ended questions about the perceived benefits of participation and a further 11 sought feedback from participants via open-ended questions about the best and/or worst aspects of a project. The majority also invited suggestions for improvement and any other comments participants wished to make.

Outcome	Examples of questions/measures	No. projects
Distance travelled		*42*
Enjoyment	Did you find the group enjoyable? (Tick box) What did you enjoy most/least? (Open-ended) How much did you enjoy the group? (Rating scale)	17
Learning / skills gained	What effect did the workshops have on your artistic skills? (Group discussion) Have you learnt new skills (Tick box) What new skills have you developed? (Open-ended) I feel I have very good performing skills (Agree to disagree rating scale + participants asked to circle the question if changed as a result of the project)	14
Self-esteem, confidence, empowerment	Have you become more confident about what you can do? (Tick box) What have you found out about yourself? (Group discussion) Where would you put your feelings of self-esteem on this scale? (Rating scale)	11
Pride in the work produced	What did you think of the work produced? (Rating scale)	1
Health		*13*
Mental health status	CORE measure HAD measure How useful was the project in aiding your recovery? (Rating scale) In what ways has the project benefited your mental health (Open ended)	7
Service & medication use	Have you been to see your GP for support with your mental health less often/more often/about the same amount? (Tick box) Has your medication been reduced/ increased/ changed (Tick box + space for details)	6
Social inclusion		*20*
Bonding capital	Have you met new people/made new friends? (Tick box) Have you met people from the group outside? (Tick box) The group helps patients to talk to each other (Agree/disagree rating scale)	4
Bridging capital	Have you become interested in something new/been to new places? (Tick box) The group motivates patients to explore creative activity as a way to develop their interests after leaving hospital (Agree/disagree rating scale)	3

	Has it interested you in joining a similar group in the community? (Tick box)	
Employment/education	Do you feel the skills learnt will help you get a job? (Tick box) Has it encouraged you to do new things such as a job or education? (Tick box)	3
Future hopes, aspirations, intentions	Where do you see yourself in three years' time? (Group discussion) Would you like to continue art as a hobby/job/study? (Tick box) Where will you go from here? (Tick box – multiple choice)	10

Table 7. Evaluation content

5.   Discussion

Our discussion of the survey findings and their implications is structured around the following headings:
- the scale of provision
- the scope of provision and the models adopted
- evaluation methods
- evaluation content.

The scale of provision

Based on the number of projects we were able to identify by the various means described earlier, participatory arts and mental health activity is a vibrant strand within the wider English mental health economy. There were indications in projects' responses, however, that the wide range of activity reported is achieved with limited resources. Even projects with established funding sources appeared to be relying on opportunistic bids to maintain their activity and our estimated national annual spend of £7 million per 100 projects is something of a drop in the ocean compared to the cost of mental health problems to society, estimated at £77 billion each year (Sainsbury Centre for Mental Health, 2003). Average staffing levels were also low, at 1.5 FTE paid staff members. Due to the type of projects that responded to our survey, this is likely to be a significant overestimation of numbers of staff involved projects, since projects with staffing difficulties may have been less likely to fill in a questionnaire. However, the low staffing levels reported have to be set against the extensive use of volunteers, which may be more in keeping with the participatory approach and intended outcomes of many projects than employing higher numbers of paid staff.

More positively, it appeared that the projects in our sample had achieved a measure of stability, with many established for eight years or more. In terms of projects' capacity to routinely evaluate their work stability in this respect is important. However, to engage in routine evaluation, projects also arguably need greater capacity than our survey suggests is the case in respect of funding and core staffing levels.

The scope of provision and the models adopted

Where the scope of participatory arts and mental health activity is concerned, health-related activity appeared to predominate. Health service funding sources provided the largest single source of funding for our sample and when funding sources were examined in relation to staffing, projects funded mainly from health service sources had more regular staff working longer hours than other projects. Similarly, when the settings in which projects were working were examined in relation to funding sources, health service sources were the main funding stream not only for 53% of projects working in healthcare settings, but also for between a

quarter and a third of projects working in community, social services, education and specialist arts settings. Overall, health service funding sources provided 33% of the total funding for 100 projects. Moreover, health services were the single largest source of referrals to projects, regardless of funding source.

Since routine evaluation is more developed in the health sector compared to other sectors, and the health sector appears to be both a main contributor to and user of arts and mental health projects, it is surprising that routine evaluation 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.

Despite the relatively low funding and staffing levels documented by their responses, the projects in our sample were offering an impressive variety of arts activities to almost 4,000 people with mental health needs each week, in a context where over 900,000 adults in England claim sickness and disability benefits for mental health conditions (ODPM, 2004). The range of sources from which referrals were accepted was wide at most projects, with self-referral second only to specialist mental health services in frequency, suggesting a high degree of accessibility. Although the response to our question about the groups of people with mental health needs with which projects worked was rather confusing, it was clear that most projects were working with people whose needs would be seen as serious and enduring. Most projects worked with a diverse range of people, rather than restricting their work to people with particular mental health conditions. That most projects also worked with people from the wider community as well as with people with mental health needs is of especial interest in relation to the promotion of social inclusion through building 'bridging' as well as 'bonding' social capital.

In other respects too, the projects were succeeding in areas where many mental health providers struggle. In particular, they were reaching above average proportions of people from Black and minority ethnic communities. In addition, levels of participant involvement in shaping the activities in which they engaged were high, as were levels of service user 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, 1999; 2000; 2005b). In our view there is real need for a more systematic approach to evaluating the processes and benefits associated with these achievements so that other mental health providers can learn from the experiences and successes of arts and mental health projects.

Evaluation methods

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 and the world view of arts in health workers. While this may go some way to explaining why only three projects in our sample were using this kind of measure, 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 might be thought.

Certainly the methods projects have designed for themselves demonstrate considerable effort and ingenuity. That the majority are participant-completed questionnaires is unsurprising, since these are relatively quick and inexpensive to use, and can provide projects with useful feedback relating to their own aims and objectives and those of funders. There are, however,

clear disadvantages to this approach, not least that projects up and down the country are 'reinventing the wheel' in designing their own ways of measuring similar constructs such as enjoyment or self-esteem.

Related to this, 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. For example, there were instances of questions that clearly required yes/no/unsure tick boxes but that were accompanied by only one box for participants to tick, and of questions that asked about amounts or levels of a construct such as satisfaction but provided yes/no tick boxes rather than a rating scale. A more coordinated approach using published, validated measures where these exist and are appropriate, or other standardised formats where no appropriate instruments exist, would both help with these design issues and generate a wealth of useful, comparable information.

That most projects are evaluating their work at only one point in time is also problematic since this does not allow for the measurement of change over time. Even where projects are using pre-and post-intervention measures, it is difficult to attribute any changes to the projects' work because these could be the result of something completely different – a new relationship, a successful football season, anything that can have an effect on how we feel and what we do in our lives. Evaluation orthodoxy sees the 'control group' or 'comparison group' approach, (using the same measures at the same time with similar people not receiving the intervention or receiving a different intervention) as the way around this problem. However, establishing a control or comparison group is likely to be impractical for projects without the assistance of external researchers, so we do not recommend this approach as the way forward in developing an evaluation measure for routine use. More practically, one project uses a standardised questionnaire (the HAD) to assess change, together with further questions directly asking participants to indicate whether the project has made a difference in relation to that aspect of their lives. We think the way forward lies in this approach.

That said, where projects are asking participants and workers/artists for feedback in order to review what is working well and less well, this is clearly valuable monitoring information and is well worth continuing on a project by project basis as at present, perhaps as part of a separate annual monitoring exercise. Similarly, reviewing the achievement of participants' own goals is clearly excellent practice, but perhaps more suited to one to one assessment than to routine evaluation.

Of the other methods being used, qualitative methods such as observation, interviews and group discussions are valuable in exploring participants' experiences and perceptions of their involvement in artistic work but these methods do not easily lend themselves to routine evaluation. Where they have been used it tends to be in the context of commissioned, external evaluations that are inevitably too expensive and time consuming for routine use. We are not suggesting that this approach should never be used. On the contrary, where funding is available an external evaluation of this kind can illuminate and augment projects' routine evaluations and it would be heartening to see more work of this kind being funded.

We were particularly interested in the arts-based evaluation commissioned by one project and we think this approach merits development through further research aimed at identifying a range of appropriate techniques, developing standardised ways of recording the results, and establishing the validity and reliability of the approach in measuring changes in personal development. However, this would be a substantial research project in it own right, beyond the scope of our study.

Evaluation content

Where evaluation content is concerned, it was clear that the 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. Some of these dimensions, such as enjoyment, learning/skills gained and pride in the work produced, can obviously only be measured 'post-intervention', but for others, such as self-esteem and empowerment, there are existing published measures that could be used in a pre- and post-evaluation design. Of the measures available we think the User Empowerment Measure (Schafer, 2000) is most useful because it is relatively brief and was developed in the UK from previously validated measures with input from people with mental health needs. The measure could be supplemented at follow-up with further questions directly asking participants to indicate whether the project has made a difference in relation to the aspects of their lives covered in the measure, and with standardised ratings of the impact of participation on the other 'distance travelled' dimensions.

Fewer projects were evaluating outcomes directly related to health and social inclusion, in part no doubt because these were not amongst their most important intended outcomes, a finding consistent with previous research (Angus, 2002). There is a view in the arts and health literature that there may be a dislocation between what researchers are interested in evaluating and what projects aim to achieve (White and Angus, 2003). However we are not convinced that arts and mental health projects' explicit or implicit aims should be the only basis for evaluation, not least because the evidence from our survey suggests they may be achieving important outcomes well beyond their aims, from which other mental health providers could learn much.

Where health outcomes are concerned, two validated, standardised health measures, HAD and CORE, are already in use at two projects. Of these we think more widespread use of CORE would be useful, because this is a relatively brief measure of general mental health and well-being that one of us has used to good effect in previous research projects, where it proved practical and acceptable to people with mental health needs. As with the User Empowerment Measure, further questions would be needed at follow-up directly asking participants to indicate whether the project has made a difference in relation to the relevant aspects of their lives. We do not of course advocate more widespread use of CORE at the expense of using HAD where reducing levels of anxiety and depression are specific project aims.

In addition to use of the CORE, NHS funders of arts and mental health projects in particular are concerned with projects' impact on medication and service use. Although one validated measure, the Client Service Receipt Inventory (CSRI), could be adapted for this purpose, it requires quite complex, detailed information which participants may well struggle to provide with the accuracy necessary for the measure to work reliably. As the table on page 33 illustrates, one project simply asks participants to indicate whether they think that their use of medication and GP services has changed as a result of their involvement in the project. Our suggestion is that this approach could be extended to cover use of specialist mental health services and used at follow-up, alongside a repeat CORE measure.

Social inclusion was clearly more problematic for projects to measure. Although 20 projects were attempting to assess relevant dimensions, in 10 cases this was based on participants' future aspirations rather than their actual experience. Our investigations indicate that the development of validated, standardised measures of social inclusion is at an early stage but we found three potential sources of useful questions: the measure used by Matarasso (1997) in his comprehensive study of the social impact of arts participation; a measure being

developed in partnership with people with mental health needs by Theo Stickley at the University of Nottingham; and questions identified by Peter Bates (2005) from national surveys that include relevant questions. The latter have the advantage of affording comparison with national norms. Our suggestion is that relevant items from these three sources could be combined in one fairly brief measure of social inclusion and used alongside the CORE and the User Empowerment Measure in a pre- and post-intervention evaluation design. Again, further questions would be needed at follow-up directly asking participants to indicate whether the project has made a difference in relation to the relevant aspects of their lives.

6.   Conclusions

On the basis of Phase 1 of our study, our proposal is that the above measures and lines of questioning form the basis for developing a questionnaire for use with arts project participants in Phase 2 of our study.

Because understanding the processes through which participatory arts and mental health projects achieve both intended and unintended outcomes is as important as measuring the outcomes themselves, we propose to allocate space on the questionnaire for participants to describe those elements of their involvement with projects that have been particularly important to them. This information will be used alongside further information from the qualitative components of Phase 2 to identify effective processes for improving mental health and increasing social inclusion.

By way of summary, Table 8 overleaf shows the outcomes, indicators and measures identified through this first phase of the study.

Outcome	Indicators	Measures
Improved mental health	Mental health/well-being status	Clinical Outcomes in Routine Evaluation used pre-and post-intervention + supplementary question at follow-up addressing project impact
	Levels of primary & secondary care service use	Questions at follow up addressing project impact
	Levels of medication use	Questions at follow up addressing project impact
Increased social inclusion	Levels of social contact likely to build bonding and bridging social capital	Scales developed from Matarasso (1997), Stckley (undated) and Bates (2005) used pre-and post-intervention + supplementary questions at follow-up addressing project impact
	Levels of perceived stigma & discrimination	
	Levels of engagement in employment, education & related activities	
	Housing security	
	Neighbourhood cohesion	
Distance travelled towards improved mental health & increased social inclusion	Levels of self-esteem & empowerment	User Empowerment Measure (Schafer, 2000) used pre-and post-intervention + supplementary question at follow-up addressing project impact
	Levels of enjoyment	Rating scales at follow-up
	Learning/skills gained	
	Pride in work produced	
Effective processes for improving mental health & increasing social inclusion	Participant perceptions of project processes	Open questions at follow-up + Phase 2 qualitative work

Table 8. Outcomes, indicators and measures

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Appendix 1

Correspondence with projects

Introductory letter

Dear …

Demonstrating the benefits of arts participation: Mental health and social inclusion

In 2004 the government's Social Exclusion Unit published a report on social exclusion and mental health. The report identifies access to recreational activities, including participation in the arts, as essential to promote the social inclusion of people with mental health needs. However, at present it can be difficult for arts projects to demonstrate 'hard evidence' that arts participation does indeed benefit people with mental health needs. It is this kind of information that is often needed to secure ongoing funding.

If we have already been in touch with you, you will know that we are developing a research project to help arts and mental health projects find ways of meaningfully demonstrating the benefits of their work. We are now contacting all the projects we have been able to locate to tell you more about the research.

The study has been commissioned by the Department for Culture, Media and Sport and the Department of Health. The research is being conducted by the Institute of Health & Social Care at Anglia Polytechnic University, based in East Anglia, and the Departments of Nursing and Social Work at the University of Central Lancashire in Preston. Our research team includes people with experience of both using and evaluating mental health services. Two members also have an arts background.

There are three main strands to the study:
1. To find out what information projects already collect that is relevant to the mental health and social inclusion of participants. We will use this information to pull together what is already known about the benefits of arts participation.
2. To develop an evaluation tool that reflects the aims of arts projects and project participants/users.
3. To pilot the evaluation tool with a small number of projects.

The study will be relevant to your project if you currently provide participatory arts activities for people aged 16 to 65 with identified mental health needs. It does not include the distinct profession of art therapy. If you do not think the study is relevant to your project, please let us know. If you know of any other projects that might be relevant please also let us know. You may copy this letter to them if you wish.

Unless you tell us the research is not relevant to you, in a couple of weeks we will send you a questionnaire, by email if we have your address or by post if we don't, asking for information about your project and how you currently evaluate the benefits of your work. You will be able to return the questionnaire by email or via our Freepost address. We have kept the questionnaire as short as possible and it should not take more than 20 minutes to complete. We will then contact projects that have evaluation data relevant to mental health or social inclusion to ask for the data. All data will be anonymised to protect participants' identity. Once we have analysed all the data we receive we will send every project we make contact with a copy of the results.

Using the information projects send us, we will establish criteria for the selection of individual projects to invite to take part in piloting an evaluation tool. We will try to ensure

that projects are as representative as possible. This will be negotiated between ourselves, the commissioners of the study and individual arts projects.

We sincerely hope that if your project provides participatory arts activities for people with identified mental health needs, you will be interested in contributing to this study. We hope that it will provide valuable evidence to help support arts initiatives in mental health.

In the meantime, if you have any questions or comments about the study, please phone Lyn Kent, survey administrator, on 07976 827534 or email her at m.kent@apu.ac.uk.

We look forward to working with you.

Yours sincerely

Jenny Secker
Professor of Mental Health
For the APU/UCLAN research team

Summary briefing

Demonstrating the benefits of arts participation: mental health and social inclusion

The Department for Culture, Media and Sport and the Department of Health have commissioned a research team from Anglia Polytechnic University and the University of Central Lancashire to help arts projects demonstrate the benefits of their work for people with identified mental health needs.

Our research team includes people with experience of both using and evaluating mental health services. Two members also have an arts background.

There are three main strands to the study:
4. To find out what information projects already collect that is relevant to the mental health and social inclusion of participants. We will use this information to pull together what is already known about the benefits of arts participation.
5. To develop an evaluation tool that reflects the aims of arts projects and project participants/users.
6. To pilot the evaluation tool with a small number of projects.

As a first step the team needs to make contact with all the arts projects in England working with people aged 16 to 65 with identified mental health needs. If this describes your work, please contact Lyn Kent, our Survey Administrator at Anglia Polytechnic University. You can write to Lyn at 3rd Floor, Ashby House, Bishop Hall Lane, Chelmsford, CM1 1SQ, phone her on 07976 827534, or email m.kent@apu.ac.uk.

Jenny Secker
Professor of Mental Health
Anglia Polytechnic University
For the APU/UCLAN research team

Appendix 2

Survey questionnaire

Demonstrating the benefits of arts participation:
mental health and social inclusion

Survey Questionnaire

About the questionnaire

As we explained in the letter we sent you a couple of weeks ago, the purpose of this questionnaire is to obtain an overview of current arts and mental health activity in England and to find out what projects are already doing in the way of evaluating their work.

Please don't be daunted by the length of the questionnaire. Many of the questions can be answered by checking a box. We estimate that it should take you about 20 minutes to complete.

How the information you provide will be used

The information you provide will be treated in confidence. The survey results will be aggregated and we will not link specific responses with named projects. The only people who will have access to individual project responses are the research team and members of the project Advisory Group. The responses we receive will inform the Advisory Group's decision as to which projects we will invite to take part in the second stage of the study, involving in-depth evaluation work.

We will send all the projects that respond to the survey a copy of the survey report. We expect it to be available towards the end of this summer (2005).

Filling in the questionnaire	
Multiple arts projects	If you are responsible for more than one arts and mental health project, or your project has different strands that cannot be included on one questionnaire, please make as many copies as you need, complete them separately and return as detailed below.
Terminology	
Mental health needs	We are interested in projects that work with people who have mental health needs. By this, we mean people with a psychiatric diagnosis (e.g. schizophrenia, bi-polar disorder, clinical depression, personality disorders, eating disorders, obsessive compulsive disorder) or people who have identified mental health needs (e.g. experiences of self harm, hearing voices, paranoia, phobias, chronic anxiety).

Primary care services	By primary care services we mean mental health services provided by GPs, practice nurses, counsellors etc. in local GP surgeries.
Secondary mental health services	By this we mean we mean community mental health teams, rehabilitation or assertive outreach services and any other services provided by psychiatrists, community psychiatric nurses, mental health social workers or any other specialist mental health workers.
Returning the questionnaire	
Email:	If you have received the questionnaire by email you can fill it in on your computer and return it by email to m.kent@apu.ac.uk.

Please save the file to your own computer first – if you just fill in the attachment your responses will not come back to us. |
| *Post:* | If you have received the questionnaire by post, or by email but prefer to fill it in by hand, please write in your responses as clearly as possible. You can return the questionnaire without using a stamp to:

Lyn Kent
Arts and Mental Health Survey Administrator
3rd Floor, Ashby House
Anglia Polytechnic University
FREEPOST NAT 10436
Chelmsford
Essex CM1 1BR |
| If you have any problems or questions as you are filling in the questionnaire, please email Lyn at the address above or phone her on 07976 827534. | |

1. Please provide the following information about your project:
Name of project **Website**
Postal address   **Postcode**
Contact person and job title **Telephone/mobile number** **Email address**
Date Project established
Main funding source Total income for arts and mental health work during financial year April 2004 - March 2005

Sector	☐ **Statutory**	☐ **Other (please specify)**
	☐ **Voluntary**	....
	☐ **Private**	

<div style="background-color:yellow">We would be grateful if you could let us have any leaflets or literature about your project when you return the questionnaire.</div>

2. Who does your project work with? Please check all the boxes that apply

☐ People who use secondary mental health services

☐ People who only use primary care services for their mental health care

☐ People with specific mental health diagnoses or identified mental health needs e.g. schizophrenia, psychosis, depression, self harm, hearing voices   (write in opposite)

Please tell us which diagnoses or mental health needs

....

☐ People with needs other than mental health needs e.g. learning or physical disabilities (write in opposite)

Please specify which needs

....

☐ Anyone with mental health needs, i.e. people receiving mental health care from either primary care or secondary mental health services or from voluntary sector services

☐ The wider community as well as people with mental health or other needs

3. On average, what percentage of the people you work with are 'adults of working age' (16 – 65 years old)?	**%** _____
4. On average, what percentage of the people you work with are female?	**%** _____
5. Please estimate the percentage of the people you currently work with who are from each of these ethnic backgrounds	
White British, Irish or other White background	_____ %
Asian, Asian British, Mixed Asian or other Asian background	_____%
Black British, African Caribbean, African, Mixed Black or other Black background	_____%
Chinese	_____ %
Other ethnic backgrounds (Please use the space to tell us which other backgrounds)	_____%

6. Who refers people to your project? Please check all the boxes that apply	
☐ People can refer themselves ☐ Informal carers ☐ General Practitioners (GPs) ☐ Other primary care professionals, e.g. practice nurses, health visitors, counsellors ☐ Specialist mental health services e.g. community mental health teams ☐ Social Services ☐ Voluntary/Community groups ☐ Educational institutions	☐ **Others (Please specify)** ....

7. If you have checked more than one referral source in question 6, please tell us which is the main source of referrals to your project	

8. On average, how many people participate in your project each week?	People _____
☐ Our project does not run on a weekly basis How often does it run?	How many people participate during that period? ....
Of the people who participate in your project each week (or other time interval if not run weekly), how many are receiving mental health care only from primary care and/or voluntary sector services? How many are receiving care from secondary mental health services?	_____People _____People
9. On average, for how many hours each week (or other time interval if not run weekly) does someone with mental health needs participate in arts activity at your project?	_____
10. For how long can someone with mental health needs participate in your project?	
☐ As long as the individual wishes ☐ Negotiated with the person depending on their needs and goals ☐ For a time-limited period - please tell us for how long	
11. Please tell us which are your main organisational partners (those that have a significant role in your project's work)	
12. How would you describe the setting in which your project works?	
Community setting - please specify .... **Healthcare setting - please specify** .... **Social services setting - please specify** .... **Integrated (health and social services) setting - please specify** .... **Education setting - please specify** .... **Specialist art setting - please specify** .... **Other setting - please specify**	

13. What art forms/cultural activities does your project use?   Please check all that apply

☐	Architecture	☐	Ceramics	☐	Circus/Carnival/ Celebration
☐	Crafts	☐	Creative writing	☐	Computer/Multimedia
☐	Dance	☐	Drama	☐	Environmental
☐	Exhibition	☐	Film/Video	☐	Glassworks
☐	Gardening	☐	Mosaic	☐	Music/Singing
☐	Interior Design	☐	Illustration/Graphics	☐	Installation art
☐	Performance	☐	Photography	☐	Landscape Design
☐	Museum/Gallery activities	☐	Poetry/other reading	☐	Site-specific public art
☐	Storytelling	☐	Sculpture	☐	Textiles
☐	Visual arts	☐	Woodcarving	☐	Other (please specify)

....

14. Which of these models of participation best describes how your project works? (Please check one only)

☐ An artist, instructor or someone in a similar role directs or educates project participants.

☐ Project participants work together on a project decided by an artist, instructor or someone in a similar role

☐ Project participants cooperate to decide on a project and work on it together

☐ Project participants motivate themselves to produce their own art works, with guidance where necessary

☐ Professional artists work with a project group to create a festival, pageant or event

☐ Artwork or artists are sited within a space or facility used by a particular community or group for a fixed time - the group takes inspiration from the work

☐ None of above - Please tell us how your project works

....

☐ If yours is a library or museum/gallery based project, please describe your model of participation, using the above headings if appropriate, and check this box

....

15. How many people directly help to run your project excluding committee members, domestic staff etc? Please tell us how many people are in each of these categories. (Hours worked means time spent directly on arts and mental health work for your project)	_____ Paid staff working 30 or more hours each week _____ Paid staff working between 15 and 29 hours each week _____ Paid staff working fewer than 15 hours per week _____ Sessional/freelance paid staff _____ **Volunteers**
16. Are people with experience of using mental health services involved in running your arts project? Please check all that apply	☐ As committee members ☐ As directors, managers or in other senior positions ☐ As paid members of staff (full time, part time or sessional/freelance) ☐ As volunteers ☐ **Other Please tell us how people are involved** ....
17. What information do you routinely record about project participants? Please check all that apply	☐ **Age** ☐ **Sex** ☐ **Ethnicity** ☐ **Diagnosis** ☐ **Mental health needs** ☐ **Participant's goals** ☐ **Other information – please specify** .... ☐ **We don't routinely record any information**
We would appreciate it if you could enclose or attach an uncompleted copy of any forms you use for your records.	

18. What outcomes do you intend your work to have for project participants with mental health needs?

Use the **LEFT** column to indicate **ALL** outcomes (*check all that apply*)
Use the **RIGHT** column to **RANK THE THREE** most important *(1= most important, 2= second most, 3= third most important)*

Check ALL that apply		RANK 3 most important 1,2,3
☐	Improved self-worth, confidence, self esteem	_____
☐	Improved access to mental health services	_____
☐	Reduced symptoms of mental ill health	_____
☐	Improved quality of life	_____
☐	Reduced use of medication	_____
☐	Reduced use of primary care services for mental health problems	_____
☐	Reduced use of secondary mental health services	_____
☐	Increased social contact with other people with mental health needs	_____
☐	Increased social contact with people other than those with mental health needs (not including people who run the project)	_____
☐	Increased involvement with the local community	_____
☐	Reduced stigma and discrimination	_____
☐	Personal growth/transformation	_____
☐	Increased artistic skills	_____
☐	Increased opportunities for employment	_____
☐	Increased opportunities for education or training	_____
	Other outcomes - please specify	
☐	....	_____
☐	....	_____
☐	....	_____
☐	....	_____

20. Do you evaluate the outcomes of your work for project participants with mental health needs?	
☐ **Yes, routinely** ☐ **Not routinely, but we have carried out evaluations in the past** ☐ **Not routinely, but we are currently carrying out an evaluation** **Please tell us what methods and measures you use or have used in the past** **Methods** .... **Measures**	☐ **No**

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Again, we would appreciate it if you could attach uncompleted copies of any forms you use or have used for evaluation.
</div>

21. If you do evaluate your work, would you be willing to share your data with us in anonymised form to protect project participants' identity?	☐ **Yes** ☐ We would like to discuss this with you ☐ **No** ☐ Not applicable
22. Please add anything else you would like to tell us about your work.	

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Many thanks for taking the time to fill in the questionnaire. As requested above, we would appreciate it if you could also let us have any documents relating to your work, the information you record about project participants and your evaluation methods.

So that we can keep track of the documents we receive, please check which of the following you are enclosing or attaching with your questionnaire.

☐ Leaflets, literature etc. about your project
☐ The forms you use to record information about project participants
☐ The forms you use to evaluate your work

If you filled in this form electronically and intend to post any of these documents separately, please check the relevant boxes above and also check **here** ☐

</div>