Interim Evaluation Report

Common Knowledge

The Tyne and Wear Health Action Zone’s Arts and Health project

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November 2001

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SUMMARY AND MAIN HEADLINES

Introduction: Arts/health is the phrase used throughout this report to describe activity in Common Knowledge (CK). It is used to try and avoid the conflicting assumptions contained in phrases such as ‘arts and health’, ‘arts for health’ and ‘arts in health’. Despite the appearance of a single field, these different approaches are based on differing conceptions of health, whether it has an individual or community focus and views on the role of arts in improving health and well-being. Tensions should not be surprising as ‘Health’, ‘Community’ and ‘Art’ are highly contested concepts. Drawing on the experience of CK, this report aims to explore some of the terrain of the arts/health field. This could have two benefits. First, it might alleviate internal tensions by showing arts/health to be a rich and varied field, accommodating a variety of approaches. Second, it might help those in the health sector commission arts/health work with approaches that meet its needs.

Part One: Common Knowledge and the Evaluation Framework introduces Common Knowledge as an initiative and the aims it has set itself. CK is a process to bring regional constituents to local negotiation of arts/health and think about ways of working together. It aims to develop a series of projects that experiment with different approaches to improve health and well-being. This evaluation sees CK as a learning initiative that aims to disseminate information, develop structures and channels for working in partnership, and promote a culture of arts/health thinking. Two questions guide the analysis of the evaluation. First, to what extent is Common Knowledge enabling ‘learning’? Second, what are pilot projects suggesting about the impact of arts/health approaches?

Part Two: The development of Common Knowledge describes the development of Common Knowledge from ‘future search’ events through to the establishment of local projects. There is a brief description of the ‘future search’ events (a full description is available from CAHMM). The section describes the ways in which CK has grown since January 1999, developed capacity in this area and areas in which it has been more limited. In the spirit of learning, there is some critical analysis of CK’s development to date; the content draws on discussions, interviews and observation.

Main headlines
- The future search process was challenging for participants and facilitators. Neither had worked through this kind of process before. A lot was learned and for the majority it was a positive experience - but the days were intense and the creative process made some uncomfortable.
- The two ‘future search’ events should have been guided by a more practical question that led to a clearer process and active conclusions
- The two future search events should have incorporated a planning element to explore possibilities for practical working.
- CK has successfully brought together a lot of people from different perspectives, catalysing and initiating relationships, and beginning the process of forming a network for arts/health work in the region
- The events acted as a launch for experimentation in arts/health approaches
**Part Three: Common Knowledge Pilot Projects** uses a series of descriptive variables to introduce the reader to the Common Knowledge pilot projects. It links the projects to the Tyne & Wear Health Action Zone priorities according to different art forms; the audience for projects and motivations of those working on the project. It then describes how evaluation was devolved and the approach taken by each project. Overall the aim is to introduce the reader to the approaches and aims of projects.

**Main headlines**

- Projects were slow to develop and the process of moving from the future search events to local groups was disjointed
- 20 pilot projects and 15 ‘tabletop’ projects have been developed from the Common Knowledge process
- The pilot projects represent the diversity of the arts/health field and relate to Tyne & Wear Health Action Zone priorities. Nine of them have extensively recorded their experience in evaluation books that could be stand alone publications.
- The CK core team has been a positive influence in supporting partnerships, developing ideas and locating and disseminating information. The large number of projects underway meant that the core team (of three) were overstretched. They worked better with pilot than ‘tabletop’ projects.

**Part Four: Insights from the Projects:** The approaches taken by projects are analysed further in Part Four. **Readers who want to get straight to the insights developed from CK projects should start here.**

The arts/health field is conceptualised as a diamond: multifaceted and prismatic. A diamond figure is used to categorise approaches into four different views on arts/health. In the top half of the diamond, the predominant focus is on creativity and in the bottom half, on health. On the left of the diamond, projects aim to engage with groups, seeing health as fundamentally linked to community. On the right are approaches more focused on holistic views of individual health.

The diamond is multifaceted: it has different faces. The four main parts are examined in turn. Greater clarity of each approach allows a clearer link between arts/health approaches and their impact on health.
Main Headlines

- The arts/health field has developed a critique of conventional views on health. From this critique the roots of different approaches can be traced.
- The field of arts/health can be thought of as comprising different aspects of this critique on health. They have different understanding of the cause of ill health and well-being and take different approaches to improve it. Some see a key determinant of health in the strength of social relationships. Others take a holistic approach to individual health. For some, arts/health supports and complements medicine and for others it is a process for participation.
- Broadly speaking four approaches can be categorised in the pilot projects.
  - Creativity and well being – projects that emphasise creativity as a route to well being. These aim to work with individuals to better understand their health, using creative approaches as a means to expression. Art is seen as a potential therapy. Projects like art on prescription bring these approaches closer to the second group of projects, which are more closely linked to health services.
  - Supporting care – projects that support the process of care by working on the softer aspects of ill-health that health services, under the strain of heavy demand, cannot reach. (Projects in the third group share some common ground with these, but they aim to communicate with communities as a whole.)
  - Engaging groups – projects that engage groups to bring communities and health promotion closer together. They use creative methods to explore, disseminate, and communicate messages about health.
  - Unity is health – projects that start from the point of using creativity to enhance social relationships. These reflect a growing school of thought that good relationships are a major determinant on health.

Part Five: Relating evidence to impact: shows evidence has been drawn from staff and participant testimony and much is concealed within stories. One of the key tasks for the evaluation is to work with projects to explore the evaluation material in more detail. Each of the four approaches is examined in turn. A preliminary analysis of the evidence shows some patterns of impacts among approaches.

Main headlines:

- The evaluation books allow these insights into the arts/health field and the contribution of the different approaches. Mining this evidence from the evaluation books is taking some time. Not all the evaluation books have been submitted and the links between evidence and impact will be explored in more detail in the final report.
- Creativity and well being approaches allow individuals to explore their own health. Creative approaches can be therapeutic, particularly in alleviating stress and poor well-being; they also provide opportunities for staff to work with patients, and for those that don’t it provides them with a point of referral.
- Supporting health services projects support staff, distract patients, entertain them, allow them to express themselves through art and improve the quality of the care environment.
- Engaging Groups projects are good at developing concrete outcomes because art is usually an outcome. They have been successful approaches to spark group communication.
• Unity is health projects can generate healthy discussion, develop the confidence of an individual using an art, allow them to express themselves and grow socially and artistically within a group.

**Part Six: How can arts/health approaches be further developed?** discusses ways arts/health partnership can be improved drawing on the experience of Common Knowledge. This leads into a broader discussion of the challenges for the field as whole.

**Part Seven - Is Common Knowledge achieving its aims?** The final section draws together the content from the previous sections to ask whether Common Knowledge is achieving its aims. The key challenges for Common Knowledge over the coming year are interrelated. They also require a lot of resources. It is a legitimate question to ask whether CK has the financial or human resources to achieve them. There is something of a Catch 22 situation in that the activities aim to develop a network of arts/health people and organizations and yet they need a network of people to draw upon to achieve the aims. Testing and strengthening the strength of the CK network will be a key issue in its final year.

**Main Headlines**

- Common Knowledge has made progress against all of its aims – though the majority of its impact is at the micro rather than macro level: For example, CK is influencing the way people work locally, but finding it more difficult to do this at a strategic level
- In its final year Common Knowledge is aiming to influence the macro level: it is due to launch a website as a focal point for the network and to launch a campaign that will include exhibitions of arts/health approaches, health promotion, and public engagement with health issues.

**Recommendations to aid information processing**

- Develop a website that meets the needs of the network
- Actively spread the lessons of the CK experience among the CK community

**Recommendations to help develop structures and channels for working**

- Create and develop partnerships between organizations who have been involved in Common Knowledge
- Share the experience of Common Knowledge with public organizations, in a reflexive way.

**Recommendations to develop culture of arts/health**

- Consolidate the community of people who have been involved in Common Knowledge by continuing to engage them in practical issues and sharing the experience of CK to date
- Develop debate amongst participants on the experience of Common Knowledge to date and the terrain of the arts/health field
Introduction
Before getting into the detail of Common Knowledge, the aim of this introduction is to locate its activities within the broader development of arts/health.

In this report ‘arts/health’ is used to describe the area of work. Behind phrases like: ‘arts for health’, ‘arts and health’, ‘arts into health’, ‘arts in health’ lies different assumptions about the roots of ill health and ways arts can be improve it. Arts/health is used as an umbrella term to cover these diverse approaches.

A number of initiatives during the 1980s and 1990s have generated a ‘field’ of arts/health work. Nichola Gardner in (as yet unpublished) work on the development of the field writes the following:

‘The 1980s and 1990s saw the establishment and success of major arts programmes in hospitals and health services across the country including the famous art commissions for the new Chelsea and Westminster Hospital NHS Trust; the founding of Pioneer Projects, a community based organization that started the health heart lantern processions in Gateshead and the Black Country; Vital Arts’ work to transform the Royal London Hospital and work with community initiatives such as the first Healthy Living Centre at Bromley-by-Bow; the King’s Fund’s national art projects schemes; the development of arts programmes at many...hospitals. There has been a World Symposium on Arts in Health held by Arts for Health in Manchester, and more recent developments such as the founding of the Centre for Arts and Humanities in Health and Medicine at the University of Durham and the forming of the National Network for Arts in Health.’

This is an extensive list of many arts/health approaches. The list is not exhaustive. The Nuffield Trust’s Windsor Conference, which led to the Windsor Declaration on Health and Humanities could be added.

The field is more diverse than sometimes thought. Approaches from a variety of perspectives and with different origins have come to be seen as part of a single approach. There has been some tension within arts/health as different perspectives battle over the definitive approach. They are better thought of as different approaches within a broad field. Some initiatives emphasise the inherent healing qualities of arts, for others the value of art approaches as a means or ‘tool’ is the outcome. Some aim to influence in a bottom up way, like community arts approaches, and others have a more top-down approach, such as efforts to influence the content of the undergraduate medical curriculum.

Gardner notes that ‘despite the popularity, widespread support and the gathering momentum in the arts and health field there are clear barriers to the more systematic application of its benefits in the NHS. Most palpably, the evidence of benefits is scattered around different sources. There are no clear policy statements on its use and benefits, and a lack of official recognition’ [Gardner, 2001 (forthcoming)].

One of the reasons there is no clear statement on its use or benefits is because to date there has been no concerted effort within the field to understand activities as a range of
complementary approaches. It might be argued that the barriers to more systematic application result from a lack of clarity within the field and the different associated impacts. For some, arts/health has a mystical element to it; there is some need to demystify the field.

The problem is that the field contains many sources of complexity and confusion. As Angus says:

‘Art, health and community are all contested concepts. They mean different things to different people, and depend upon the values and interests of those concerned’.

There are three key questions that help to explain the contours of arts/health.

**What is health?**

Angus notes the pocket Oxford Dictionary defines health as a

‘state of being well in body or mind’ referring only to the mental and physical condition of the person. Medical care has often taken this view as well, concentrating on curing ailments of the body and mind, without reference to a broader picture of the person or a holistic definition of health ‘(1).

There are all kinds of philosophical arguments that could be pursued when trying to locate an understanding of health. There has long been debate on what health is, how broadly it should be understood, and its determinants and cures. The debate continues with growing intensity. It has been suggested for example, that medical services make a fairly modest impact on health outcomes.

The work of Angus(2) represents a key dimension of the arts/health field, which promotes exploration of what we understand by health. He has noted a shift in societal understanding toward a more holistic approach. He says

‘through a participatory and communal process, the arts are used as an aid to understanding and a means of communication to provide a description, exploration, affirmation and promotion of health in its widest sense’.

Attempts to better understand health increasingly have a receptive audience. Health is no longer understood solely in terms of traditional medical and therapeutic interventions. The arts are attractive to those who want to redefine health in a number of ways. They can be a creative process to understand health in new ways of promoting and treating spiritual and emotional health needs aligned to and separate from medical care.

What are the causes of this shift in understanding? Angus says it is ‘difficult to say’ – and it is hard to explain. It seems to be a cocktail of several trends. One is a growing mistrust in institutions, in government capacity to provide for health needs, in the medical profession having all the answers or the competence to deliver health care. Another trend is an increasingly individualistic society, in which health cannot be cared for en masse. People need to take a more individual and therefore rounded approach to their own
health. Paradoxically, there is also a trend to take a more collective approach to health. It is now mainstream to consider the effects on health of economic and social factors such as lifestyle, inherited behaviors, income inequality, education, and social relationships.

**What is community?**
Community has re-emerged as a major political issue and is another key dimension within the arts/health field. Whereas the dominant perspective for some is to redefine health (and consequently health interventions), those who approach health from the community perspective locate ill-health (and its increase) within the broad area of social relationships.

For example, in Tyne and Wear, the decline of traditional industries has changed the structure and culture of community. People live in different areas, work in different roles, live in different family relationships. The family division of labour has changed with many more female ‘breadwinners’. Traditional social relationships have changed (3).

Some work is starting to emerge on the importance of social relationships to health. Richard Wilkinson has emphasized the ‘health benefits arising from a more cohesive society’. He argues the quality of the social life of a society is one of the most powerful determinants of health and that this is related to the degree of income inequality. (4)

The sociologist Ray Pahl agrees: ‘the quality of our social relationship in micro-social worlds is coming to be seen as having a vital role in maintaining and achieving better health’ (5).

The remedy is complicated and cannot be solved through traditional health promotion alone:

‘If the whole thing were a matter of eating too many chips or of not taking enough exercise, then that in itself would not necessarily mean that the quality of life which people experienced was so much less good; you can be happy eating chips. But sources of social stress, poor social networks, low self esteem, high rates of depression, anxiety, insecurity, the loss of a sense of control, all have such a fundamental impact on our experience of life.’

Pahl also points out that income inequality is not the whole story either because money cannot necessarily buy health needs.

‘Rather, it is people’s feeling of self-esteem or self-worth and of being valued, coupled with close personal relations and wider social networks, which bear so heavily on their health.’

Robert Puttnam, an American political scientist, puts these trends down to the erosion of ‘social capital’. He wrote a book in the mid-90s called ‘Bowling Alone’, in which he reported that Americans tend to bowl alone rather than in leagues. This is a metaphor for disappearing togetherness, as measured by a decline in all sorts of communal behaviour and what he calls “social capital”. He has massively quantified this term and his
measurements show that communities with bags of social capital tend to have better health status, schools, less crime and so on (6).

Work from Campbell et al at the LSE has used some of this thinking to analyse whether areas in Britain with greater social capital (as defined by Puttnam) have higher levels of health. She found that predominately they do (7).

**What is the relationship of the arts to health?**

Rather than asking what art is – in many ways an impossible question, and certainly beyond the scope of this report – it is more useful to ask how people in the field see the relationship between ‘arts’ and ‘health’.

Arts/health does not tie itself to any particular art form or application. Alongside the different perspectives described above, arts/health is further complicated by a wide variety of arts based approaches.

The Common Knowledge pilot projects in this report draw on a great variety of approaches including: drama to engage young people in exploration of the health issues they face, and a range of visual art techniques, working with old people, those with mental health problems, school children, young mothers. Other visual art forms, such as photography and animation are used to explore the delivery of health, promote health, or to engage people in discussions of how to improve their care. Writing is used reflectively, for example, with cancer patients as a means of expression. There are some music-based projects: singing to relieve stress, voice techniques to understand expression, singing requests in health settings. Other art forms include embroidery and silk painting. Some projects have aimed to produce good art, others to strengthen social relationships. Some have aimed to reduce stress and others explore issues with health professionals and the public. Some think of art as a therapy and others as supporting health services in the art of care.

Because the field is broad, it is not easy to define arts/health. For the purposes of this report it is thought of broadly, as:

> Arts based activities that aim to improve individual/community health and health care delivery using arts based approaches. The relationship between art and health is explicable, rational and not subservient.

If discussion of the previous questions - what is health and what is community? – reflects the philosophical terrain of arts/health, how the arts relate to health is a methodological question. The choice of methodology depends upon what you set out to do.

Although there are differences in approach, as a whole the arts/health field has developed a cohesive critique of health delivery. Its approaches reflect the critique. As a whole the field aims to approach health in a holistic way, understand health more broadly, engage people in understanding health needs, and use creative methods to improve health and well-being.
If the field is understood as having various and complementary dimensions it will have two important benefits: (1) it will relieve unnecessary and potentially destructive tensions within the field as it searches to define itself and (2) it will help those in the health service interested in arts based techniques to understand the range of interventions and the potential impact of each.

**The aims of the report**

It may seem strange that the introduction to this report has concentrated on the more philosophical dimensions of the arts/health fields. But these issues are a critical part of the evaluation and Common Knowledge cannot be considered in isolation of them.

This report has three aims:

1. Describe, reflect upon and examine the progress of Common Knowledge. This is an interim report, written two thirds of the way through the initiative.
2. Contribute to a better understanding of the arts/health field
3. The key objective of the report is to set out a way of looking at the progress on Common Knowledge to date in order to encourage debate amongst participants on its content and the future of Common Knowledge.

This is the first opportunity to collectively reflect with all participants on the experience of Common Knowledge. It is an invitation to participants to challenge and help shape preliminary thoughts. Some projects may feel they have misunderstood and should say so. It will help develop understanding.

Producing an interim report at a midway stage is never easy and is inevitably inconclusive. It draws on an incomplete picture and runs the risk of constraining the way the project is looked at in its final phase. CK is an evolutionary process; there is more data to be collected and to a greater or lesser extent understanding of CK will change.

**PART ONE: Common Knowledge and the Evaluation Framework**

This section explains the origins of Common Knowledge and its aims and approach. It also outlines the evaluation framework.

**The Health Action Zone**

Common Knowledge is a Tyne and Wear Health Action Zone initiative, which has two main priorities:

‘The first is Healthier Citizenship…concentrating on disadvantaged groups. ‘Second…is Modernising Services and Improving Standards of Health and Social care’ with key areas such as: child health; heart and circulatory disease; mental health, cancer services; and services for older people (8).’

Health in Tyne and Wear is among the worst in England and Wales. Out of all the health authority areas in England and Wales, the three authorities in Tyne and Wear all rank in the bottom 16 (Newcastle and North Tyneside 84th, Gateshead and South Tyneside 94th and Sunderland 97th).
The HAZ arts/health initiative
The project came about in 1998 when the Chief Executives of Newcastle City Health Trust and Gateshead/South Tyneside Health Authority invited a bid for a three-year programme to place arts in health at the core of the Health Action Zone. A proposal was developed by Gateshead Libraries and Arts and South Tyneside Arts Studio.

Under the twin banners of ‘healthy citizenship and ‘creating capacity’ the bid proposed to apply arts in health to the key themes and target groups of the Health Action Zone.

Mary Robson was appointed Project Director and Mike White, Project Manager. Mary Robson is a freelance arts worker with many years experience of developing arts/health projects. Mike White was until recently Arts Officer for Gateshead Council, but is now Director of Projects at the Centre for Arts and Humanities in Health and Medicine at Durham University. The other members of the ‘core team’ are Dawn Williams with administrative support from Hannah Murray-Leslie of Newcastle City Council.

What is Common Knowledge?
Common Knowledge began engaging with people in January 2000 with the first of two ‘Future Search’ events. They brought together constituents for arts/health work to begin to build relationships and explore joint working.

In its own words:

‘The Common Knowledge project pioneers a new approach to placing arts activities at the heart of community health development and clinical practice’(9)

What are the aims of Common Knowledge?
The aims of Common Knowledge were originally outlined as follows:

- To disseminate useful knowledge and information
- To mutually define arts in health for the Tyne and Wear Health Action Zone
- To achieve community participation
- To support collective aspirations in community health
- To change the way that people work
- To create a positive emotional environment for the project

Phases of the project
There are three phases to the project. The first phase is future search meetings. The second is the development of projects, and the third is sharing the insights and benefits of the programme. These are outlined in Figure 2.
What is evaluation?
Evaluation is most usually thought of as a process of collecting and analyzing data in order to make a judgment about whether a set of aims has been achieved. This is complicated in Common Knowledge for three reasons: manifest measures are often difficult to connect to an aspirant question that was the starting point; second, views can differ depending on the perspective of the commentator; third, project aims are emergent rather than pre-defined, the specific direction will be set by participants and cannot be guessed before hand.

John Angus’ *Enquiry on possible methods for evaluating arts for health projects* makes some important points about evaluation. He says

‘Arts for primary and community health is new, both as an approach to health and as an artistic activity. Those who have taken part are already convinced of its benefits but as its essence concerns personal involvement, it is not easy to communicate the full effects to those who have not participated (2).’

The approach of the evaluation
One of the criticisms of research in this area is that a predetermined evaluation guides the project. Although this is the recommended starting point for evaluation, it is not necessarily an appropriate starting point when evaluating a project without preordained content working in an area that is not well understood.

Evaluation in this area needs to be grounded in the experience of participants and have an analytical structure that accommodates change and development. The evaluation tries to achieve this by looking at Common Knowledge on two levels: (1) at CK as a
developmental learning initiative, focusing on how it develops over time (2) at the experience of projects and participants.

Learning
How do you examine learning? A literature relevant to collective learning has mushroomed over the last 10 years. It has been promoted as a participative way of pursuing partnership and developing new approaches to working that are responsive to a constantly changing environment. Organizational learning has a complex and broad literature that contains many strands. It explores many nuances. Work about to be published by the author (10) has conceptualized three strands to learning. These are used to evaluate the extent to which Common Knowledge facilitates learning.

1. Information processing
Some writers within organizational learning focus on information processing as routing learning. One way to simply explain their approach is to suggest they see organizations principally as giant processing machines, like computers. The aim in learning is to efficiently and effectively store and retrieve information, sharing it throughout the organization.

Common Knowledge is an organization too – albeit an unusual one. It aims to develop a network form of organization by linking together constituents in arts/health. It aims to create two way channels for information processing in this network. It wants to develop a way of sharing artists’ names and skills with other artists and health partners. Websites are good ways to link these kinds of organizations together.

2. Structures for learning
Another way writers look at learning is to think of the organization as a brain. Each part of the organization is a separate brain cell and the aim is to structure the organizational thought process to enable learning. In Common Knowledge it is focused on how to practically develop arts/health work.

The future search process is a recognizable approach to learning in this strand. It structures dialogue and reflection between people who work together towards practical outcomes of learning.

The challenge for Common Knowledge is to be able to develop new structures of working between organizations and individuals, which enable people to bridge sectors in arts/health activities. This aim is complicated by the different cultural viewpoints of participants.

3. Cultural perspectives on learning
The final view on learning is the most complicated and relates to culture, itself a minefield of definition. A couple of useful shorthand ways of thinking about culture is (1) as the lines of demarcation between ‘them’ and ‘us’ and (2) the things groups of people believe to be true. Writers from this perspective have a less technical view than the others. Their metaphor for the organization might be to see it as a society and the
challenge in creating learning is to bridge these different perspectives and find commonalities in viewpoints. Learning is the process not the outcome.

The challenge for Common Knowledge is to find ways for the different perspectives of its constituents to engage with each other.

**Local Projects**

One meeting in Newcastle’s West End provoked a lot of thought on how to evaluate the second phase of Common Knowledge. Chris Bostock, a local story teller, explained (and paraphrased below):

> It has been difficult to demonstrate the outcomes of this kind of work. When people are asked what they think of the project, for evaluation purposes, they have said “very nice” or “Chris is a nice man”. Not convincing testimony. Many of the benefits from these kinds of projects are very soft, things not easy to record. The stories can trigger individual memories and often stimulate discussion; people interact with one another. An example of a benefit that is difficult to record came from one elderly woman who suffers from Parkinson’s disease. She finds it difficult to use her hands. Yet the story telling sessions mean so much to her that she makes a big effort to make herself presentable for the group; she puts rollers in her hair, which ordinarily she would not have the motivation to do. In an unexpected and indirect way, the storytelling sessions have had an impact on her health”.

At the same meeting, a community worker at the Riverside Centre said that she had found it difficult to gain funding for Chris’ work. She is frustrated at not being able to demonstrate the value of it. She says,

> “The impact of his work can be seen from anyone who observes, but can’t necessarily be communicated to others”.

Conversations like these led to a decision to devolve the evaluation of local projects to the people who understand the benefits. The challenge for them was how to record their experience.

In part research has failed arts/health, but the field can also let itself down. It has a responsibility to help articulate its impact. The lack of insights into these local projects cannot simply be put down to a case of “you don’t understand” or “you had to be there”. It is important to get into the detail of this work. As Matarasso has said, there is a ‘need to demonstrate to external organizations the benefits of projects, beyond descriptive value judgements’ (11).

Angus argues convincingly that projects should lead their own evaluation within a researcher-established framework. Local practitioners are aware of the impact of arts/health initiatives and with appropriate guidance might help develop outcomes from projects.

Local projects have gathered and put together material on the project to enable evaluation. They were given blank books and some guidance on how to tell the story.
There is methodological value of involving participants in the evaluation. Involving participants in evaluation and in the identification of measures could help identify new indicators. It is difficult to clarify outcome measures, but identifying impact measures might be more attainable. One of the objectives of the project is to identify measures that are relevant to participants and can be replicated in other settings.

Questions guiding the evaluation
The questions guiding the evaluation are as follows.

1. Is Common Knowledge creating capacity or arts and health projects in the region?
   a. In what ways is Common Knowledge a conductor\(^1\) of information and knowledge about ‘arts/health’ across the region?
   b. In what ways has Common Knowledge developed structures for cross sector arts/health initiatives?
   c. In what ways has Common Knowledge changed thinking among its constituents about arts/health based interventions?

2. What do Common Knowledge pilot projects suggest about the impact of arts/health projects?

Data sources
The content of this report has been drawn from the following data sources:
- Observation and notes of events, meetings
- Project documentation: minutes of meetings, promotional materials, proposals
- Evaluation books and materials form local projects
- Discussions and interviews: with Steering Committee members, the core CK team, and Common Knowledge participants

This approach is perhaps unusual in evaluation. Professor Ken Judge has encouraged a different approach to evaluation of HAZ projects and suggested evaluations should focus on programmes, which ‘create mechanisms for change by modifying the capacities, resources, constraints and choices facing participants and practitioners’… He says: ‘a programme works by introducing new ideas/resources in existing social relationships.’\(^2\)

Figure 3 illustrates the approach of the evaluation.

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1 Conductor is a word with a few meanings: as a leader or guide, as energy transfer or holding different components together. The structural and cultural ways of learning aim to capture these elements.
2 From a presentation on evaluation in Health Action Zones
PART TWO: THE DEVELOPMENT OF COMMON KNOWLEDGE

Common Knowledge has become the title of the whole project, but initially it referred to the Future Search phase, which was searching for projects.

Part Two looks at the development of Common Knowledge from the future search events up to the development of pilot projects. It examines the early development of Common Knowledge by looking at how it approached learning in three sections: (1) Information (2) Structures and channels for arts/health work and (3) The culture of arts/health working.

The aims Common Knowledge set itself are examined within these sections. They appear in italics at the start of each section. The aims were for the whole of the project, but it is worth looking at the early development of Common Knowledge and whether and how it advanced its aims.

Common Knowledge has successfully brought together diverse groups of people to explore common ground. One of the key benefits of the Common Knowledge process has been to allow people to make contacts. Some relationships blossomed outside the Common Knowledge process. It helped them to break down barriers between people that work in different sectors and it provided a space for people to talk and stimulated creative thinking. The event also made Common Knowledge a focal point for arts/health activities.

Despite the successes, its development has not been pain free. The first future search event in particular was very challenging for participants and the CK core team. It is worth
exploring some of the tensions. They illustrate many of the things Common Knowledge has learned from its experience.

(1) Information

CK aims to:
• disseminate useful information and knowledge

Information to develop the network
Participants started sharing information at the Future Search events. There were notice boards for people to exchange addresses, information about projects, and skills.

Participants said further information of this kind would help to keep a network together. The group should not lose the interactions that have been created. It would be useful to establish a database of all the constituents of this initiative and for participants to have access to lists of names from the two events. In a similar vein, they said it would be useful to have a directory of participant's skills/areas of work. This would hopefully emerge in a strong regional network.

Getting information about things - and knowing what is going on - is an important part of being in a community. If someone wants to highlight an event, then like-minded people can gather together. A popular idea is the creation of a Common Knowledge web-site.

Through phase 1 CK tended to rely on low-tech ways of disseminating information. The core team have themselves been the main conductor of information. Mary Robson, in particular, has attended almost all local meetings and given verbal updates on other groups progress and of Common Knowledge generally.

During the future search and project development the core CK team has been very supportive in getting projects of the ground by linking people together, providing contacts, suggesting avenues of enquiry, circulating information about other projects, and helping groups think through projects.

(2) Structures and channels for working

CK aims to:
• achieve community participation
• support collective aspirations in community health
• change the way that people work

One way of thinking about Common Knowledge is as a methodology. It is an approach to bring together people
aligned to the arts, health, and local authority organizations to pool their ‘common knowledge’ of skills and perspectives and explore ways to work together to improve health.

To what extent did the future search events move Common Knowledge towards achieving this?

Community participation
Common Knowledge has achieved community participation in two senses. People from local communities have been involved in the future search events and local projects (approximately 1000 have been involved in total). In a second and important sense CK has achieved community participation. It has involved people from different perspectives; the potential community of arts/health. Common Knowledge would have been unable to progress beyond the future search events without community involvement.

System thinking
A key part of future search thinking is that they are based on whole systems thinking. The notion of systems thinking has become an established way of thinking about organization. Within organizations, as they become bigger – or operations are dislocated - and different directorates and departments are responsible for different aspects of the business, a key challenge to organizational effectiveness is that over time these become distinct and disparate. Senge (12) is probably the best known advocate of this approach to learning. He believes that one of the barriers to learning is that people are not always aware of their position in the whole system. For example, in hospitals, people who work in A&E and on wards are often critical of each other’s process management. A future search process might bring them together to explore together the patient journey from being admitted in A&E to being discharged from the ward. It might involve the bed manager of the hospital, GPs and patients so that any solution incorporates all necessary perspectives.

The aims of future search would apply similarly to Common Knowledge. It is bringing together different pieces to think through a complex and unclear puzzle – how to work together?

Whole system thinking is an ambitious but integral part of Common Knowledge. It is ambitious because the people involved are not already in direct working relationships or working for the same organization (such as the NHS). And because it aimed to do this using creative approaches. Both make an already challenging event more difficult.

There are very few coordinating mechanisms for developing collaboration between individuals and organizations in different sectors. Figure 4 shows the Common Knowledge participants, the regions of Tyne & Wear they represent, and the overarching question they came together to explore.
Common Knowledge has developed a number of projects through its process and developed a network for arts/health. But its development has not been smooth and this section looks critically at the early process. A lot was achieved from the process, but it could be improved – more could have come from the events.

**How engagement was structured by the Common Knowledge future search events**

CK took a cultural approach to future search; they saw it as an event to build a common culture between people working in arts/health. This is a more narrow aim than building capacity for arts/health, which would include thinking about ways to facilitate strategic relationships and form ideas for working together.

The majority of future search participants got a lot from this cultural and creative process: meeting new people, starting working relationships, thinking about issues in a different way. The fruits of the cultural approach offered in the next section balance the critique offered of the organizational thinking in this.

The future search events were a new experience for everyone: participants and CK team alike. At the outset, there was some confusion on the thinking behind the process. In planning the process no balance was struck initially between three aims: to structure enquiry into how people work together and ways they can work together, to demonstrate a creative process to enable creative conversation, and an opportunity for like minded people to bond.

The following sections offer an analysis of the approach of CK to the future search events and a description of how it learned throughout the process from the things people said and felt. The critique is from the perspective of those who represented organizations.
(even if that is an organization of one) – from the arts, health, local authority sectors- who wanted to strike up working relationships.

The approach of Common Knowledge was more cultural than organizational. It did not have an explicit strategic element. It used a creative process to develop ‘bonds’ between people. As an approach it can be placed in top left corner of the arts/health diamond (see Part Four for an explanation of the diamond and the summary for a quick description).

CK’s cultural approach to future search concentrated on aspirant thinking. It was not as successful at strategic thinking. This can be seen in the Common Knowledge modification of the future search process. It differed from the more usual mode in two very important respects: (1) every session was arts based and (2) the people attending do not routinely work together. Both have a big effect. The first means that people do not necessarily engage in the detail of working together. The second makes it difficult to formulate and address a question for participants to explore. Normally in future search, participants have a more clearly defined relationship and to some extent are compelled to find solutions. Neither of these applied to Common Knowledge – participants were more diverse.

To an extent the process of CK prevented talk of how to create more formal links between arts and health managers present. Instead the event focused on creative tasks to develop bonds between people. This has worked, but it has some influence on the subsequent direction of Common Knowledge. It has worked at a micro level developing links and information between people. It missed an opportunity perhaps to also work at a more macro level developing links between organizations.

**CK began without a clear structure**

Ways to explore the question were not initially well structured by the activities. They were fun, gave symbolic insights, but the process did not have clear signposts. As a result people felt confused. They did not understand where the process was taking them, if anywhere. There was a guiding question on the wall and creative processes, but the connections between the two were not obvious to all.

During the event one participant was ‘getting a bit frustrated by the mysterious nature of the process’. Another wrote ‘why not write everything down so people know what is expected of them?’ A participant who greatly enjoyed the event added ‘I do think the introduction could have been clearer and more helpful’. Another wrote, during the second morning, and referring to the metaphor of a journey, ‘when will we arrive?’ Another wrote ‘it may be better to travel than to arrive but it would be very good to have an indication of where we're going - or what we might see on the way’.

Some felt that the creative tasks made an obstacle course for exploring the questions. Some felt manipulated: they thought CK was hiding its own agenda for arts/health behind the process rather than opening discussion about it.

In the first event, CK was not trying to lead people blindly; it was leading people blindly. A lot of the process and guidance in the first event was finalised and refined in real time.
It was in some ways as much of a learning exercise for the core team as it was participants. This could have been made clearer – that the event aimed to explore the question together.

CK devised sessions they felt would encapsulate the partnership between arts/health and would create space to explore the questions. They had the right idea and learned quickly. But the lack of structure in the first event lost some people. It was a problem, for example, that the end of the first event did not end with a practical discussion, in the way the second one did.

It was important that the second event ended with a discussion about suggesting arts/health ideas in regular small group discussions. There needs to be some balance between arts based and other approaches. There are two main reasons why this was problematic: it made some people uncomfortable and left no time for non-art approaches.

**The process was uncomfortable for some**

For some the process was not particularly comfortable. Some people had come to the event hoping they would be able to learn about arts and health approaches or for advice on how to get involved in projects. For them the onus on creativity distracted them from exploring their agenda. One person ‘nearly cried at having to do drama’ and later left.

One person explained the feeling well in the introduction to an evaluation book

‘One aspect of the course was that we were all comrades in adversity. I discovered for myself there were lots of people there who were in a totally alien environment to what they were used to (me included). These were mostly professionals – managers, doctors, health workers and organizers etc. ‘organizers’ being the operative word. These ‘folks’ are used to advising others… I think a lot of them felt threatened or (if this is too strong a word) under pressure, by being thrust into ‘buttock-clenchingly’ embarrassing positions where it was someone else telling them what to do. They were also doing things that they didn’t really feel comfortable with and they weren’t in control as they usually are’.

It was not the aim to make people feel ‘colleagues in adversity’ but as colleagues in tackling common questions. Reflecting on discussions with participants and within the core team has led to a conclusion that a future event could learn from the experience.

With hindsight, Common Knowledge could have explained in advance the philosophy of the future search events more clearly and in different ways. Not everyone understood until it was too late that the participants guide the direction of the process. It is an unusual mode of working and not easy to grasp. Some were overwhelmed by the creative approach and an apparent lack of direction.

There are inevitable tensions in trying to produce an event that will work for everyone. For example, some people thought it was a good idea not to have name badges – the idea was it would be a leveler - while others felt it hampered networking opportunities. While many were pleased by the open philosophy of the event and the fact there was no predetermined aim others felt something more structured was needed.
The guiding question was not very practical
Perhaps the arts based approaches would have worked better if a different question had been asked. The question asked - How can we meaningfully connect and become healthier neighbours? - does not necessarily lead to an active solution. The question was aspirant. It aimed to facilitate the formulation of arts/health and what it meant to participants. The question reflects the cultural approach to learning of the organizers: that what occurred in the event could be replicated outside. The thinking was that people within the room would discover how they could meaningfully connect and at the same time how they could work to enable others to meaningfully connect. The question is poetic or symbolic; more an essay question than a practical examination.

It meant that participants did not get into a detailed discussion of tensions in the aims of arts/health and what it might look like practically. There was no discussion on the different approaches of sectors and groups, on how they might be reconciled, or any structured discussion of how people could work together. Some of the frustration at the first event was born out of a frustration at not having the means to give their point of view. Some people felt the creative task-focused sessions limited discussion.

Some people, those accustomed to debating in conferences and meetings, were frustrated by the creative onus on every session. They wanted time to discuss in a more traditional way; it would have been better for some time to be set aside to discuss in this way. At the second event some time was allowed at the end for people to discuss possible ways of working and this helped. Other discursive sessions would have given more opportunity to those who are most fluent in these forums to contribute.

If others wanted to run a Common Knowledge type event, the creative sessions are very important, they require people to think differently and explore issues collectively. But sessions need to relate questions to practice. Because of the emphasis on being creative, to some the event felt more like a big workshop discussing aspirations for health rather than a structured exploration of the potential for working differently.

One of the difficulties of creative sessions is that some are more used to it than others. As well as making some uncomfortable, some of the artists felt they were taking the burden. Because of the creative onus of the event, and because they were the ones with the skills, they felt they were not getting as much out of the event as those from the health sector; some felt exploited by it.

There is something in the criticism in that the first event was too arts orientated. The future search events should have given a greater voice to health to enable artists to think about how the arts could help meet challenges and to provide opportunities for artists to suggest other possibilities.

Several people have commented that future search processes depend upon what people put in. This is true, but people also have to be clear about what they are being asked to
contribute. A more clear explanation of the aims of the event, a more practical question and a greater mix of sessions would have helped people contribute in different ways.

Those problems meant that Common Knowledge had to work harder to develop a network. Lots of connections were formed at the events, but CK had to put a lot of resources into shaping these connections into arts/health collaborations.

**Next steps from Common Knowledge**

Both events ended with an explanation of the future of Common Knowledge and the aim of developing pilot projects to demonstrate collaboration between sectors and health promotion through participation in the arts. At the end of the second CK participants were asked a practical question: How do we maintain the community that has emerged from this event and what might we practically do?

**Culture**

CK aims to:

- *create a positive emotional environment for the project*
- *mutually define arts in health for the Tyne and Wear Health Action Zone*

**The cultural approach of future search**

It is much to the credit of Common Knowledge that it was able to learn from the problems of the first event and improve the experience of participants. It learned that some participants wanted different things from CK, that some didn’t like participating, but more than anything it learned that behind an exclusively cultural approach was an assumption that insight about new working relationships would develop automatically from participation, as if by osmosis. In the second event the aims and process were made clear in advance of and during the event.

The first event was an art events talking about health, the second used arts sessions to explore health and think about what arts/health perspectives looks like. Both focused on creating an emotional environment conducive to bonding. Ideas about ways of working were discussed between people within the process. The process did not explicitly address this.

Although not formally stated in the aims, the main focus of Common Knowledge has been to develop bonds between people. The largest successes of Common Knowledge are cultural and a logical progression from the approach taken in the future search events. This section looks at the ways in which CK has helped develop a different culture of
thinking. Most of the impact of CK can be seen at the micro level. It has led to new ways of working in local projects.

**Bonding**

Common Knowledge aimed to bond people. For many it did. One participant explained in an interview a year later that this happened because CK was a process for exploring people’s experience.

> ‘We went on to focus on life experiences. I found this to be a thoughtful and reflective part of the day and sharing my own personal memories with others was quite an enjoyable experience. There is so much feeling in a memory. I enjoyed listening to other people’s memories too; in fact their memories jogged more of my own. The global memory session brought home to me just how diverse we are in our perception of what’s important to us as individuals but also what’s important to us as a collective’.

Many have commented that the strengthening of relationships resulted directly from the process. Because of this it was ‘great that it wasn’t a conference’. It stimulated exploratory discussion beyond the level that people who have just met usually get into. It helped to develop relationships (in a cultural rather than strategic sense).

**A positive emotional environment?**

The first future search event was not necessarily a positive emotional experience for the facilitation team. The large groups and complex process made them tired and one or two confrontations left them shell-shocked.

They were shell shocked by the contrast between, on the one hand, a great volume of positive feedback. People were making contacts and engaging in discussions with people from different sectors, exploring what health and the arts meant to them from their different perspectives. There were some really exciting ideas about future work, but the strength of feelings from the minority who had objections knocked them for six.

Common Knowledge as an initiative has been a steep learning curve. A lot was learned from the first future search, which was more problematic than had been imagined.

But having already dwelt on the critical aspects of the approach. It is important to acknowledge that the vast majority were uncritical. For example, Common Knowledge had been a positive emotional environment.

> 'Have had fun, fun, fun…'Enjoyable and challenging’… 'Thoroughly enjoyed myself'. 'Had a great experience and I'm interested in what will happen'... 'Dead good fun'...'Brilliant'...'Can I do it again?'...'Fab'...'Dead good'...Great Fun…extremely interesting...a chance to play…a good laugh!...Very fun process…Other peoples views, perspectives, shapes and sounds all added to the music!...Fun - using different methods of communication…Beats working, but it cost some people more to be here (unpaid people)...Laughter - there was lots...fun...Thoroughly enjoyed it, I want a fortnight residential...Fun, fun, fun...How do I go back to work? This wasn't hard work - relaxing, creative, engaging…enjoyable, good humoured and well structured...Arts enhanced conversation which is different from discussion - reciprocal, different.'
It’s also true to say that many who were initially uncomfortable with the creative sessions came to value the process. They came to understand that focusing on a creative task can be a bridge between people and a microcosm of arts/health projects. One person explained several months later:

‘We were given time to put a piece together which we were then to take back to the whole group to share. This was the most challenging part for me. Our group spent a lot of time discussing and what seemed to me to be going round in circles not being able to come up with a joint idea. When time began to run out I began to feel quite panicked. I really didn’t want to go on. I thought whatever we managed to put together would be crap. Then all of a sudden, we all seemed to be thinking in a similar way…we were cooperating and supporting one another and came up with something presentable just in the nick of time’.

Others agree:

‘Everything we did yesterday seems more relevant now…The process worked so well because we were able to utilise a large block of time rather than lots of little slices. The intensity helped develop relationships very quickly.’

The main contribution of the CK events has been introducing people and providing a new means for them to communicate. Practically everyone has praised CK for that. It was

‘Great to meet people from other communities of existence... Sharing with peers and colleagues has been rejuvenating and supportive...Enjoyed the connections made - and the suggestion that we make geographical links now....A chance to listen to and meet others of like mind...good diversity of participants - good for meeting other people working in connected fields, for example, an artist meeting someone from their health authority.’

For those who were comfortable with the creative process, CK provided an innovative way of talking and thinking. It was:

‘thought provoking…new, different, interesting ideas…communication and respect for individuals were vital keys to the process…variety of ways of communicating - not using words, but doing, seeing, listening and creating… It was useful splitting up into geographical groups at the end and getting to know who was who in Sunderland. I liked the fact that we didn’t know much about the process or about each other to begin with. Didn’t talk about roles - that was a challenge. …It created a new dynamic…

One person summed up well what the core team had hoped to achieve:

‘The last two days demonstrated to me that without our 'badge of office' we can collaborate in new non hierarchical teams more effectively.’

The guiding question
Because the guiding question was an essay question, it was very helpful in developing ideas. It was articulated in discussions prior to the event by the Common Knowledge
facilitation team and reflected their cultural approach. During the first events participants began to usefully pull the process toward an interrogation of the question, breaking it down into chunks. The second event learned from the first and did it more explicitly. Figure 5 conceptualizes the way the cultural examination of the question by participants in the first CK event and how this continued in the second. The two events are best seen as part of the same seamless discussion.

**Figure 5**

The question is not an easy one to answer. As one participant at the first event subsequently explained:

‘How can we meaningfully connect and become healthier neighbours?’ was in foot high letters on the wall. This was what we were working towards answering, but I felt it did not pan out this way. I felt there seemed to be far more questions coming out than answers, I felt all the actions were opening up more questions all the time.’ ‘As one door opened – it led into a corridor with a hundred other doors - maybe, that’s what ‘Common Knowledge’ is all about.

People have said the creative process was a route to stimulate discussion. A number were particularly happy that they had the opportunity to see different ways of expressing views -'doing was better than talking'. The majority of participants enjoyed the process, though a few were nervous about the performance. Occasional discomfort with the process was expressed as ‘no pain, no gain…painful and pleasurable…a mixture of embarrassment and ease’. Others described their experience as ‘forming, storming, norming, performing…regrets, I've had a few - etc. - but we did it our way…The clichés started to give way to sharing…actions speak louder than words'.

Those who attended the event as individuals got more out of the process than those who did not. Most did not mind the lack of structure and the level and engagement: ‘I liked it
not being a normal conference/not structured. Doing, from the start, you have to be engaged. Another said the process ‘confirmed what the arts are about, organic/unstructured but real thought and clarity about the process - well planned.’

Talking and thinking in new ways?
The development of projects came from people experimenting in new ways of thinking and working. A journal from one project – Music for Health – helps explain how one group shaped a project. A GP, singer and cellist met at a Gateshead group meeting and developed their interest in music as a therapeutic and engaging process. The extract below is from Margaret Frayne’s diary.

‘I met Tabitha Tuckett (classical cellist), Christina Cock and Helen Ramsay (doctor and nurse of Oxford Terrace Surgery) at a meeting of Common Knowledge in September. Tabitha mentioned that she was interested in taking music into hospitals, having heard about the work being done at the Chelsea and Westminster Hospital in London, and having done some work in care homes herself. I was already singing in local hospices and Christina (a GP) and Helen (practice nurse) were very keen in using arts in health care situations, so everybody was there at the right time to get things going’.

Tabitha’s diary records the process that followed:

‘The four of us, with the help of Mary Robson, worked through what we might achieve, where we wanted to work, and how much we could do within a limited budget. We all felt we would like to visit areas of health care that didn’t usually receive attention from arts projects and funding. With Christina’s and Helen’s invaluable knowledge of local health care services, we settled on elderly care and mental health as key areas, with ICU and palliative care as other options to investigate. It was a great relief to settle on a reasonable fee for us musicians, and the confidence of Common Knowledge in its creative artists was again inspiring. We discussed the possibility of bringing in other musicians for one or two events. I felt strongly that the quality of the music and its performance should be high in order to be communicative and effective. I agreed to handle administration for the project, and have been overwhelmed by the positive response of people we’ve contacted, especially Kate Monaghan, Head of Public Affairs at Queen Elizabeth’s Hospital Trust, who provided me with a list of contacts in various hospitals covering the areas we were interested in, and came up with other ideas too. She mentioned how difficult it was to convince funders that work without a concrete visible outcome at the end (eg: a piece of art work to be displayed) was nevertheless valuable. The great advantage of our project for cash strapped hospitals is that we bring our funding with us.’

Another diary tells a similar story. This one is from a Sunderland project, written by Chris Hollis.

‘May 10th
‘I met Mrs Trish Stoker, the Head of Southwick Primary for the first time at this meeting of Common Knowledge Sunderland group. It’s some time since the seminar (Trish was on the other two-day course). Memories of my seminar experience are fading, but I’m interested in working on a pilot project’
June 15th
Meet Trish again. We are both eager to get on with a project. “Come and take a look at my school” she says. ‘

Following the future search events, regular meetings were held in locality based groups. Participants in Common Knowledge and others joined the groups which met to get to know people locally, discuss their roles and priorities, discuss potential projects and the ways people can work together.

Each of the local groups met regularly from Spring 2000 to formulate projects which began in October 2000. They met in a variety of forums doing different things. The South Tyneside group, for example, spent a day on Marsden beach making sand sculptures and talking about ideas for future projects. Part of the process has been learning about each other’s interests and holding meetings in non-conventional locations. The Newcastle group mostly met at the home of a Gosforth GP. On one occasion they had a presentation on storytelling at the West End Health Resource Centre.

Groups started with people stating what they would like from Common Knowledge, the kinds of support and knowledge they are looking for and the things they have to offer. This has included information, skills, sharing their networks or potential venues for meetings. Most of the projects have developed in local groupings with people discussing different possibilities. For example, in South Tyneside, an occupational therapist in a local hospital teamed up with the South Tyneside Arts Studio. STAS had been interested in accessing different health settings and the OT interested in finding new ways to work with patients.

Groups have also discussed the different perspectives on arts/health. It is interesting how different arts/health themes have developed in different areas. In Newcastle, expression has been a key theme. This is the common ground between local members. In South Tyneside it has been communication, which has connected a group of people who are each keen to develop the potential and raise a profile for arts as an exploration of health information, in its broadest sense.

As well as talking about projects, people have shared experiences on health and about the difficulties of defining projects: are they community projects, art or health projects? The groups have continued the discussions from Common Knowledge on a smaller and perhaps more manageable scale.

The local group meetings have continued as projects have developed and changed in tone. They became support groups discussing projects and the problems that have arisen. They have offered each other solutions or suggestions for how to overcome problems. They have also been forums to reflect on the progress of projects. Many of the projects have reached stumbling blocks. One of the interesting aspects of being a support group is for artists and health workers to learn insights from each other’s perspective.

This has been the case in every local group. One of the things that worked well in South Tyneside has been that a couple of organizations serve as strong focal points for a local
network. The projects participants in South Tyneside all attended the local groups, which became a collective way of organizing activity. The discussion was reflexive, questioning the aims and direction of projects.

In some localities people involved in projects have not become involved in the local groups. In the evaluation books, a couple of groups commented on the “missed opportunity” of not being involved. This is true not only for them, but for other members of the group and for the projects themselves, which may have benefited from collective discussion on their development.

To a greater or lesser extent, the groups have had a core of people attending and others who come and go. This frustrated one participant who said that conversations over the months were disjointed. New people would arrive and the conversation would begin again.

Despite the frustrations, all local groups, with the core team present, went through a similar process. Beginning with a discussion about likely projects, they progressed to talk about aims and then about the specific direction of projects and became support groups for regular attendees.

**Region-wide meetings**
As well as local meetings, there have also been a number of region-wide meetings that have focused on specific areas within arts/health.

There have been sessions on arts on prescription for interested people to learn about approaches in other settings. There was also a music day bringing together music therapists and practitioners. And there have been trips organised to other arts/health projects.

Common Knowledge has developed in a biological fashion. Figure 6 shows the development of Common Knowledge between March and October 2000. It illustrates how a network has developed from the Future Search events
Part Three takes up the story beyond the development of projects and introduces the reader to the content of projects using some descriptive variables.

**PART THREE – COMMON KNOWLEDGE PILOT PROJECTS**

Parts Three and Four look at the Common Knowledge pilot projects in some detail. Part Three is descriptive and Part Four is more analytical; it explores the differences between approaches and the contributions of these as well as the evidence to support these claims.

The content of this section is drawn from three main sources: interviews with participants, observation of and informal discussion within local groups and (the main source) the evaluation books of participants.

First it lists the pilot projects undertaken as part of Common Knowledge. Secondly, these are described in the context of the Tyne & Wear Health Action Zone’s priorities.

The projects are then outlined according to the following descriptive variables:

- Art form
- Setting of projects
- The audience for projects
- Motivation for projects
- The approach to evaluation
- The style of the evaluation book
**Descriptions of projects**

The following sections aim to introduce the reader to the projects according to different descriptive variables beginning with a list of the projects.

There were 20 Common Knowledge pilot projects in Year Two. Table 1 lists them.

**Table 1 – Common Knowledge pilot projects**

<table>
<thead>
<tr>
<th>PROJECTS</th>
<th>BRIEF DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Music for health</td>
<td>Take music (cello and singing) into various NHS venues engaging residents through digital arts to learn about their experience</td>
</tr>
<tr>
<td>2 Video Conferencing for older people in residential care</td>
<td>Using arts to explore alcohol and drugs within a local community</td>
</tr>
<tr>
<td>3 Chopwell time experience</td>
<td>Arts on prescription for stressed people (music therapy and silk-painting)</td>
</tr>
<tr>
<td>4 Create well-being</td>
<td>Arts to distract and engage cancer patients</td>
</tr>
<tr>
<td>5 Writing and Painting at the Northern Centre for Cancer Treatment</td>
<td>Arts (writing, photography etc.) used to explore issues in long-term care</td>
</tr>
<tr>
<td>6 A better life in later life: older people in residential and nursing care</td>
<td>Using arts to explore communication and expression with a group of speech therapy practitioners and users</td>
</tr>
<tr>
<td>7 Celebrate the Power of Communication</td>
<td>Arts to explore expression on hospital ward – work with mentally ill</td>
</tr>
<tr>
<td>8 Voice work on Ward 21, North Tyneside General Hospital</td>
<td>Stitching and embroidery for groups in care homes and community groups</td>
</tr>
<tr>
<td>9 Stitch and relax</td>
<td>Craft based arts techniques to gain referrals from GPs</td>
</tr>
<tr>
<td>10 Arts on prescription, North Tyneside</td>
<td>movement and theatre to explore issues in health and healing</td>
</tr>
<tr>
<td>11 Winter</td>
<td>Artist developed information sheets for mothers around food and feeding infants</td>
</tr>
<tr>
<td>12 Community Mothers’ Nutrition Leaflets</td>
<td>Using arts to work with ethnic communities on ways to recognise diabetes</td>
</tr>
<tr>
<td>13 Looking out for…</td>
<td>Using arts media with patients to develop information for patients – including mental health patients</td>
</tr>
<tr>
<td>14 Bede Wing Information Project</td>
<td>Exploring communication between a surgery and its patients</td>
</tr>
<tr>
<td>15 Have we made ourselves clear?</td>
<td>Work with vascular patients to produce a CD and radio programme on their experience to generate information for patients</td>
</tr>
<tr>
<td>16 Hospital Radio</td>
<td>Using arts to explore bullying, the emotional side of friendship and mentorship in a school</td>
</tr>
<tr>
<td>17 Friendship Garden Project</td>
<td>Developing links and friendships between young women through creative process</td>
</tr>
<tr>
<td>18 Food, Friendship and Candlelight</td>
<td>Work with young women to produce and present theatre on young people’s relationships</td>
</tr>
<tr>
<td>19 The Drama Queens</td>
<td>Working with teachers and children on emotional literacy in Sunderland</td>
</tr>
</tbody>
</table>

In addition, there was a major pilot project in which 15 groups across the region worked on decorating tables. Each group worked with an identical table, one that seats 6 people.
They are curved along their length and have been designed to exhibit together. The table legs can be folded and the table used to decorate a wall. The theme of the project is food. The original idea came from a finding from the Food Foundation report in 2000 that 70% of U.K. homes do not use a dining table. The reliability of this statistic may be spurious, but the idea struck a chord. The idea is to create furniture that can be used to bring people together. Each of the 15 groups chose from 5 themes: Roots, Shoots, Flowers, Fruits and Seeds. The groups chose an edible ingredient central to the design. Each group produced a design template to be turned into marquetry by a furniture designer, and set into the middle of each table is an additional unique feature designed by each group. It could be glass, mosaic, ceramic tiles etc.

This interim report concentrates on the pilot projects as not all information on the tabletop projects has yet been brought together. The experience of ‘It’s on the table’ projects will be further explored in coming months. More is said about the management of these projects in the sections below.

**Health Action Zone priorities**

One way to look at projects is to how they align with the Tyne & Wear Health Action Zone (HAZ) priorities. Projects are listed in Table 2 below against HAZ priorities.

**Table 2 – Tyne & Wear HAZ priorities and Common Knowledge pilot projects**

<table>
<thead>
<tr>
<th>Tyne &amp; Wear HAZ priorities</th>
<th>Common Knowledge Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Healthier Citizenship</td>
<td><strong>Food, Friendship and Candlelight</strong></td>
</tr>
<tr>
<td></td>
<td>The project is to bring together groups of young mothers to work on a creative project and explore health issues relevant to this group. The book is a diary of the things they explored as a group</td>
</tr>
<tr>
<td></td>
<td><strong>Winter</strong></td>
</tr>
<tr>
<td></td>
<td>Winter is a project for adults of all ages, often with experience of serious illness. The project offered people a chance to explore the relationship between health, sickness and healing both as individuals and as a group. Art forms included dance, movement, music and video.</td>
</tr>
<tr>
<td></td>
<td><strong>The Drama Queens</strong></td>
</tr>
<tr>
<td></td>
<td>This project presented piece of drama developed by six teenagers to peers. The six wrote a script, developed characters, and performed the play with the help of a theatre company. The ideas for the play were developed by actors brainstorming ideas and developing relevant health issues for young people</td>
</tr>
<tr>
<td></td>
<td><strong>Celebrate the power of communication</strong></td>
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<td></td>
<td>This project included people with a variety of voice and speech difficulties: stroke patients, stammersers, voice patients (including a teacher and a lawyer) who have vocal problems, and speech therapy students. All participated on an equal level, working with voice, creative writing, music, movement and drawing, and aiming to provide an exploration and celebration of communication through artistic and creative media. The aim is to create a group in which the participants can discover more about their own voices and the voice generally and explore ways in which they can communicate - especially emotionally.</td>
</tr>
</tbody>
</table>
Modernising Services and Improving Standards of Health and Social Care This is a broad area and many of the projects have been included in this category as a broad area of work

Have we made ourselves clear?
Exploring the process and methodology of "communication" between patient and professional health care staff in a health care community setting, capturing elements of meaningful and real exchanges between people using digital art and then using this in some way to inform others of good practice

Music for health
The project has taken music into NHS venues, from hospitals to a GP waiting room and from a formal concert to playing and singing for individual patients at their bedside. Of all the projects, this one attracted most media interest

Looking out for...
Using the arts to help Health Professionals and the local ethnic communities to work together in new ways to recognise the early symptoms of diabetes

Care of the elderly

Video Conferencing for older people in residential care
This is a long standing project which has explored the experience of people in long term care and their issues through the arts: photography and creative writing. The Common Knowledge project aimed to draw together some of the insights in order to highlight these to policy makers and managers. It aims to encourage a debate

A better life in later life: older people in residential and nursing care
Phase one of this project used creative writing and storytelling 'taster' sessions in an attempt to get the views of older people, relatives, friends and staff about residential and nursing care. Phase two saw the photographer and storyteller spending some time in a nursing home, observing and photographing daily life. The CK phase of the project was to share the insights with policy makers and care managers

Stitch and Relax
Although not exclusively, this project primarily worked with older people in residential care who can benefit from learning/re-learning a stress free art form and work in communal groups. It is particular beneficial to Alzheimer’s sufferers.

Cancer Services

Writing and Painting at the Northern Centre for Cancer Treatment
There is no provision from some existing arts lottery funding at NCCT for patients undergoing chemotherapy in ward 36 or those admitted as seriously ill in ward 37. It is vitally important that time spent having chemotherapy should be positively enhanced, that some very ill patients get a chance to express themselves and that staff be given the opportunity of participating in an arts project. Writing and painting provide the means of expressing oneself at whatever level is comfortable. Staff participation could be an important element of this project.

Mental Health

Voice work on Ward 21, North Tyneside General Hospital
A voice work group was created on Ward 21. Sessions included: working with voice, group improvisation, singing, breathing, simple non verbal vocal sounds e.g.: humming, using simple percussion and instruments brought in by members of the group. The aim was to provide creative activity for ward members that are enjoyable and fruitful hopefully resulting in increased confidence about using their voices and making sound and music together.

Bede Wing Information Project
There is a need for NHS clients to be able to access relevant, clear and simple information about services, their rights and responsibilities and generally what to expect whilst in hospital. This project worked directly with psychiatric in-patients to produce information and communication tools using a variety of artistic media.
**Create well being**

Some projects are not strictly related to mental health - in the sense of clinical diagnosed ill mental health. Instead they relate to spiritual well-being and to encourage participants to take up further art/leisure activities.

**Arts on prescription, North Tyneside**

Following artists' demonstrations of different techniques during surgery hours, the project has worked with referrals from local GPs for those patients whose mental health might benefit from involvement with art.

**Community Mothers’ Nutrition Leaflets**

This project tells the story of overhauling and reviewing a range of information leaflets for mothers on health. The project book is remarkably detailed, covering many sensitivities in communicating to this group, as well as negotiations between health professionals.

**Heart disease 15 table top projects**

Each of the projects have a theme of food and healthy eating and are to be used for communal celebrations at which the theme of healthy eating is promoted.

**Hospital Radio**

Artist worked with vascular patients to produce a radio programme to be broadcast on Sunderland Hospital Radio. Vascular patients are admitted for various surgical intervention prior to decisions for amputation and are therefore well known to the nursing staff. The majority of amputees see the surgical removal of a limb as a chance to free from pain. However, anxiety and depression can feature prominently before and after surgery. Early discharge from hospital can be hampered by problems. The project aims to generate useful information for patients.

**Young people Friendship Garden Project**

An artist worked with a school to help them explore issues around bullying at school and create a friendship garden. The children created images that the artist transferred to buildings in the school. Parents toured the school and helped with the project. Parallel to the project the school introduced a 'buddy' system, making older children mentors to younger ones.

**Emotional Literacy and Human Values**

Common Knowledge introduced a practitioner in emotional literacy to a school where several weeks of lessons explored emotions and social relationships. Lesson plans were developed for teachers to use with children.

**Chopwell time experience**

Chopwell Timeline Experience is a community-focused project that employed art as a process to inform on health and well-being. They created art work for the new youth centre, soon to be open in the village. The theme of the work was the effects of alcohol in the community.

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**Art form**

Common Knowledge projects employed a variety of art forms:

- Music
- Craft
- Digital
- Drama
- Movement
- Visual
- Voice
• Writing
• Mixed art forms

Settings of projects
Projects have taken place in a variety of settings. All except five took place in health provider organizations, including
- Mental health wards
- Primary care surgeries
- Acute trusts
- Cancer hospital
- ITU unit
- Residential care homes

Of the five that did not take place in a care setting: two were in a school, one in a voluntary organization working with community health professionals and two in youth centres.

The audience for projects
The principal audience for the work varied too. They include: the elderly; the mentally ill, and the stressed; a whole community; young people; patients, cancer sufferers and people with speech problems; mothers, clinical staff, primary care and acute sector care managers.

Motivations for projects
Motivations for projects varied. The list below is a summary of the some of the different motivations. They not only reflect the aims of the project, but also those of the participants and organizations that some of them represent.

- Innovate with different health interventions
- Generate discussion on what health means
- Experiment
- Pilot an approach
- Finish a previously abandoned project
- Develop profile of organization
- Attract referrals from local GPs
- Exhibit work to share lessons of project
- Take arts to people
- Convince others of their approach
- Develop partnerships and links with health/art
- Develop new skills
- Develop personal role
- Produce good work
The evaluation of local projects

A meeting was held in South Shields in December 2000 to discuss the evaluation of forthcoming local projects. The Common Knowledge Planning and Evaluation Books were distributed to each project with an explanation of how they should be used.

The evaluation books contain great detail about the projects. They will be very useful as a resource to learn about the impact and process of projects and to inspire future projects. It is the intention of the core team to give central access to these as a Common Knowledge resource.

‘These books are designed to help you plan and evaluate your project. They should be used to provide a creative record of your project. These books will provide a rich description of the experience of working on an arts and health project.

The books will be made available to people interested in learning from Common Knowledge. Books from each project will provide a library of experience that will collectively be mined by the researcher to explore impacts and insights from Common Knowledge projects. The books should capture in as much detail as possible how the project develops and record what is learned throughout the project.

Evaluating projects like Common Knowledge has proved difficult and many practitioners remain frustrated that the impact of their work is not shown. The problems have been that those planning and delivering the projects are often not involved in the development of evaluations and that evaluation instruments are not sensitive enough to capture the impact of such approaches.

An evaluation and planning sheet is included with the book. It is designed to plan the project and evaluate its progress. The form asks three questions which you should address within the project each time you meet. (1) What should we do next? (2) How will this develop the project? (3) What might this development lead to?

Your books may help to identify more sophisticated ways of gauging arts and health projects to do with process and impact, as well as outcomes.

In a sense, the books issued a challenge to the projects: to find ways in which to convey to the reader in their own way, the impact and issues within arts and health.

It proved a challenge that some were interested in; a project working with older people explained the motivation for their project

‘we wanted to find out some of the type of information we come across by chance, anecdotally, to understand the impact of our works, but that would not be accessed by a more traditional evaluation.’  ‘Elsewhere in the book the theme is taken up again. ‘We knew we’d have something to say, but we didn't have a preconceived idea of what that would be. We allowed work to inform us’.

An arts on prescription project said:
'the main objective was to have a positive effect on the clients mental health. Fifteen weeks are not long enough for huge changes to be wrought but can give an indication of what is possible: becoming less dependent on medication, fewer visits to GP, enjoying a fuller social life, establishing artistic activity.'

The books need more study. The researcher will work will the projects to find ways in which the reader can better understand the project. They contain a mine of information and it will take some time to fully understand their contents.

It has been said that it is very difficult to capture the experience of an arts and health project. The benefits as perceived by patients and practitioners are ‘magical’ and are not easily grasped. To an extent, this will always be true. Some of the richness of experience can only be judged if you are there to taste it.

Part of the aim of this project has been to try and improve the clarity of insight into projects. This has been done by devolving the evaluation to local projects in order for them to record the experience of projects; the successes and difficulties.

The project books have been gone through and aspects recorded. For example, categories include: the evaluation process, aims of project, motivations of participants, view on relationship between arts and health. These are being coded in a database along with the other data collected during the evaluation. Analysis in the final report will then examine relationships between them.

It will take some time to analyse the books and understand fully what they contain, as well as further conversation with those who produced them. They contain a lot: diaries, examples of work, comments from staff, patients, participants. They offer insights into the problems of working on arts and health projects and of evaluating them. They are a rich resource. It is possible that some of the books could be published because they provide such a clear insight into the process of a project; they articulate the benefits of the work as they see them; they record with great clarity and honesty some of the difficulties and tensions in this work. Many of them tell a very clear story (some do not, however).

**Detailed descriptions of insights and process of projects**

Of the 20 pilot projects, 15 have so far submitted their evaluation books for evaluation. The remainder are in the process of being put together.

The following books could each stand alone as an independent publication. Each provides remarkable insight and a very clear story of creative approaches to health issues. They are briefly described below.

‘**Are we making ourselves clear?**’

An artist works with a primary care practice on the information given to patients. It contains very clear exploration of the culture of communication between a practice and its patients and provides very clear insights into some of tensions between arts and health practitioners.

‘**Friendship Garden**’
The story of an artist going into a school for the first time; it explores the twists and turns of working in a new setting and what it might achieve. It also gives clear insights into the experience of an artist working in a new setting. It is very accessible, written like a story (and in parts is very funny!).

**Writing and Painting at the Northern Centre for Cancer Treatment**
A writer and painter worked with newly admitted patients at the NCCT to give them opportunities for self-expression. This book is not as well put together as others, but contains a lot of insight from the project facilitator and both artists. It also offers useful insight from staff on the unit on how they saw the development of the project and from the artists on the relationship between relatives and patients during treatment.

**The Drama Queens**
A group of six children write and perform a play on relationships to present to their peers. The book records the entire process, from brainstorming about health issues, to shaping a script, developing characters and performances. It suggests benefits of participative exploration of issues and has all the drama of production – two of the six actors drop out a fortnight before the opening performance.

**A better life in older life: older people in residential care**
This project received funding from Common Knowledge to complete a project that had not been completed. It pulled together previous work and completed other work in a residential home with a writer and photographer. The artists’ aim was to explore the experience of people in residential care. And the aim of the exhibition was to share the insights of the work with care managers and those who fund residential care.

More work is needed to pull together the personal insights of those who worked on the project on the difficulty of engaging the health sector with the suggestions that follow from the work. At the moment these are absent from the evaluation book.

**Arts on Prescription, North Tyneside**
This project worked with local GP practices – Common Knowledge put them in touch with local practice managers – to try and attract referrals from patients who GPs felt would benefit from creative activity. Like the project above more work is needed to pull together the experience of the project. The value of this book is the insight it provides into evaluation. Of all the books, this one has the most reflexive and interesting comments to make about evaluation itself. It has tried to pull in evidence for its impact from a wide range of sources.

**Music for Health**
The people in this project sang and played cello in hospitals, GP surgeries, residential homes and clinics. The unusual approach led to articles in local newspapers: ‘It’s music to get better to’, ‘music keeps way the blues’, an interview on Radio Newcastle and a news item on Tyne Tees. The book includes press clippings, and tapes of the radio and TV coverage. It also contains a lot of audience evaluation. The story is told in two separate, and very detailed, journals by the singer and the cellist. Thought provoking reflections on the power of music, the benefits for staff, and whether working class people want to hear classical music.

**Community Mothers Nutrition leaflets**
The title gives the aim away! These two books give great detail of what goes into getting an artist working on delivering health information – negotiations between different professionals,
searching for information, and working as a ‘professional artist’. Reflections and doubt are all honestly recorded and each stage of production is clearly outlined.

**Music and Voicework on Ward 21**

Much of the creative work speaks for itself, though a journal of the sessions provides a way to make sense of the development of understanding. Poems were written in groups and individually.

**Create well being**

Arts on prescription initiative in Newcastle involving silk-painting and music therapy. The book draws on a variety of evaluation sources: a measure of the effects of singing, discussions with participants, and journals of practitioners.

Some of the books are intriguing; they contain bright and interesting pictures, tapestries and sketches. However, no sense can be made of what happened or why they were doing it, and whether these aims were satisfied. Some need some encouragement to change the format and find ways of recording sensitive information and elusive insights. A poor book does not necessarily mean a poor project.

**It’s on the table**

The majority of the ‘tabletop’ evaluation books are of limited use for others to learn from. This is partly the nature of the process, a limited contact between an artist and group to produce artwork within a health theme. It is difficult to produce a story of these projects; they don’t have the same aims as the other pilot projects. The process is centred on the design of a table top.

Some of the strongest criticism of CK’s activities has been of the table projects. One person expressed the view that “CK took a decision to create an art work for the consumption of the artistically literate at the expense of other routes” and has created a region-wide project at the expense of local projects that could have been developed.

An artist who worked on one the table projects found the process constraining. An artist was commissioned centrally to make all tables and a limited number of colours and themes were available for artist-led groups to work on. A couple of artists felt this limited their creative freedom and ability to develop ideas as a group.

The core CK team is delighted with the product and disappointed by the process. On reflection, they did not give enough guidance and were too pressed for time with the many projects happening at the same time. It has been suggested that the groups might come together centrally to reflect on the process while discussing the kinds of events that the tables will be used for.

The table projects, unlike any of the pilot projects, are about the output of the project. It is difficult to extrapolate the process. Some of the frustrations around the project may be relieved when the tables are brought together and used in the way they are intended. This is due to happen in 2002 as part of CK’s celebration of its artwork.
PART FOUR: INSIGHTS FROM THE PROJECTS

The aim of Part Four is to examine the insights the projects have to offer and analyse the contents and aims of the projects. This is done in the following sections:

- The arts/health field critique of views of health
- Views on art/health
- Contribution of projects

A good starting point is to understand the critique the arts/health field make of the NHS and the way health is understood and delivered. From this the wide variety of arts/health approaches can be better understood by tracing projects to their critique of health. The second section then tries to map the different approaches of the arts/health field, related to their critique of health. The aim is to explain the contours of the field and the route and aims of different approaches within it.

Mapping the terrain of the field is a useful endeavour for two reasons. First it may help to ease the tensions within arts/health that result from arguments over its defining features. Secondly, it may help people in health understand the potential of different interventions so commissioners can better match the aims of project work to the potential impact of different approaches.

(1) The arts/health critique of health

Figure 7 shows some of the critique of arts/health on the health field and its implications for the field. It characterises the arts/health field as growing out of a critique of health. The two questions it asks: what is the cause of ill health and how can the arts improve health show how different approaches within arts/health have different approaches resulting from different answers to these questions.

**Figure 7**

<table>
<thead>
<tr>
<th>What is arts in health saying about ‘health’?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bad health results from?</strong></td>
</tr>
<tr>
<td>Lack of engagement with people about health</td>
</tr>
<tr>
<td>Art is a means of communicating new knowledge/information</td>
</tr>
<tr>
<td>Poor social environment/networks</td>
</tr>
<tr>
<td>It enables people to engage collectively with important issues</td>
</tr>
<tr>
<td>Not fully understanding determinants of health, eg: stress and social factors</td>
</tr>
<tr>
<td>Art is therapeutic / art is a therapeutic activity</td>
</tr>
<tr>
<td><strong>Art improves health because…</strong></td>
</tr>
<tr>
<td>Lack of means of creative expression/isolation</td>
</tr>
<tr>
<td>It is a alternative form of expression and self understanding</td>
</tr>
</tbody>
</table>

Common Knowledge Interim Report
One of the realizations of the researcher around a year into the project was that people in this field had very different perspectives. They had quite different assumptions about the work although connected by the use of arts in the field of health. These diverse trends had converged to a mass, which despite seeming similar is a composite of several movements loosely but bundled as ‘alternative views of health’.

Different projects have different aims and motivations. Understanding the range of the arts/health field will help reduce definitional tension in the field, if the different components can be understood

**(2) Views on arts/health**

Figure 1 (referred to in the summary) illustrates health as a diamond. It is a useful analogy because it allows us to explore different views in several ways. First health is like a diamond because it is multifaceted. Second, like a diamond, health has prismatic qualities meaning that it looks different from different perspectives.

This conceptualisation is not intended to be a definitive view, but rather a suggested way of exploring the multifaceted nature of arts/health. Fundamentally, the diamond reflects the different ways in which health can be understood and ways in which art is thought of as an intervention.

The diamond navigates the focus of arts/health projects. In some ways the four corners of the diamond reflect the tensions within the field. Projects in the top half emphasise creative activity as a route to health. In the bottom half of the diamond, the focus of the arts/health activity is focused more on the formal health agenda. The higher up the diamond the broader the health interventions are understood to be.

*Figure 1*

**The arts/health diamond**

*Common Knowledge Interim Report*
The left-right axis reflects a different unit of analysis, whether health is seen of as an individual or collective thing. On the left hand side of the diamond arts/health activity is more focused on social relationships, within the community, or between health services and people. On the right hand side of the diamond, the focus is more individual.

You can look through a particular face of a diamond and it will affect the way you see other parts of the structure. Some people look at health from a community perspective, reflecting a growing literature, for example Richard Wilkinson (4) that an important determinant on health is the strength of social relationships, that “unity is health” (13). Other people look at health from a more individual perspective, with an emphasis on individual emotional, spiritual and physical health. Alternatively people can look at health from the perspective of clinical service provision or from the perspective of a creative process. Each view affects the way health and health interventions are understood.

Overall the diamond reflects a philosophical orientation of the relationship of an understanding of health and interventions to impact on health. The following pages explore in more detail the projects within the diamond. Figure 8 tries to make the different approaches within the arts/health field clearer.

**Figure 8**

Approaches within the arts/health diamond

- **Community**
  - ‘Health is unity’
    - healthy activity=healthy discussion
    - supporting communal thinking

- **Engaging with groups**
  - Artist generated information
  - Process for participation

- **Health Services**
  - Supporting Health delivery
    - Prescribed art
    - Exploring process of care from individual perspective
    - Environment of care

- **Art**
  - Individual creativity and well-being
    - Explore individual health
    - Stress relief
    - Art as therapy

A strong message emerging between the lines is the need to articulate arts/health as, by its very nature, a multidisciplinary and pluralistic movement. For the community to have any sustainable impact joint working across sectors between different professions and different institutions needs to be developed and demonstrated. Arts/health based approaches provide a spectrum of interventions and potential ways of working. To demonstrate this spectrum a good deal of effort is required to think through, portray, and demonstrate the value of the variety of approaches that exist.
The following sections look at the diamond of health in more detail by rotating clockwise around its quadrants.

(3) Potential impacts and contributions of projects
It is important to point out that projects sometimes combine two or more of the approaches. They have been categorised according to their primary approach. Two of them, Create Well Being, in which partners take different approaches, and Stitch and Relax, which aims to promote a healthy environment for a care setting and develop a social group might be located more centrally between two different approaches. Both have been categorised according to their primary focus.

(a) Creativity and well-being
This section of the diamond reflects a broader understanding of health than in the lower segments. Well-being is seen as an important part of individual health. For example, the arts on prescription projects reflect a recognition from the referrer that creative activity can have a positive affect on health. The approaches tend to be more focused on individual than collective health and the art forms try to enhance individual creativity.

As well as an artistic understanding of health, some approaches in this area see creative activity as a health intervention in its own right. Others see creativity as a way of exploring individual health. Table 3 below lists the pilot projects in this area

Table 3 – CK projects working on creativity and well being

<table>
<thead>
<tr>
<th>Creativity and well being</th>
<th>Providing referral routes for creative opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create well-being*</td>
<td>Arts on prescription for stressed (music therapy and silk-painting)</td>
</tr>
<tr>
<td>Celebrate the Power of Communication</td>
<td>Arts to explore communication and expression</td>
</tr>
<tr>
<td>Arts on prescription, North Tyneside</td>
<td>Demonstrate arts techniques and encourage referrals from GPs</td>
</tr>
<tr>
<td>Winter</td>
<td>movement and theatre to explore health and healing</td>
</tr>
</tbody>
</table>

Creativity
Creative writing is mentioned by several books to be an important skill to help people think and express themselves; one writer in Newcastle thought it would underused as a health care skill and lacked an evidence base. There is not widespread awareness of work in many areas. For example, Gilly Bolton at Sheffield Hallam University has produced good work on the creative potential of therapeutic writing (1999).

Inspired by a photograph of a dark sky casting above a rolling landscape, one participant from a North Tyneside General Hospital wrote Straight and narrow path:
'On lake and distant moors
Sun rays piercing though dark clouds
Standing on coarse, bristling moorland grass
Above me are heavy clouds threatening to pour rain or snow.
The bleating of sheep and the rushing of wind on long grass
The smell of animal dung and peat and
Cold fresh air.

I can feel the weight of the mud on my boots, the bite of cold wind on my face, the
thickness of my clothing
Protecting me from the elements.

I am completely on my own and feel free to go where I please.
I’m thinking about the distance
From here to the horizon and anticipating the pleasure it will give me to walk
From here to there.
Next year, I’ll walk from that horizon to the next.

Working with the arts can have a therapeutic effect
The GP who worked on the project Create Well Being is firmly convinced of the need for creative therapies that are directed at emotional and spiritual health. Their project has used assessment forms to evaluate health before and after music therapy. Dr Anand says it is not a miracle cure, but is a legitimate health intervention that can have dramatic effects on people’s lives. It can reduce reliance on medication, enable people to cope better with everyday demands, it can calm people, and enhance self confidence by the individual gaining a better understanding of their health.

A bridge to clients
An OT working in a psychiatric hospital attached to the general hospital at South Tyneside made some comments about the therapeutic aspect of this work

‘The use of art as a therapeutic medium relates to the innate creative potential of individuals as humans. It allows a person with mental health difficulties to express him or herself using a non-verbal medium. It allows the therapist an opportunity to better understand the world of our clients enhancing our ability to assist them. It can facilitate the expression of powerful thoughts and feelings using media that feel safe.’

Explore expression
One of the themes from projects is that arts and health projects allow a different kind of language. Most communication is verbal, but some of the things we might want to express can be communicated through other means. Better ways to communicate is a project working with speech therapists and patients of speech therapy.

‘We considered verbal and non-verbal as two different cultures. We talked about how we are trained and habituated to using words and how in this project we are trying to look elsewhere.'
We asked, where are you most familiar and comfortable in terms of verbal and non-verbal worlds? What is it like to move from one to another? From making sound to describing what that experience is like? What is it like to step out of words into making music, to move from verbal into non-verbal? Or what is it like to move from singing to drawing to writing?

What might we gain from exploring how we move between these two realms? What are the benefits? How could they be more integrated? If they could, we decided we might gain influence, creativity and confidence in how we express ourselves, as well as better relationships.’

The people in the session experimented with sound and thought afresh about the sound of their own voice and what it put them in mind of.

(b) Supporting the art of care in health services

Table 4 shows the CK pilot projects within this segment. These projects employ creative activities to complement health care delivery, whether in an acute setting, a primary care surgery or a home.

The arts are seen as supportive to medicine and clinical activity.

<table>
<thead>
<tr>
<th>Supporting the art of care in health services</th>
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<tbody>
<tr>
<td>Improve care environment</td>
</tr>
<tr>
<td>Music for health</td>
</tr>
<tr>
<td>Creative opportunities to support care</td>
</tr>
<tr>
<td>Writing and Painting at the Northern Centre for Cancer Treatment</td>
</tr>
<tr>
<td>Voice work on Ward 21, North Tyneside General Hospital</td>
</tr>
<tr>
<td>Stitch and relax*</td>
</tr>
</tbody>
</table>

* also included in another category

It supports health

A GP who worked with artists in her practice explained that she does not see arts/health as a therapy, but nevertheless playing a very important role in health. GPs want to do their best for everyone, but under pressure to provide more consultations, it is the social aspect of their work that has suffered. This is the area arts/health can help with.

Another GP in North Tyneside referred patients to the arts-on-prescription scheme whom he felt would benefit from engaging in creative activities. He wrote to the project after sessions reporting that the people were happier in themselves, which in his view tackled the root cause of their health problems.
Engaging with patients
The evaluation of *Writing and Painting at the Northern Centre for Cancer Treatment* shows how arts based activities at the very least help to distract patients. The writing sessions can also be a way of exploring issues around their illness. Most often, and perhaps not surprisingly, people don’t; they write about other parts of their life.

It improves the environment of care
*Music for health* attracted a lot of publicity because of its unusual approach. A cellist and a singer performed in a variety of health settings. People enjoyed it and the project lifted the atmosphere and environment. They sang for a couple on their 50th wedding anniversary, one of whom was an inpatient. They sang in primary care settings. Most liked that but some people “didn’t know where to look”; it made them a bit uncomfortable. The performances in care homes, on acute wards and in ITU were very well received. One nurse claims an ITU patient’s blood pressure reduced significantly during the performance. She pressed the artists to investigate this, (so a further series of sessions is planned this winter).

It can improve the environment for staff
*Stitch and Relax* is also discussed in a later section because one of its main outcomes was the development of social and artistic groups through stitching and embroidery. The primary focus of the project was to distract people and give them something to do. Staff on the project have said participants are much more relaxed after the project, it has enhanced their concentration, and makes them more pleasant people to be around. It can help staff by improving the environment.

(c)Engaging with groups
Table 5 below shows the projects in this segment. Although the projects have been grouped together there are some differences in approach and thinking between them. What they have in common is that creative activity can generate insights and information to improve the way health and health interventions are understood.

<table>
<thead>
<tr>
<th>Engaging with Groups</th>
<th>Exploring experience of service delivery through arts</th>
<th>Video Conferencing for older people in residential care</th>
<th>engaging residents through digital arts to learn about their experience of care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A better life in later life: older people in residential and nursing care</td>
<td>Arts used to explore issues in long-term care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have we made ourselves clear?</td>
<td>Exploring communication between a surgery and its patients</td>
<td></td>
</tr>
<tr>
<td>Creative forms of health promotion</td>
<td>Chopwell time experience</td>
<td>Using arts to explore alcohol and drugs in community</td>
<td></td>
</tr>
<tr>
<td>Community Mothers' Nutrition Leaflets</td>
<td></td>
<td>Artist developed information sheets on food and eating</td>
<td></td>
</tr>
</tbody>
</table>
Some projects provide a creative process to engage with people about their situation

The arts provide expertise in communicating messages to people; particularly where the health information and the context in which it is applied are complex.

South Tyneside Arts Studio worked on the Bede Unit to design more effective information. ‘The leaflets needed to be purely visual as the majority of patients referred to the department have little or no literacy.’

The clinical team at the Unit had worked really hard to create leaflets appropriate to the client group, however their access to visual imagery only went as far as clip art and were all of men in suits; at best bland, at worst inappropriate. There was no way the clients could recognize themselves in the context of the medical procedures depicted.

They didn't have the necessary skills or resources to use art to engage with people. Artists have professional insight into how to communicate using non-verbal language.

Better communication

As Nichola Gardner points out:

‘The NHS is perhaps one of the biggest distributors of information in the country – everyday thousands of people are communicated to in some way by health staff from letters, patient information leaflets, health promotion posters, care plans, prescription advice’ and so on. It has to take its communication very seriously.

The way information is presented has an effect on how it is used; art has the potential to provide a new perspective on communication and to help the NHS understand how to communicate with people.

Communicating information is an important aspect of work in this area, but the arts can also contribute to our understanding of how the health service communicates.
**Arts as an exploratory process**

*Have we made ourselves clear?* is a project that has produced some insight into this process. The project shows that whether or not the health service has a conscious strategy to communication, it is still communicating in all the things it does, sometimes with negative consequences.

This project in South Tyneside used the arts to explore the way things work in a surgery. The artist, Sheila Graber, had used creative methods to explore complex health issues before. (She has previously worked on publications for the RVI in Newcastle, *Why did my Daddy Die* about the family of a leukemia victim and *What’s the matter with Mum?* helping to explain the effects of cancer.) She took up a residency in a primary care practice, drew what she saw - the expression on people’s faces, the activities of staff – and used her artists eye to raise questions in her mind:

1. Receptionist at work with computer/card/phone - looked at the stack of cards in back office – question: *how does the appointment system work?*
2. Receptionist at work dealing with many requests for prescriptions – question – *How does the prescribing system work?*
3. Patients waiting for an appointment – some relaxed with newspapers – other nervous, looking at clock, twiddling thumbs, one baby and family waited nearly an hour for the Doctor on “emergency call” – question – *Is there a way of using this time to help communication between all parties?*

The practice wanted the artist to update their information leaflets into poster form or leaflets to help lighten the load of staff and inform people waiting. For example, many people come to the centre to pick up a repeat prescription – it was agreed that a flow chart on how the prescription works would be useful for all concerned and also a clearly illustrated poster to remind folks to tick the right boxes on prescription requests before handing them in.

The project produced 23 A3 information sheets. There is more to this story because the project had an exploratory element to it. More is said about this in the next section.

**Projects can generate lessons for policy makers**

One project began from the position: how do we do justice to the material we have collected? Two people, a photographer and a writer, spent several days in a residential home. “I didn't just go and take photographs, I got to know them first and always asked for permission.” Then they took the pictures and showed them to the people

The project deliberately set about thinking about the ways in which policy can be influenced.

A number of projects in the arts/health field are motivated by developing ‘creative learning processes for local people to explore their own ideas on issues that impact on health and quality of life’ (14).
Arts/health work offer a space where people can explore barriers and opportunities for building relationships to strengthen local involvement in decision making processes.

*Arts can tell it how it is*

The Drama Queens project is remarkable because the characters and script for a piece of drama were developed by teenagers to present to their peers.

Most of the audience comments attest the value of this; it makes the issues and the situation feel real. Talking about relationships in principle has not changed too much, but the context, and slang and generational issues can distance the message of a play from its audience if they cannot connect to the script.

The process of writing the play proved a dynamic vehicle for the exploration of issues as the young people saw them. 'What do young women worry about? Drugs, smoking, food, sex, above all, relationships.'

*Insights for policy and practice*

One of the projects – *a better life for older people* - looked specifically at how you share the insights from projects with a policy audience. Sometimes artwork can provide direct forms of communication. The work developed by people speaks for itself and the implications for health services can easily be drawn out.

**THE COMMUNAL ROOM**

In the communal room
no one
is talking

Betty

*(d)’Health is unity’ – creative approaches to communality*

Table 6 below shows the CK pilot projects that have focused on creative art forms to strengthen a notion of communal health.

**Table 6 – CK pilot projects from the perspective of ‘health is unity’**

<table>
<thead>
<tr>
<th>Health is unity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Creative activity and communal discussion</td>
<td>Arts on prescription for stressed (silk-painting)</td>
</tr>
<tr>
<td>Create well-being*</td>
<td></td>
</tr>
<tr>
<td>Stitch and relax*</td>
<td>Stitching and embroidery for groups in care homes and community</td>
</tr>
<tr>
<td>Food, Friendship and Candlelight</td>
<td>Develop links and friendships between young women through creative process</td>
</tr>
</tbody>
</table>
IT'S ON THE TABLE

| Creative process for communal thinking | 15 projects producing table tops within a common theme as a communal resource |
| Friendship Garden Project | Using arts to explore bullying and emotional side of friendship |
| Emotional Literacy and Human Values | Working with teachers and children on emotional literacy |

The tabletop projects could all be included in this section. The projects have been troubled (as noted in a previous section) but it has not yet reached fruition. The projects are more output orientated than other projects. They will be used in a communal setting throughout the finale celebration next year.

Although the diamond of arts/health has been broken into quadrants, the relationship between each of the sections is very strong. They have been broken down to explore the different approaches within the field, but there are, of course, strong links between them. The diamond as a whole equates to the whole field and it is important that there is a strong understanding of the relationship between different parts.

For example, there are strong links between the top two. Many of the projects that centred on creativity make strong claims about the ability of creative activity to form bridges between people. Art can be a communal act, strengthening bonds between people and, for those who understand health to be closely related to social relationships, enhancing health.

**Creativity and communication**

*Create well being* is a project that used music therapy and silk-painting as prescriptions for people suffering from stress. Glynis Johnston believes that creative activity is a catalyst for communication; it creates an environment that is safe for people for talk. She has described the point at which she made the connection, while working in Kenya.

‘It was during this period that while reading a book on anthropology…I was introduced to a concept I’d never thought about before although it has come to mind on many occasions since. What I read was that when man began using tools there was a connection between the action of using the tool and vocal chords. As the tool making actions increased and developed so did the vocal chords enabling us to develop speech and language. If you watch a child or even an adult for that matter concentrating on cutting with a pair of scissors you will often see tongue movement at the same time. If this piece of information is correct then could it be that while being creative, in whatever form we choose, that we also feel encouraged to verbally communicate? That is if we’re not concentrating too hard. And if so, is this not an ideal situation to create a congenial space to enable people to share and discuss ideas or to talk about whatever is on their mind and their feelings at the time? The benefits are learning, developing a skill and enjoying yourself at the same time’.
The link with health is more direct in *Stitch and Relax*. A member of the Embroiderers Guild has been working with five groups, three care homes, a group of younger women from a housing trust, and the Alzheimer’s Society. She describes one of the care home groups.

‘As an individual volunteer, I have been working with a small group of residents in a care home. Overall I work with 12 residents but only with a maximum of 6 at any one time. Nine are severe dementia cases - violent, abusive and with a small attention space. Of the other three, one is paralysed down the left side. Over a period of twelve months there have been some positive results. Stitching and knitting for an hour at any one time (built up from 5 minutes initially), three of them stitch following simple patterns, others do ‘free hand, surface embroidery’ and one insists on taking part but only for the juice, biscuits and conversation. The care workers tell me they are calmer after their stitching morning.’

The project *Celebrate the Power of Communication* used some interesting imagery to describe the kind of environment they wanted – a nest. The idea being that the group is safe and nurturing. The group will be a temporary place in which people can learn skills of expression.

‘when you feel ready
make your most effortless sound
it doesn’t matter what it is
you are not going to be judged.
Continue making one out breath
in tune with the rhythm of your breathing’

Another project with a similar style was an arts project between STAS and the *Adam Bede Wing Information Project* working with acute psychiatric patients. An OT on the wing worked with the artists. One of the participants sums up well what people get from these projects

‘I was wondering what would happen when I first arrived in the art room. I had feelings of loneliness, but the staff and my mates made me feel more relaxed. I have enjoyed working with the art materials, this helps me to feel relaxed and do things I haven’t done for long time as well as trying new things. Hearing about other people’s problems makes me feel that mine are a lot smaller. I enjoy being a part of the conversations with other patients, to understand what they think.

I found when I first arrived on the Bede Wing that time passed by quickly. But as I’m getting better I find it harder to fill my time. Having activities to do makes me feel better.

The mix between group work, creative tasks, and discussion can be a difficult mix. One person commented

‘the medium upon which participatory arts projects hinge, has to be easy to do, not ask for great skill, ongoing commitment, or depend upon portraying intensity of feeling.’
PART FIVE – RELATING EVIDENCE TO IMPACT

Evidence collected by projects
There are two main weaknesses in this report. Both reflect the fact it is an interim report and more in-depth exploration of the data is needed. One is a weak understanding of the role of local groups in formulating, supporting and debating projects. The second is that the ‘evidence’ provided in the evaluation books is not as well understood as it will be. The evaluation books are a great resource for this project and in the future will provide excellent insights for those wishing to learn from different activities.

At the moment evidence is concealed within the structure of stories. The Chris Hollis story tells reveals lots of insights. One of the boys are the school told him he’d told his brother about the project at school and got him to pose for him while he sketched him.

‘Brilliant. How did it go?’, asked Chris. ‘Good. But I couldn’t quite get the tattoos right’.

Within the projects there are hundreds of stories. What do they suggest about the impact of projects? How can these insights be further teased? What other corroborating evidence exists?

It is difficult to strip stories of their narrative and difficult to relate impact to stories. This section looks in turn at the four approaches and draws on stories from evaluation that suggests the impact. One of the advantages of looking over lots of projects is that certain insights might be patterns. Having organized arts/health into four approaches, do projects within each offer similar insights?

Stories for some represent nothing more than anecdotes. These people will argue that the plural of anecdote is not data. But this is a view that is increasingly challenged. Stories are a way of presenting data, they are a structure that can conceal, but not hide, the motives, actions and impacts of actions. Reading across projects, consistent experience of these can be set as objectives and demonstrated. And in this sense, plural anecdotes may lead to data.

The researcher is building a database of the various components of CK and its pilot projects and this when this is fully developed, it will be used to illustrate which claims are justified and others that require greater evidence and possibly more work.

The long term objective of building such a database to understand more about the projects is to try and help practitioners to state their own objectives at the outset of a project in a more clear, concise and realizable way.

How can projects improve the way they communicate the benefits of work in this area? First, it is important that projects draw together information from a variety of sources that help to build up the story. Secondly, it is important for people to have a story to engage with so that they can draw their own conclusions. Thirdly, the impact of projects is often
small. Sometimes projects are perhaps a little defensive about this and distort the impact by concentrating too much on the possible impacts of these small improvements. To outsiders this looks like exaggeration. Finally, it is important for arts/health to be honest about the difficulties of generating evidence to indicate hard to grasp improvements.

The evaluation books are a rich resource for different comments and outlooks on the projects. But many projects find it difficult to demonstrate to outsiders the impact of local projects. A key task of the evaluation in the final year is to work with local projects to better understand the linkages between the contributions the stories suggest and sources of ‘evidence’ that support these further.

**The evidence for and impact of different approaches**

(a) Creativity and well being

As mentioned earlier, and true of all the projects, the evidence to be found is between the lines of the story, revealed within its structure. It is only by getting into the story and understanding the context that what appear in textual terms as circumstantial evidence comes to life. A key challenge for the final report is to mine the evidence from the story through further work with projects.

Table 7 shows the projects that have been grouped in this category, the contribution of each project and the evidence with the evaluation material.

<table>
<thead>
<tr>
<th>Project</th>
<th>Contribution</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create well-being</td>
<td>Therapeutic</td>
<td>SF36, testimony of patients</td>
</tr>
<tr>
<td></td>
<td>Healthy discussion</td>
<td>testimony of participants</td>
</tr>
<tr>
<td></td>
<td>explore understanding of health</td>
<td>testimony of participants</td>
</tr>
<tr>
<td>Celebrate the Power of</td>
<td>Explore health issue: the meaning of voice</td>
<td>story process</td>
</tr>
<tr>
<td>Communication</td>
<td>produce work with insights for others</td>
<td>story process</td>
</tr>
<tr>
<td></td>
<td>professionals and patients creating equal and safe environment</td>
<td>testimony of participants</td>
</tr>
<tr>
<td>Arts on prescription, North</td>
<td>alleviate stress and anxiety: has a therapeutic effect</td>
<td>testimony of participants</td>
</tr>
<tr>
<td>Tyneside</td>
<td>creativity offers new opportunities to work with clients</td>
<td>Testimony of staff</td>
</tr>
<tr>
<td>Winter</td>
<td>explore health issues</td>
<td>testimony of participants</td>
</tr>
</tbody>
</table>

Some examples of stories that point to impact are summarised below.
Well being
One GP wrote to the a project participant on *Arts on Prescription* in North Tyneside to comments on one of the patients he had referred to the project.

‘She came to see me today and I was amazed at the improvement she has made. It was lovely to see her smiling and hear her laughter, which I have not heard for a long time. I would be more than happy for her to carry on working with you. She was full of enthusiasm for it today and I would be very grateful if you could continue with the art work which she has been doing.’

One of the patients wrote a poem for the evaluation book to explain the way the project had helped her.

Ain’t it great
to create.  
To draw a line so fine  
which then becomes  
a flower  
a bird  
a tree  
a butterfly or bee.  
Imagination running free.  
Mind and hand agree  
To tell the world  
How good you feel.  
With colours bright  
you work day and night.  
And come the dawn  
you look and see  
Brightness, Light  
in words you write,  
in pictures drawn,  
in glass remade.  
Funny  
when you thought  
the world was black.

Irene C.

Another person involved in the project wrote the following:

‘It is not easy when you have lost your self-confidence and self esteem to walk into a new situation, but I am glad I persevered and gradually found my way of fitting in to the Art Studio. I did not see myself as an artist, but I knew I had a lot of creativity which was not finding an outlet in my stressful work situation, and I bless my enlightened GP who recommended creative arts and physical exercise in Meadowell Health Centre gym as therapy while I recover from depression.

I did not return for two weeks, but in that time, in the security of my own home, I sketched, drew, coloured and painted, and loved it. When I came back, I chose to experiment with glass and all the different techniques for working with glass.'
As pieces were produced, I gradually integrated with other artists as we admired and evaluated each others work, shared ideas and skills, and eventually our stories, jokes, crosswords and the odd words of comfort and support when needed.

Attending the centre has helped me motivate myself to come out of the house and to attend the gym. It has given me the confidence to start painting and develop my interest in glass. My friends have helped by challenging me to produce an individualized water-colour for each one’s character and interests. As I experience their pleasure – and surprise – I begin to believe I have artistic potential.

But more than all these pleasures and discoveries, it has helped me to concentrate on non-work related activities and gives me the space to heal my mind and body until I am ready to return to work. My house and my friends houses are now full of lively pictures and colourful glass world. The world outside may still be grey, black and threatening, but my creative energy provides my oasis. My art pleases me – that’s a start.’

Figure 9 illustrates this area of the arts/health diamond and summarises its potential impact

**Figure 9**

**Placing CK projects on the arts/health diamond**

- (a) creativity and well being

![Diagram of the arts/health diamond]

**Potential Impact of projects**

- therapeutic qualities
  - Alleviate stress and anxiety
- Generate healthy discussion
- Explore health issues
- New opportunities to work with clients
- Complementary approaches to explore health

Common Knowledge Interim Report

*Creativity activity can provide new opportunities to work with clients*

The OT who facilitated access to the Adam Bede Wing says in the evaluation book that she was

‘constantly looking for new ideas, new approaches that could successfully reach out to clients and engage them. The idea of occupational therapists working together with artists to me is the perfect partnership. Occupational Therapy offers the evidence base to support the use of creative art techniques to engage people in meaningful activity and therefore
increase their health and well-being. We also have the clinical knowledge and skills to provide support and supervision to artists who choose to work with people who are experiencing a reduction in their functioning due to their health. Artists have the skills and creativity to inspire people. They have the practical knowledge about art media and techniques which often therapists lack. They are people outside of the medical model who do not have to work within the constraints that this model places on health professionals, they have the potential to be client centred in the true meaning of the word.

Explore health
Creative activity can be a way of exploring health and what it means to people. A participant in one project *Celebrating the power of communication* wrote in the book of his experiences of searching for almost 20 years for different ways to overcome his problems with speech. He writes about his understanding of ‘my best and worst situations:

WORST
a) Being called upon to speak instantly
b) Almost all situations when using the telephone
c) Being called upon to make person to person introduction

BEST
a) In a situation where there is a high background noise, such as workplaces where many people are talking
b) Reading a passage from a book or paper in tandem with someone
c) When imitating

He said: ‘when I rehearse a presentation on the screen of my mind I never stick or stammer. I sing and whisper fluently.’

(b) Supporting the art of healthcare
Characteristic of the approach, evidence for these kinds of projects draw more on the testimony of staff than on participants. This is because primarily these projects are supportive of health delivery. They try to support the art of care. As stated in a previous section, the pressure on health services have meant that in meeting increased demand it is often the social and human aspects of care that have suffered.

Table 8 shows the projects and the impact suggested by those aiming to support the art of health care.

<table>
<thead>
<tr>
<th>Project</th>
<th>Contribution</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Music for health</td>
<td>helped staff by relieving pressure of the environment</td>
<td>Testimony of staff</td>
</tr>
<tr>
<td></td>
<td>relaxed people</td>
<td>Testimony of staff</td>
</tr>
<tr>
<td></td>
<td>made people happy</td>
<td>Testimony of patients</td>
</tr>
<tr>
<td></td>
<td>gave people a way to join in and express themselves</td>
<td>video</td>
</tr>
<tr>
<td></td>
<td>improves care environment</td>
<td>testimony of patients</td>
</tr>
<tr>
<td>Writing and Painting at the</td>
<td>Give tools to for people to express themselves</td>
<td>examples of writing</td>
</tr>
<tr>
<td>Northern Centre for Cancer Treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Some of the insights from the evaluation books are discussed below.

**Arts health approaches in this area can improve the environment of care**

One of the projects *Music for Health* visited various health settings. The extract below from her diary describes the way they affected people. There is a video of what she describes in with the evaluation material. You could watch it and see if you agree with her analysis.

**March 2001**

‘The effects of the music have been much more far-reaching than I had the imagination to anticipate, motivating volunteer workers, relieving staff, offering creative opportunities
for staff, helping visitors and relatives to feel included, prompting social interaction between patients and communication from patients, encouraging musical participation, celebrating special occasions in a hospital environment, and most of all allowing the emotional experiences and inspiration that listening to music can provide.’

In other words using arts to improve the care environment can improve the experience of interactions within that environment. Figure 10 summarises the potential impact of projects in this area.

**Figure 10**

**Placing CK projects on the arts/health diamond – (b) supporting health delivery**

<table>
<thead>
<tr>
<th>Art</th>
<th>Community</th>
<th>Individual</th>
<th>Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Potential impact of projects**
- Helps staff by easing their role
- Relaxes people
- Make people happier
- Give opportunities for expression
- Promote different form of exchange between patients, staff and relatives
- Creative activity a bridge for people
- Therapeutic effects of activities

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**Common Knowledge Interim Report**

(c) Engaging with groups

The third area of projects aim to engage with groups; half of all pilot projects (10/20) can be placed in this area.

Table 9 below shows the contribution drawn from the evaluation for each project as well as the evidence that has been linked to the contribution in the evaluation material.

**Table 9 – Contributions of projects that engage with groups**

<table>
<thead>
<tr>
<th>Project</th>
<th>Contribution</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video Conferencing for older people in residential care</td>
<td>engage with people about their care</td>
<td>output</td>
</tr>
<tr>
<td></td>
<td>learn about care of the elderly</td>
<td>output</td>
</tr>
<tr>
<td>Chopwell time experience</td>
<td>generate discussion with local community</td>
<td>Discussions with local groups</td>
</tr>
<tr>
<td></td>
<td>better information for patients</td>
<td>story process</td>
</tr>
<tr>
<td></td>
<td>give healthy messages about drugs and alcohol</td>
<td>output</td>
</tr>
</tbody>
</table>
A better life in later life: older people in residential and nursing care

- learn about experience of the elderly
- engage with people about their care
- Good outputs
- creative learning process

Community Mothers' Nutrition Leaflets

- a creative way of engaging discussion between health professionals
- improved information
- review of information and influences on people

Looking out for...
Bede Wing Information Project

- New ways of working with patients
- engaging patients help shape services
- better information for patients
- increased motivation of patients

Have we made ourselves clear?

- produce better information for patients
- greater understanding of system for patients

Hospital Radio

- explore views and feelings of patients

Friendship Garden Project

- broaden horizons of children
- improved environment
- involvement of parents in school
- improved emotional environment

The Drama Queens

- develop creative material for health promotion
- develop skills of teenage participants
- engage with community to explore health issues
- More relevant health information

This approach is focused on the relationship between communities and health services. Aside from the focus, one of the advantages of this approach is that the output, what is produced, serves as evidence for the approach. For example, approaches that produce information for communities can point to the output. For this reason, the impact is perhaps easier to demonstrate than in other segments. It is one of the distinctive features about this approach,

Figure 11 shows the contribution of projects within this approach. The two common themes in this approach are: (1) engaging with groups and (2) generating information from that engagement.

**Insights into health service delivery**

Information projects can aid health services by improving information and by providing an artist’s eye on the process. The same eye can sometimes offer some insight for health service delivery. Sometimes the tension in the partnership relates to the fact that art has
challenging things to say to its health partners. Between the lines of the evaluation book, *Have we made ourselves clear?* is saying that the practice did not treat its users as people not did it trust them. It is an understandable reaction, as the following story shows, but it is nevertheless a problem.

Although the practice was cautious about the project, the artist was able to animate some of their concerns and messages for patients. For example, one doctor thought that perhaps 10% of hospital admissions were due to over-prescribing. While uncomfortable about printing this, the artist was allowed to make the point in a different way, with a caption that read ‘too many pills can make you feel ill’. The artist also worked with other health professionals: with a district nurse on diabetes – animating key messages – and the receptionists on administrative information. The project produced 12 A3 posters specific to the surgery and 12 general A3 posters to be used in other sites. The posters specific to the surgery produced colorful easy to read posters in place of handwritten, time-faded, paper notices.

Looking at the designs, it is interesting to note that a colourful poster looks friendly, while handwritten notices seem to issue instructions and give out a different sort of message. One of the notices, peeling off the wall was written in bold capitals with every word underlined:

```
WHEN YOU BRING CHILDREN TO THE SURGERY PLEASE DON’T LET THEM RUN AROUND AS THEY COULD INJURE THEMSELVES OR SOMEONE ELSE.
```

It suggests it would be better not to bring children to the surgery. This was replaced with basically the same words, but written in a different font, in lower case, and in colour, with funny cartoons of children chasing around,. It gives out a different message using similar words. ‘*Please don’t let your children run around in the waiting room. As they could injure themselves or someone else.*’ The design, rewording and animation changed the tone of communication.

The artist’s time at the practice led her to think about the ways doctors and patients talk to each other.

‘The communication gap between doctors and patients is unbridgeable in the present system…no one has time to consider how communications can be improved’.

The artist was frustrated that she couldn’t explore these issues with the health professionals. The project went beyond its deadline as the artist tried to spark some discussion. The artist felt there was no way to improve communication if there was to be no time to explore the issue more fully.

Sheila set about changing the climate of the practice to better aid communication. As Sheila says ‘a friendly image can make a huge difference as to whether a notice is actually noticed…and whether or not it is then followed.’

Buoyed by the success of the posters, Sheila went a step further. She asked staff if they would like a poster of all people working in the practice with names and job descriptions.
‘The answer was a big YES’. The posters look great; they contain colour photographs of all staff displayed around a central message: ‘We are here to help YOU’. They were met with great interest, something to look at while waiting.

Three days later the posters were removed, a known local addict had been seen looking closely at the names and faces. “We get some hard cases in here”, said the practice manager. Fear of him identifying and tracking someone at home resulted in the removal of the posters.

It seems a sad outcome. The culture of the practice, the way it sees its relationships with patients, is not conducive to new forms of engagement with patients. This is what the staff poster hinted at. If the practice is afraid of some people – and you can understand why – it will be difficult to rethink communication. Sheila’s work improved the practice’s information and provides insight into a problem of working between arts and health. They have different assumptions about the nature of the professional-patient relationship.

**Figure 11**

**Placing CK projects on the arts/health diamond**

<table>
<thead>
<tr>
<th>Art</th>
<th>Community</th>
<th>Health Services</th>
<th>Individual</th>
</tr>
</thead>
</table>

**Potential Contribution of projects**
- Engage with people about their care
- Explore patient centredness
- Produce better information
- More creative health promotion
- Creative learning process
- Engage people in shaping services
- Greater understanding of system for patients

**Common Knowledge Interim Report**

*Insights into experience of health service delivery*

As stated in the previous section, sometimes the contribution of projects can be drawn directly from the output. *A better life for older life* is seeking to engage managers and people who direct care in its findings. For example, the following poem says a lot about the culture within the home it is written about.

**WHY?**

Why, when I ask to go the toilet  
Do I always have to wait?
Why do I have to ask?
Or wait?
Why do you all go for a smoke break
Together? Why must the television
Screech all day? Why can’t we have
a nice film instead?
Why do I have to be here anyway?
It’s not my home.

Billy

Creative forms of engagement
Hendon in Sunderland’s young people’s project found inspiration from previous plays
that had addressed health issues. For example, ‘Sent Off’ is a play about a great young
footballer signed by Newcastle United as a fifteen year old. But his rise to fame reveals
the real circumstances of his birth and adoption, long hidden from him by the adults in
his life. Another is ‘The mechanic and the car dealer’s daughter’. She’s the daughter of a
rich car dealer and he’s a mechanic who works for her father. Her parents are appalled
when gets pregnant, and do everything they can to keep the couple apart from each other
and their baby’.

Drama Queens, a group of teenagers, developed a play working on a script and
characters. Some of the audience comments show it hit the mark:

"I liked it because it was honest, just what its really like.
"It was realistic and it sounded like me and my friends.
"it was simple and told it how it is" "it covered a lot of feelings we think about ."”
"I thought it was excellent how you kept your laugh coz we couldn't"

The experience of Drama Queens begs the question: Would the NHS ever commission a
play to deal with health issues like this in a rich and complex way?

The main advantage of this script is that it is developed from people who are part of the
target audience. Could the NHS use this similar technique to understand the perspectives
of different groups and generate a common message through drama? It is something the
NHS has done before. In its 50th anniversary conference alternative scenarios of the
future were enacted to help the audience think through challenges for the future. It is an
approach used in housing. Dramatizing the experience of the homeless helps people in
public sector roles think through different ways of working.

(d) Unity is Health
Table 10 lists the CK pilot projects categorised as part of this approach. It shows the
source of evidence for the main impact described. Evidence for these projects draws more
of the views of participants than the other approaches. The common theme with these
projects is the notion that creativity is a bridge between people and collective creative
activity can lead to ‘healthy discussion’. Common Knowledge’s future search event was
based on this perspective. And it’s interesting to note that the background of the project
manager and director is work in this area.
Table 10 – Contribution and evidence of ‘Unity is Health’ approach

<table>
<thead>
<tr>
<th>Project</th>
<th>Contribution</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create well-being</td>
<td>Healthy activity to relieve stress</td>
<td>testimony of participants</td>
</tr>
<tr>
<td></td>
<td>Healthy activity leads to healthy talk</td>
<td>story process</td>
</tr>
<tr>
<td></td>
<td>creation of a safe, comfortable and ‘healthy’ environment</td>
<td>testimony of participants</td>
</tr>
<tr>
<td>Food, Friendship and Candlelight</td>
<td>develop healthy talk</td>
<td>testimony of participants</td>
</tr>
<tr>
<td></td>
<td>develop commonality between participants</td>
<td>testimony of participants</td>
</tr>
<tr>
<td>Emotional Literacy and Human Values</td>
<td>Expand children’s understanding of emotional health</td>
<td>Testimony of staff</td>
</tr>
<tr>
<td></td>
<td>Develop links between education and health sectors</td>
<td>story process</td>
</tr>
<tr>
<td></td>
<td>Healthy discussion</td>
<td>testimony of participants</td>
</tr>
</tbody>
</table>

The main aim of some projects is to bring people together around a creative activity. They are driven by a belief that these group sessions develop well-being, the skills of participants, and collective sense of group. One of the *Stitch and Relax* projects works with groups of people on embroidery, young and old. One woman in a home writes really clearly about what she values.

‘Though sometimes the work is challenging, we have expert help…People in the group enjoy the morning for the companionship, the sharing of worries, the good fun generated, as well as the work itself. I enjoy the different mix of people. It is fascinating to see the different pieces of work growing, together with people’s confidence and our sense of achievement.’

Figure 12 summarises the potential impact of projects in this area.

*Figure 12*

Placing CK projects on the arts/health diamond  
– (d) unity is health

<table>
<thead>
<tr>
<th>Potential Contribution of projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Create healthy discussion</td>
</tr>
<tr>
<td>• Healthy activity leads to healthy discussion</td>
</tr>
<tr>
<td>• Creation of safe, comfortable and healthy environment</td>
</tr>
<tr>
<td>• Develop links between people</td>
</tr>
<tr>
<td>• Expand vocabulary of health</td>
</tr>
</tbody>
</table>

*Common Knowledge Interim Report*
**Broden horizons – think in new ways**

Some of the ways that projects in the creative half of the diamond make an impact are difficult to anticipate. Chris Hollis from *The Friendship Garden* project tells a story, which is part of what convinced him that working in a school can broaden the horizons of children.

‘Now, one day at school, I was happily continuing with my mural and the only blight on the horizon was the slightly stressful thought that I might just not finish it on time, when a group of infants came around the corner – full of it.

“Chris, we are writing about famous people, past and present, and we wonder if we could interview you”.

Now as they had just mentioned famous people I had some difficulty in understanding what they wanted me for and said so. ‘What for” I said .

The girls in the group got that patient look on their face which says “speak slowly – he’s only a man”, They do this a lot with the boys – wives and girlfriends in training I suppose.

“Well we have done famous artists past and present’ and you’re one aren’t you? – so we have decided to write about (wait for it) – S Club 7, David Beckham and you”.

“How do you become a famous artist?” (that word again).

I told them I had always painted and that I come from an artistic family. My grandparents were amateur artists; both brothers are talented, but one has the sense to be a fireman and the other one has a ‘proper job’ as well. I’m the only one to take up brush and pencil to try and make a living. I outlined the usual route for artists to take – school, A-levels, foundation course, degree at university etc. They did like the catalogues of my work and could relate to the murals I had produced in hospitals

“Do you paint dogs”, “Yes and any other animal you can think of”.
“Do you paint Kevin Phillips (Sunderland footballer), “Not yet”.
“Do you get paid for this” “Well, hopefully”.

The children may never have considered art as an option before. While the project was on some of the children started painting earnestly.

**PART SIX: HOW CAN PROJECTS FURTHER DEVELOP?**

The discussion of relating evidence to aims is one of the key challenges in developing the field further. It will require more work and new methodologies to try to understand the links. But the problems in drawing out the benefits do not relate only to evidence because an ability to effectively mine that evidence depends on a variety of other things, such as the relationship between artists and health settings and resources for longer projects in which variables can be selected and set.
The previous section has drawn attention to a variety of contributions. Arts/health projects need to highlight their aims in advance and the methodologies they will use to achieve them.

That is one important way the field can develop. There are also more practical problems. This section tries to explore ways in which the field drawing on the insights made by Common Knowledge participants. The second part looks more broadly at arts/health and some of the challenges to sustainability, including the paucity of the evidence base.

**What are the practical things that can help the field to develop?**

There are practical tensions in this work. The following couple of pages try to draw out some examples and reasons.

**Arts access to/relationships with the health sector**

*Have we made ourselves clear?* – one of the South Tyneside projects found negotiating access very difficult. Not so much getting agreement to work with the practice, the difficulty was around how the project could work. The specifics were discussed in the previous section.

There was some tension about how the project would work in the surgery. The artist was discouraged from speaking with people in the waiting room. Gaining access to the doctors to discuss ideas was difficult, they are very busy, and extra patients cut down the time they are available during the day. Part of the difficulty is that doctors do not really know what to expect from artists’ observations. For the doctors the artist was at the surgery to produce well-designed information. The artist wanted to explore more about interaction in the surgery – using the artist’s eye to find a new way of seeing the system, identifying areas that might be improved. The doctors did not see the role of the artist as a creative analyst. They have different understandings of the way the arts can work with health. It is understandable perhaps that the doctor would initially dismiss the idea that an artist could contribute to complex problems many, of the causes of which are outside the jurisdiction of the practice.

In order for work between the arts and health to develop, inevitably the relationships between health professionals and artists must develop and mature. In the South Tyneside project, producing useful leaflets for the practice is helping to develop this relationship. It may develop over time to one in which a more exploratory approach can be agreed.

In some ways the ability of art to say difficult things to health requires a closer relationship between the two sectors. From a distance the things art has to say can appear more destructive than constructive. It is a key challenge to further these relationships, not only on a local operational level, but also across people that manage services.

Arts/health activities need the right ingredients. They need artists with an understanding of how creative processes can impact on health, and health partners who are able to articulate their needs. CK has used its network to put partners together, but further connections need to be made.
Relationships are critically important in this area; a point made by a few of the projects. Digital conferencing for older people in residential care worked with two residential homes. One they had worked with previously and staff trusted them. The second home they had not previously worked in and the lack of trust and suspicion from staff made the project difficult. Establishing trust between partners requires positive experience of working with the arts.

One suggestion is that CK should seek to bring together middle managers from health and arts sectors to discuss more formal approaches to joint work.

Artists working in sensitive environments
One of the insights from the project working with cancer sufferers is that artists should work alongside trained counselors: ‘this is because people with cancer or family members accompanying them, want to talk about being ill which gets in the way of the art production and requires an informed, sensitive response. As an arts manager, I would not feel comfortable in regard to both artists and patients welfare if a degree of knowledge about cancer treatment, what to say to patients and what not to say to patients, were not evident.’

The facilitator role
Many of the people that lead projects are holding together quite difficult roles. In many circumstances they are the lead artist, trying to enhance the creativity of individuals and they are counsellor and inevitably host difficult conversations. Facilitating projects is emotionally demanding and requires great sensitivity. There is a key issue about support for people leading projects. How do you cope as a project lead if the environment created by a project leads to talk about health and moral issues for which people are not necessarily trained?

What would make it work?
The artist involved in the communication project with a South Tyneside surgery has identified three things that would improve the relationship.

- ‘A true understanding of what the artist has to offer and what the health centre might need
- From that understanding it would be hoped that health professionals would FIND the time to give to the project
- A place and time to meet with all concerned’.

It is not negative to ask what would have made projects work better. One of the key aims of the project is to learn from its experience and be open about the difficulties faced. Many of the projects struggled to achieve their aims.

All pilot projects are experimental. Translating this ethos to local projects has had benefits. One of the problems of arts and health projects is that they cannot honestly state on a grant application form that they will create emotional experiences, hook a couple of people on art, and relieve degrees of stress. The insights from the project books help us to create some hypotheses about certain projects.
All projects found their circumstances challenging and these tensions have led to insights about the ways projects can be improved. A writer working at the Northern Cancer Treatment Centre found it difficult to find the quiet needed to write in a hospital and the distance needed to draw participants back from their illness. The ward she worked admits new patients and people can be waiting for hours before they are seen by staff.

If a central writing group were developed, referrals could come from other centres, like Marie Curie, hospices as well as the NCCT. A central group could also involve medical students and counselors able to advise and clarify aspects of the disease. One advantage of this approach is that patients who have finished their treatment at NCCT will not have to return there to write, for some it would feel like a retrograde step.

**Strong relationships across sectors**

One project noted the importance of good relationships. Not simply between the artist and the participants, or even between the health setting on the artist, but between:

‘commissioning organizations and host; host and artists; artists and homes, staff in home and older people; and relatives. ‘No one individual can make these projects work, we need support across a whole system’

**Champions**

People within health services who can champion art-based approaches are important. For example, an OT in South Tyneside facilitated two projects in the hospital she worked in. *Writing and Painting in the Northern Cancer Treatment* is another example. The Superintendent Radiographer who recommended the project was laughed at. Reinforcing the important of positive experience, five months later, the ward sisters were asking if the work could become a regular part of the unit.

**Problems with resources**

But despite the interest, it is not possible to continue the project without resources. One of the advantages of Common Knowledge cited by many people is that its approach amounted to relatively low risk for health partners as artists brought resources with them. Health partners did not have to invest any money. If they had needed to, it is unlikely that the above project would have got underway.

A few of the projects were frustrated that due to a lack of money they could not satisfy the desire of health professionals to carry on with arts work. Sisters at the Northern Centre for Cancer Treatment have asked for the project to be continued. The person heading the project is very experienced and has managed to find some money to extend the project until October 2001. What about other projects?

One of the aims of arts/health work is to try and enhance the status of the field so the NHS sees it as legitimate approaches; this will greatly enhance the chances of work in this area being funded and becoming more mainstream. A forthcoming report
commissioned by the NHS Executive will boost this aim. It acknowledges ‘there is currently a haphazard \underline{and} under recognized status of the use of arts in health care’. And continues ‘the arts can contribute very significantly to the 21st century’s more holistic approach to health care provision’ (15).

**The role of staff**
Along with the need to identify internal champions of arts-based approaches, staff participation is an important part of this work. At a minimum their support is needed to legitimise the activity and to help identify participants. But over time, the impact of work could be enhanced by an increased role for staff joining in the discussions that result from this work. The art form could serve as a broker for engagement between patients and staff.

**Communicating the benefits of arts and health**
It is likely that the aspects of arts and health projects with practical outcomes – producing information and creative messages - will develop more quickly than others.

It may be that the development of this work will lead to a stronger relationship and more experimental ways of working.

**Health needs to take the needs of artists more seriously**
Artists find it difficult to get paid for the work they do in this area. It is very difficult to scrabble money together for projects. Some interpret this to mean they are not taken seriously by health partners and that somewhere might be an expectation that artists are rewarded by access alone and the payment of expenses.

In one of the project books, the artist records their thinking about working as a professional artist. She doesn’t know how much she should be paid, whether she should be self-employed. Somewhere in her words is a touch of defensiveness about whether she should be paid. These personal issues are very important. If activity in this area is to develop, people need to understand how they develop a career.

Another artist wrote in their book

‘it’s good to be paid a decent fee for creative work. It seems wrong that so often artists do work for token payments or for nothing or because it seems like ‘good exposure’. We are professionals who have trained over many years. I’m grateful that this funding enables us to do valuable work that we want to do and pays a good rate for our services.’

**Artists need to take the needs of health more seriously**
As well as health taking art more seriously, which it can only do over time through experience, artists need to engage more with the needs of health. In a sense the two are closely related. Health is more likely to take arts/health seriously if it demonstrates an understanding of health priorities and has practical strategies to help meet those aims.

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3 The report by Nichola Gardner is expected to be published in Autumn 2001
**How can the field be further developed? Gaining greater understanding of sustainability**

Continuing to work with mainstream health is important. There are on-going debates to which the arts-in-health community should contribute. What is health? Is it purely physical? What is the potential of the arts? To what extent are arts and particularly community-based arts able to engage with communities of people to identify health needs, to meet these needs locally, and to help promote awareness of health issues and services?

Figure 13 highlights some of the challenges. Arts/health encompasses a variety of approaches; for the community to have a sustainable impact, joint working across sectors, between different professionals or different institutions needs to be developed. Existing projects are building bridges that should be sustained, and there is a need for new bridges to be built between these different approaches to health.

Although people approach arts/health in different ways, with projects that look very different, all involved in this work have shared challenges.

**What are the current challenges and the important themes to explore in the future?**

There are a number of future challenges illustrated in Figure 14. They are placed on a spectrum of conceptual challenges (on the left) and operational challenges (on the right). There is some gray area between them. The major component is the different conceptual starting points of arts and health - is arts-in-health about promoting health through participation in arts? Or is it a health intervention in its own right. Is it a means or an end? Is it about production or creation? Can it be both?

There is a danger of arts-and-health becoming stuck in a Catch 22 situation. In an increasingly evidence-based world, interventions that compete for Government funding
must have some support for their case. Some fear arts-in-health will be seen as a fad, but it takes time to develop a reliable evidence base.

The discussion raises a number of ongoing issues among the arts in health community. For example, is engagement in the arts healthy in and of itself? Is it a healthy activity? Or should the arts be more about promoting health, a health intervention? Are arts a useful vehicle to explore health? And what do we mean by an arts in health community?

**Figure 14**

**challenges for the arts/health field**

<table>
<thead>
<tr>
<th>Conceptual</th>
<th>Operational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to understand how to understand “soft” outcomes and how to engage the research community in this.</td>
<td>Promote the benefits of creativity</td>
</tr>
<tr>
<td>Evaluate the evaluators</td>
<td>Learning how to marry informal and formal processes</td>
</tr>
<tr>
<td>What do people mean by health?</td>
<td>Experimenting with different approaches</td>
</tr>
<tr>
<td>Develop a deeper understanding of the potential of the arts</td>
<td>Map the different arts and health approaches</td>
</tr>
<tr>
<td>Is the art the means or the end?</td>
<td>Sustainability</td>
</tr>
<tr>
<td>Legitimating emotional/cognitive qualities</td>
<td>Proving art helps</td>
</tr>
<tr>
<td>To what extent is individual health about quality of life?</td>
<td>Compete for mainstream funding</td>
</tr>
<tr>
<td>Engage the research community in what is conceived of as measurable</td>
<td>Strengthen arts-in-health community</td>
</tr>
<tr>
<td>How to fit with existing practice?</td>
<td>Common Knowledge Interim Report</td>
</tr>
</tbody>
</table>

Unless these big questions are approached, and arts-in-health engages with these policy and research issues, it will struggle to establish a credible case. The challenge is to engage with these questions, and to demonstrate the breadth and depth of arts-in-health as a range of approaches.

**PART SEVEN: IS COMMON KNOWLEDGE ACHIEVING ITS AIMS?**

So far this report has spent a lot of time exploring the terrain of the arts/health field, looking at its different dimensions, assumptive underpinnings and the thinking behind its aims. The conceptual ground covered so far is summarised in Figures 15.
In this concluding section, having examined the experience of Common Knowledge and the pilot projects, this final and concluding section examines Common Knowledge as a vehicle for learning. As they were in Part Two the aims Common Knowledge set itself are examined within three areas: (1) information processing, (2); developing structures and channels for working and (3) cultural perspective on the arts/health relationship. The points made in Part Two are not repeated, this section looks at Common Knowledge as an organization reflecting on its aims two thirds of the way through the project.

To what extent is Common Knowledge enabling learning to build capacity for arts/health work?

To cut what has been a very long story short, Common Knowledge can truthfully claim to have achieved all of its aims. But in the spirit of learning, it is important to problematize this because the issues involved are so complex and all aims are relative. To fully achieve them is more than Common Knowledge could hope for.

What is meant by learning?

In order to understand Common Knowledge better it is worth drawing out a little more detail on the ‘learning’ focus of the evaluation.

Organizational Learning has already been described as something that can be looked in different ways. In the academic literature, it is approached from three perspectives:

(1) information processing around the organization. This is thought of on many levels. From the flows of paper, through information systems, to a more social-cognitive approach on how knowledge is shared within organizations.
(2) Second are more structural ways of learning relating to the way people are organized. In work elsewhere (Op Cit), the author has described this approach is focusing on organizational cognition meaning it is concerned with how organizational thought processes are structured. The aim is to structure the thought of organizational members on key issues.

(3) The third approach relates to ideas and how groups come to endow meaning. Cultural approaches see learning as the process rather than the outcome. Learning arises from exploring different perspectives.

Different people can locate themselves within the three approaches to learning. In most organizations these different approaches can be observed. In the NHS, for example, parts of it are focused on disseminating information, ensuring practice is evidence based, as an organization it is thinking about how to best structure itself to meet its aims and address future challenges, and it is thinking about the relationships it needs with staff.

Learning enhances an organization by increasing capacity in its different relationships: information, structuring role relationships and issues people think about, and relationships between people and groups. The approach of the author is that a balance between all three are necessary. However, in the academic literature and within organizations these are sometimes in tension, people tend to emphasise one approach.

Some of the tension in the initial future search events can be examined this way. Although CK was thinking about information and organizational relationships it saw this resulting from bonds between people, their primary focus. The core team emphasised cultural development while others wanted to look get straight into sharing information or structuring potential projects and areas to work.

Figure 16

Prismatic qualities of learning

Common Knowledge Interim Report
The tension is in part philosophical and therefore not always obvious. People can be talking about the same thing, but have quite different conceptions of it. Figure 16 illustrates what the author has called the ‘prismatic qualities of learning’. Concepts such as ‘dialogue’, ‘reflection’ and ‘knowledge’ mean different things to different people. An opportunity to talk can mean different things, for example. Reflection is a good example of something that looks different depending on the surface of the prism it is viewed through. In information processing it is a comparison between what we know and what we do. In the organizational cognition perspective it is a comparison between what we do and what we say we do. And in the cultural perspective it is a comparison of different social perspectives and ways of thinking.

Common Knowledge has taken a cultural approach. Because of the murkiness of the field and its newness it was probably a sensible approach. It needs to explore issues between people because concepts in the area are so contested. However, if it is to build a sustainable network for arts/health work, it will need to look at the needs of the other perspectives. For example, the organizational cognition view will help develop the organizational relationships that are necessary. And the informational view will lead to discussion of how Common Knowledge relates effectively to all of its network, not only the people who attend local meetings, and how it processes its insights and information inside and outside the network.

(1) Information

CK aims to:

Disseminate useful knowledge and information

Despite its cultural perspective, and its orientation to win hearts and minds, CK needs to share its experience in an open and reflexive way. They need also to provide information to forge practical links between people and organizations and help these draw on its experience to aid joint working.

Sometimes are/health projects take an evangelical approach to sharing information. One speaker at a London event told the audience: ‘I hope we shall all come away today like apostles from a Pentecost, fired by passion, speaking with the tongues of our art to all nations, and that many shall be converted (16).’

It is important that people in the arts/health field promote the insights and impacts of the field. But one of the problems with evangelism is that it is a faithful assault rather than an argument that engages with reason. Those who have not been converted are often unconvinced by others’ faith. As the experience of CK suggests, people who are sympathetic to arts/health aims, do not often see things in the same way. Some care should be taken to communicate with people who think differently and have different motivations. Not to spin things in a different way, but engage with their thinking.

Information is a key need for all participants. Since the inception of CK they have requested information about different approaches, such as arts-on-prescription or
opportunities to visit and learn about other arts/health projects. They have also been keen to have contacts of people in the region interested and involved in arts/health activities.

Participants also want information that will enable people from different sectors to work together. CK has a directory of CK participants. But as people have pointed out, hard copies are difficult to update, make comprehensive and they can be expensive to produce

As a core organization, Common Knowledge has not shared all the information people would like. In part, this is due to its lack of resources. Even mailing people in a large network is a major organizational exercise and Common Knowledge’s core team is only working part-time. It has tended to use low-tech methods of disseminating information, mainly talking to people. It is fair to say that they have found it difficult to do anything more hi-tech without securing additional time and resources (skills and money), though a website is being developed.

The main information role Common Knowledge has played is putting artists in contact with organizations and vice versa. CK has helped many projects develop links and contacts. It has run trips for local projects to visit other arts/health centres, such as the Looking Well in Bentham.

CK aided this process by producing hard copies of the names, organizations and skills of the approximately 140 people who attended the future searches – and the network has grown to 250 members so far. The core team, and particularly Dawn Williams, have been at the end of an email address and phone to give information to people.

CK has also held information days for people to learn about different approaches, such as music therapy, and another on arts-on-prescription projects, where people involved in other projects around the UK came to Newcastle to share their experience.

Common Knowledge hosted a national conference for people working in arts/health approaches in UK Health Action Zones. A report of that day, highlighting key issues and areas for development was disseminated to all attendants and CK participants. It has also distributed reports of the Future Search events to everyone who has been involved to share the insights across both Future Search events.

CK has worked very hard to disseminate useful information, and has been successful. But it is true to say that its efforts have been on the whole low-tech. For example, one of the chief ways of sharing information in CK is through Mary Robson. She attends local group meetings and discusses what other local groups are doing and next steps of CK as a central initiative. She likewise takes information from groups she speaks to and shares with the other forums. She has also produced a number of summary diagrams in the process that have proved accessible and useful in group planning.

There is a need for Common Knowledge to be more sophisticated in its use of information. It has perhaps been slow to develop central information, such as a website which was an idea raised in the first future search events. The problem has been partly
money - CK has had to raise extra funds to develop a website – and partly a need to determine over time a content that will be appropriate and useful for regional/national audiences. It has now been very lucky to procure the services of an expert at minimal cost, an opportunity it has been seeking for some time. It has designed a website that will be launched in early 2002.

CK plans to make a big informational push in its final year. In terms of information processing, the centrepiece of its strategy is the development of this CK website. This will be launched at the same time as it begins to exhibit work and launch a campaign of images.

There is a great deal of support across local groups in the idea of setting up a permanent website as a forum for the arts/health community. Since the future search events, people have been keen for a contact list of all people involved in Common Knowledge, information on projects, evaluation, and funding opportunities. If hosted on a Website, it would be easier to update the information and prevent it dating; which is people’s experience with paper lists.

The CK website includes details of its participants, their areas of work and skills. It will also contain links to other UK and international projects; information about evaluation, and the knowledge base for arts/health, and it will contain examples of the work produced during CK.

Having spoken to many participants in Common Knowledge, a practical and well designed website will be a major way of cementing a Tyne & Wear wide network for Common Knowledge.

Another way the core team can share information is to draw together some insights from the several Common Knowledge pilot projects that are engaged in information processing. There are some useful lessons for health in disseminating and producing information, one of the main tasks for the NHS. *Community Mother’s* has produced a series of information leaflets and learned that it is important to consult widely, that good information is developed iteratively by gauging what it means to different audiences. *Chopwell time experience* has employed artists in exploring views on alcohol and drugs and delivering healthy messages. The *Bede Wing Information Project* and *Hospital Radio* both used different art media to look at patient experience in order to generate more useful information for future patients.

Projects not only produce information but are also exploratory. *Are we making ourselves clear?* suggests that most practices do not think clearly about how they can communicate to their patients. The health sector does not necessarily appreciate, as artists can, that communication often requires creative engagement between two parties. *The Drama Queens* project worked with young people to explore health issues and present them in a play given to young people.
A better life in older life has taken work developed by patients and tried to use the output to engage with policy makers and managers about the experience of older people. They have found this difficult and Common Knowledge should draw on its network to think through ways to present insights from arts/health work.

This takes us into a discussion of the ways in which Common Knowledge is developing structures and channels for working.

(2) Structures and channels for working

CK aims to:
- change the way people work
- achieve community participation
- support collective aspirations in community health

Changing the way people work

Approximately 60 organizations have been involved to some extent with Common Knowledge. They have: hosted projects, for example NHS Trusts and primary care practices; employed people working in projects, such as local authorities; they have been involved in projects themselves, like the South Tyneside Arts Studio and Flabbergast Arts, or representatives have attended Common Knowledge meetings; they have helped shape thinking, like Northern Arts and the Gateshead and South Tyneside Health Authority.

Many of the connections CK has formed are between people as individuals. Some of these represent organizations - a head teacher of a school and a small arts organization, for example. Other ‘organizational’ relationships are between employees who have formed informal working relationships. This fits in with the cultural approach of Common Knowledge - for this reason the aims change the way people work is discussed in the next section on culture.

Having said that, a key challenge for Common Knowledge is to try to further the relationships between sectors and organizations that have been developed through future search and strengthened in projects.

New working relationships across organizations

There are signs that projects with related interests in the same sector or having a similar orientation to arts/health work will work together in new ways. For example, there is interest from the schools who have been involved to pilot and develop lesson plans to highlight emotional literacy.

Common Knowledge has been successful at developing and strengthening relationships between organizations at a local level. For example, in South Tyneside, the heads of Customs House, a local arts centre and the South Tyneside Arts Studio (STAS) knew each other, but have developed a working relationship through CK. STAS had held exhibitions in Customs House, but they had not previously worked together on projects.
The individuals are so senior within their organizations that working together amounts to an organizational relationship.

At project level, CK has been a good conductor for relationships between organizations. Building on these relationships and working through its links with key managers in regional arts and health organizations should be a priority. Common Knowledge has relationships with people at regional, even national, levels, in Northern Arts, the HAZ, and Health Authorities. It has a number of individual links within organizations. The gap is at the middle level that sets up more formal organizational links.

**Organizational channels**

CK taking a cultural approach to future search is one reason for the lack of organizational channels. Another is that links with people at the strategic level have not resulted in organizational relationships. The push made by the bottom-up approach of Common Knowledge has not seen a push from the top down.

Its links at the strategic level are with a group of people that came together to make the bid for an arts/health component to the Health Action Zone. The group that still meets periodically has some senior members: the Chief Executive of a local health authority, a representative from Northern Arts, from a local health trust and the arts officers of the local authorities. There have been two problems with this group. First, its members have not always been able to regularly attend. And second, not all its members have maintained a close relationship with the development of Common Knowledge. As a result, something of a gap emerged between that group and the core CK team.

**The Common Knowledge ‘steering committee’**

As the project developed a gap between the ‘steering’ committee, the group that tabled the initial bid for Common Knowledge, and the core CK team. At times this distance led to uneasy tension. Its source is that several steering group members were not individually involved in CK as it developed. The further the project went, in a sense, the larger the gap became until as a group it was decided to rethink the management of CK.

At various times, the distance has frustrated both the core team who are more closely connected with the local projects and some members of the Steering Committee who are dislocated from local projects. Over time, frustrations grew. From the core team because they felt overwhelmed by the practical management of the project and needed support. And the frustrations of those with dissenting views correlated with their sense that the direction of CK not being steered by the committee; they felt were losing control.

This tension has meant at times some committee members have questioned the direction of projects in an attempt to understanding and influence the thinking behind decision. This in turn created a sometime atmosphere where the core team felt they are being held to account.

The core team were sometimes stung by this relationship. Sometimes they were a little defensive. Their reaction is understandable. From their perspective some conversations
were adversarial and as such against the spirit and central ethos of the project. They wanted a supportive and positive emotional climate and to work free from the constraints of bureaucratic structures. The team at times see themselves as accounting officers facing members of a parliamentary committee. The core team and steering group were working with cultures that clashed.

The people who are making the criticism do not necessarily see themselves as playing politics. In the view of the researcher they are concerned with the direction of the project. A couple of members face the paradox of feeling alienated from the project and somehow responsible for it.

From the perspective of the researcher, there are three reasons for the tense moments – on the whole the relationship has been fine: first, not all health representatives have regularly attended meetings. Second, with few exceptions none of the members got involved with CK beyond central meetings. This is one of the two major causes for the growing distance between critical members of the steering group and the core team. The second cause and third reason is perhaps more important. There has never been an in-depth negotiation of the aims of CK, the philosophy of the approach and so on; the discussions on the orientation of arts/health in this report been absent from this group; at least not to the knowledge of the researcher who has attended several of these meetings and read the minutes of almost all.

The deeper tensions within approaches ranging from community based approaches versus individual, a creative emphasis or a focus on health services are implicit not explicit. They have been touched on at times. For example, one questioned whether Common Knowledge has too many projects for an evaluation, wouldn’t the experience be too diverse to be of wider use? The same person later raised some concerns about one particular project which was finding access difficult. On another occasion, someone else expressed their discontent with the decision to top-slice funding for the central tabletop projects at the expense of extra pilot projects, which would be developed by participants rather than the core team. These questions fundamentally relate to the philosophy of the approach. The first rightly recognises an extremely broad range of projects underway. The second is questioning whether the core team shouldn’t be playing a more central part in projects, and the third is probing the thinking behind giving a central priority to a particular approach.

These are questions that can be discussed and explored. But within the constraints of times, and the complexity of associated issues, discussing the views behind the questions is difficult, if not impossible. Sometimes exchanges on these and other points have felt personal. For example, the question about the obstacles on a project could be interpreted as questioning competence. Because the core team are ‘insiders’ to the development of Common Knowledge and the steering group feel they are ‘outside’ the process, meetings have felt to the core team a bit like they are reporting progress and being monitored rather than talking through issues amongst colleagues.
The core team have found these discussions difficult because in their minds they are trying to move beyond bureaucratic ways of working and political modes of talking. The cultural approach of Common Knowledge to an extent took it apart from the steering group for two reasons. First, it did not carry everyone’s support. Second, it pointed them away from pursuing the committee way of working.

The fact a steering committee was not the right forum in which to plan events and that it represented very few people active in the CK network led to a review of its role in April 2001. It was decided that as CK entered its final year the main aim should be to consolidate the network and try to sustain impact by more closely managing its activities. It was agreed, to introduce an operational group to guide the detail of the CK project and to review the membership of Steering Group meetings. This process has been driven by a review of the structures needed to meet the challenges of the project in its final year.

**Accountability and the politics of partnership**

One or two individuals involved in Common Knowledge – not on the Steering Group – worry that there is a lack of accountability in the way Common Knowledge is organized. They don’t feel their constituency is represented on any of the structures.

It is very difficult position for the core team to incorporate every perspective in its organization. They do not want an unwieldy operational team and see no use for a parliament of interests that will be of little use in helping to manage the practical development of the projects. But on the other hand the criticisms have to be listened to. It is a difficult tension for CK to aim to incorporate different perspectives.

An important aspect of CK moving away from the steering group model and working through CK network directly has been Mike White –CK Project Manager – moving from his role as Assistant Director of Gateshead Borough Council to Director of Projects at the Centre for Arts and Humanities in Health and Medicine. It has created a sense of independence for Common Knowledge and aided the move working with a ‘steering’ group alone to the formation and addition of an operational group, made up of participants in the CK network to help manage the project.

**The operational group**

An operational group has been established to help manage CK over its final year. It includes a representative from each region, people that have been involved in pilot projects, local and regional CK events since its outset. The individuals approached to join the operational group also represent different professional groupings.

The Operation Group has now met twice and is the group that will direct the detail of the final year. It has a member from each area who also are members of different constituencies, a GP, an arts officer, a head teacher, two artists, for example. Each member is an active participant in local projects and the CK network.

A GP in Gateshead who was involved in the music for health project and one of the arts on prescription projects has joined the Operational Group. She is keen that the
operational group should be concentrated on a practical and local level so that CK can continue to influence local practice.

Some of the issues are cultural. There is inevitably a clash between modes of working. CK has aimed, at times naively perhaps, to work in a bottom up way. However, all of its work requires a close relationship with the public sector, for whom formal accountability and decision making (in all its forms) is very important. These are issues which CK cannot ignore because its continued development depend upon forming links in health authorities and trusts. It may seem counter culture to CK to work in this formal way, but it will have to work this way to develop capacity.

**Achieve community participation**

Common Knowledge set itself the target of 15 pilot projects and 5 action days in response to participants requests; this has been more than achieved. In total 20 projects have been developed and just over 250 people have been involved in Common Knowledge network initiatives to date.

Through its projects it is conservatively estimated that over 1000 people have been involved.

Defining community is complex. CK has been involved with several communities of interest including the more traditionally understood geographical communities. Several of the projects have worked with communities targeted by the Health Action Zone. (see earlier table linking CK pilot projects to HAZ priorities.)

It has also worked with other communities defined as targets by HAZ, such as children, young people, mothers, cancer patients, those at risk from heart disease.

**Support collective aspirations in community health**

It is not that easy to tie practical outcomes to this aim. The aim is so broad, not to mention seemingly impossible.

It has already been discussed that some approaches to arts/health come from the perspective of ‘health is unity’ – a growing argument that argues that social relationships, capital and the relationship between individual and collective function are the predominant determinant of individual health status. Some of the writers who support this view were discussed in the introduction.

By pursuing projects from the different approaches in arts/health, CK has supported the aspirations of different communities within Common Knowledge. Many different ideas and ways of working were suggested. It is to the credit of Common Knowledge that so many different approaches were supported.

**(3) Culture of working**

CK aims to:
mutually define arts in health for the Tyne and Wear Health Action Zone
change the way that people work
create a positive emotional environment for the project

It has been said that the CK approach has been generally cultural. It has developed projects by working on a micro level of depending bonds between people. It took a cultural approach working through individuals to develop projects between people from different perspectives.

*What is meant by culture?*
Culture is a complex term. A couple of shorthand expressions help to communicate the sense in which it is used here. Culture can be thought of as the demarcating lines between ‘them’ and ‘us’. These lines are most obviously between the health and art worlds, but there are other lines within this divide. The second shorthand way of expressing culture is to think of it as the parameters around things people think and believe to be true. The two are closely related. At the extremes, those within the health service are wary of over emphasis on creativity in arts/health and those within the art world wary of being constrained by politicised objectives.

*How far apart are the worlds of art and health?*
Perhaps there is an element in which arts/health work is permanently in tension with the medical view of health. Although some see arts the arts as supporting the medical model, still elements of that approach are fundamentally in tension with a scientific philosophy on which medicine is based. Matarasso (11) states that ‘the primary value of the arts in health care is as a balance to the process of medicalisation, as a humanizing and socializing force. Its evaluation should reflect those values’.

Arts/health activity should not be limited to battling with the status quo. It should work to develop partnerships with areas of health with which they can forge a respectful working relationship. Positive experience will attract the attention of different areas. There are other areas of health that are not dominated by a medical viewpoint; indeed there is lots of evidence to point to a changing view within health delivery. Different clinical services have a different balance between the art and science of care. For example in primary care, the former is strong and in palliative care it is dominant. There are many clinical areas in which quality of life and non-medical views on healthcare are strong considerations.

Health promotion is another area in which social and human views of health and care are important.

If arts/health is articulated as counterculture, it should not be surprising that there will be some resistance from the ‘health sector’. To understand arts/health as revolutionary activity threatening the medical view of health is not particularly helpful. This view, in any case, is not representative of many people involved in this work. The differences between ‘arts’ and ‘health’ should not be overplayed; but understood.
There will always be tensions between the two fields. Perhaps the most important is epistemological. The two regard empirical data and its analysis in quite different ways. For this reasons the credence given to aspects of experience make forming a common pool of knowledge a difficult challenge.

Medicine is a field of knowledge that aims to categorise, shape and order knowledge about health. The arts by contrast seek to change the way things are viewed; in fact it is one of its major drivers. The arts also extract knowledge in different ways, giving credibility to subjectivity, to intuition and insight – areas that will remain marginal to medicine.

The following quote from Nietzsche is a good one because it exemplifies the benefits of an artistic view and the reasons why it so exasperates science and those seeking to classify knowledge. In Neitzsche’s view art:

‘continuously muddles the rubrics and compartments of concepts, presenting new transcriptions, metaphors, and metonymies; it continuously reveals the desire to give the subsisting world of waking man a figure so multicolored, irregular, devoid of consequences, incoherent, exiting and eternally new, which is that provided by the world of dreams’ (17)

The sentence sums up the strength and the weaknesses of an artistic view. Art looks at things in seemingly limitless new ways. But it does not necessarily have a capacity to make these insights practical or to transfer them into a positivist knowledge pool.

The tension between the arts and health is potentially a ‘healthy’ and creative one. But they are not natural bedfellows. It will take some time to develop “common knowledge” between the two. In order to work together, a great deal of negotiation of viewpoint and aims is required for the two to work in partnership within medical settings. Arts/health has to find ways of translating dreams to “reality”.

**Is it possible to mutually define arts/health?**

It is not clear that Common Knowledge has been able to mutually define arts/health activity. The majority of this report has tried to explain why this is a difficult, if not impossible, aim.

To an extent, the process of formulating a local definition of activity was hindered by the lack of a practical question at the future search events, as discussed earlier. However, even though a defining conversation could have been started earlier, it is unlikely that a relatively short process could have been able to produce such a definition.

This interim evaluation report is a product of the Common Knowledge process. It is a formal document that will serve as a basis for continuing discussion within Common Knowledge. It has drawn on the Common Knowledge experience to categorise different approaches within arts/health. It has suggested the area is a broad one and there are different approaches within the field. The report may help generate discussion to help mutually define arts/health for the Tyne & Wear region.
Figure 1 is reproduced from Section Four to illustrate one way of looking at the different arts/health activities within Common Knowledge.

**Figure 1**

**Approaches within the arts/health diamond**

- ‘Health is unity’
  - healthy activity=healthy discussion
  - supporting communal thinking

- Engaging with groups
  - Artist generated information
  - Process for participation

- Supporting Health delivery
  - Prescribed art
  - Exploring process of care from individual perspective
  - Environment of care

- Individual creativity and well-being
  - Explore individual health
  - Stress relieve
  - Art as therapy

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**Common Knowledge definitions**

The core team of Common Knowledge as people are most naturally located in the top-left of the diamond, but their own orientation has not taken Common Knowledge particularly in that direction. The exception is the tabletop projects. These involved 15 major projects. The aim of the core team is to create a common resource for the network. It will be used for communal eating and celebration. The thinking is definitely ‘unity is health’ - communal events lead to healthy discussion and the strengthening of bonds between people.

Recognising the range of activities within the field, the term arts/health is used in this report to cover the range of activities. It has been careful to avoid associating arts/health within any one approach. In many ways one of the challenges for the field is to further understand the complicated structure of the health diamond. Definitions are useful, but in ontologically laden situations (and which ones are not?) it is necessary to separate definitions from process. The definition adopted therefore is a broad one.

*Arts based activities aiming to improve individual and community health and health care delivery using arts based approaches. The relationship between art and health is explicable, rational and not subservient.*
Are some approaches more likely to flourish than others?
Is it more likely that some approaches within arts/health are more likely to flourish than others?

As mentioned previously, the approaches in the top half of the diamond place greater emphasis on creativity than the approaches in the bottom half, which are more focused on health.

Some have said CK emphasizes creative aims over health ones. But this is not borne out in the range of projects. The overall distribution is weighted in the bottom half, in fact 50% of all projects are in the bottom left.

Because the projects in the bottom part of the diamond have greater proximity to health priorities it is more likely that health funders will support them. It is likely that the impact of these approaches will be more clear to health services.

More than that, when the Secretary of State for Health spoke at Common Knowledge’s "6-hour coffee break” conference in February 2001 he said:

I believe the arts can play a very, very important role in ensuring those messages about healthy lifestyle, [and] about engagement between the service and the communities that they serve, can be enhanced’.

The approaches referred to are in the bottom left part of the quadrant. The interest in these approaches perhaps reflect the critique the health service has of itself: a need to engage more with the public, both in terms of delivering better information and health promotion and learning more about what being “patient centred” means. This quadrant more than any other has greater potential for future working. It is also the case that in CK, the projects that reflect this approach have been able to provide a story and insights, which are likely to strike a chord and be recognizable to those in health. The insights and contribution from projects in the top-half of the diamond are harder to determine and to share.

Change the way that people work
This aim originally appeared in the section on structure in Part Two. It has been made a cultural aim in the light of phase one, as it has become clear that changing the way people work is a cultural perspective for Common Knowledge.

One of the major contributions of CK is that it introduced people working in similar areas who may have been on nodding terms or known each other vaguely, but had not previously discussed their work in any detail.

One person working in health promotion said through CK she had met all kinds of people she would not normally meet – painters, sculptors, weavers and silk painters - and if she had would not have understood the relevance they had to her work. These kinds of
sentiments are echoed by many of the participants. A GP said he had met “quality people”.

Some projects have not needed Common Knowledge to help make links, but for several projects the core team have put artists and health organizations in touch with each other.

Create a positive emotional environment for the project
There are many levels in which to examine this aim. One the ground, it seems to have been achieved. One of the things many of the projects like about CK is that it has worked hard to foster a positive emotional environment for local projects. It has achieved this in part by not making the same demands of projects that a traditional commissioner of work might.

It has also paid a lot of attention within small groups to the needs of people, recognizing, for example, that work in this area is emotionally challenging and draining. It has tried to construct local groups as ‘learning sets’ in which the positive environment allows people to support and challenge each other.

Equally, the future search events were designed to take place in a positive emotional environment, but in the early stages of the project when people were not sure about the direction it was taking, not everyone felt relaxed enough. For most people the future search events were incredibly positive. For most, it was a mode of talking and engaging they had never before experienced. But the first event in particular had many tense moments. Some of which were very public.

Local groups have been conducted with a positive emotional environment. Groups have been supportive. It has been easier to maintain this in groups of 10 or so people.

Changing thinking on arts/health approaches
The future search events were in hindsight a missed opportunity to try to develop a stronger collective understanding of arts/health. It has already been commented on that future search events are usually seen as a way of bringing together different components of a puzzle in order to think through how they relate to each other. A combination of being over reliant on creative activity and asking a poorly focused question meant that there was little exploration of cultural issues.

Having said that, at the local level, CK has made some inroads into the culture of what is seen as health and a health intervention. People involved in Common Knowledge, in any case, think it is unlikely that CK can change culture as this is determined by things that are out with its jurisdiction. For example, the financial constraints around the health service and the fact that society is unlikely to sanction an arts-based health intervention over an additional bed or input from a clinician.

In some senses, CK is working bottom-up and trying to change the culture of local relationships rather than negotiate a new strategic settlement for arts/health activities, which perhaps is beyond its powers.
In what ways is Common Knowledge helping to change local culture? Some have already been discussed, such as new relationships being formed between artists and health professionals and between local arts and health organizations.

One interesting development is collaboration between those interested in music therapy. The participants in *Music for Health* have made contact with a researcher team from the department of primary health care at Newcastle University. The team are reviewing literature on whether singing can improve health. They are formulating empirical research into the health benefits of singing. The team have been provided with a copy of the evaluation book as descriptive evidence of the projects’ impact.

This work may be an example of a collaboration that can develop from Common Knowledge. The work of the Anands – *Create Well Being* will also link into this collaboration. From the same department in the university, the Anands project has been observed by medical students ‘to see how alternative healing can complement traditional remedies’ (18).

**Collaborations around themes**

Common Knowledge has quite successfully provided links for people with common interests to make connections across the region. For example, a regional day has been held on music, and arts-on prescription projects.

**CK has given people freedom to develop partnership in the way they chose**

One of the ways in which CK has helped promote a different culture is the more experimental way it has supported projects. The following quote reflects the views of several projects:

> ‘It’s quite liberating to conduct this project in our own way, as Common Knowledge is not prescriptive and appears to encourage people to work independently. In the past I’ve got so wrapped up in trying to fulfill criteria that I’ve ended up putting in proposals for projects that I didn’t wholeheartedly want to do’.

Another person said.

> ‘CK was great because we had so much freedom to enact art as we liked’.

**Final year campaign**

The final year of the Common Knowledge project, and any activity beyond that, is aiming to make an impact on the culture, how people think, of arts/health activity. Part of it final year is a campaign promoting messages, slogans and images developed in Common Knowledge.

An agreement has been reached with the operators of the Newcastle Metro who will make advertising space available on stations around the region to exhibit images developed by CK for the campaign.
In a sense, the campaign revolves around making the “brand” of CK known. Alongside the Metro promotion, it aims to display materials in GP surgeries, hospitals and other health settings. They also plan a campaign on the local radio and will distribute postcards and bookmarks of associated images.

**Exhibiting arts/health approaches**

One of the ways Common Knowledge aims to sustain the network is by exhibiting some of its interventions. They will present different ways of working with health in workplaces and public buildings, including health settings. This will draw upon the health interventions employed in pilot projects.

**Recommendations**

There are a number of recommendations from the interim report for Common Knowledge in its final year, and many of these are already being acted upon.

**Information**

- Developing a website is only the start. CK will need to ensure that it is meeting the needs of the network. The information will need to be updated regularly and be receptive to the information that is placed on it by interested parties.

- This report has made a starting point in trying to understand the parameters of the arts/health field and in trying to explain how different approaches can meet different needs. It is important that participants use this document as a basis to discuss more about CK and to refine the understanding of the relationship between approaches and evidence. CK should use some of the content of this document to share the experience of the project and continue to refine the understanding of Common Knowledge.

- As well as sharing the successes of local projects, Common Knowledge needs also to share some of the problems. CK should be open about some of the shortcomings of the project and engage in discussion with people about how they can be avoided in the future.

- As Common Knowledge enters its final year and embarks on fewer and more targeted projects, it should take the opportunity to explore the impact and evaluate in greater detail than has been the case with the 20 pilot projects and 15 tabletop projects.

- This is related to information. CK needs to build upon its ability to target health organizations, schools and local authorities in further exploring possibilities to hook up partnerships.

**Structures for working**

- Among those who participated in Common Knowledge there are people who want to be involved in Tyne & Wear initiatives although they will not necessarily be active in regional groups. There is a need for activities that will involve these people.
• People are interested in Common Knowledge continuing to facilitate partnership across the region, along the lines of the regional days that have been held so far. Other regional projects will aim to provide resources that can be used across the whole region. An example is a mobile arts-in-health unit. An existing trailer unit can be transformed with specially created décor and then made available for projects/events.

• It has been suggested that CK should try to facilitate links between arts and health at different levels For example, CK should try to target managers in arts and health organizations to explore the potential for more formal partnerships

• CK needs to carry on making connections between arts and health organizations by increasing awareness of each others’ aims and needs.

• CK needs to find ways of engaging more with the health sector, to better understand its aims, and engage with it over ways to work in partnership. Some of the channels of communication that CK had to health, through the steering group, have been difficult to open.

**Culture**

• There is a need for CK to become more aware of the bigger picture of arts/health activities and engage its own findings with that of others. And to contribute and listen to a debate on the field and its impact

• To an extent, CK has yet to fully engage with people about what arts/health activities mean. It needs to engage with different views in order to make more progress on its aims to mutually define arts/health activities

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