

FROM ICE TO FIRE – ARTS IN HEALTH FOR SOCIAL INCLUSION

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The Centre for Arts and Humanities in Health and Medicine was invited to speak at a Downing Street seminar in May 2003 on arts and social inclusion. Mike White and Mary Robson here present some of the issues they raised at that seminar.

Twenty years ago the cultural critic Raymond Williams in his book *Towards 2000* predicted that by the millennium the radical means of cultural production in British society would be forced to the margins, but there they would re-group and become mainstream.¹ This rather cryptic prophecy becomes clearer in the context of social exclusion. The margins are not geographical but social - instances of exclusion can be found in most communities.

If arts interventions are to be pervasive and of quality they will also on occasion be radical and challenging - to participants, to artists, and to the sectors that support and fund them. It is inherent to the effectiveness of arts in health intervention that it is permitted, within safe and supportive parameters, to engage with the 'madness' of art and its making. By its very nature art pushes against barriers, boundaries and pre-conceptions and its creative energy in promoting social inclusion may necessarily be volatile. This is why qualitative evidence from participants repeatedly affirms the felt experience through art as a counter to the circumstances and symptoms of ill health. The most successful projects are those that lay down a social pathway to channel awakened enthusiasms.

The sheer size and complexity of the tasks at hand with regard to the contribution of the arts to tackling social exclusion means that at present gaps both in practice and the evidence base are inevitable. As the British Medical Journal pointed out in July 2001, social inclusion is much more than simply targeting services to certain groups but is rather a problem for society as a whole:

Policies to address the problems of target groups are welcome, if they work, but essentially provide micro solutions for a macro problem. Targeting misses large numbers just above the arbitrary threshold. Sinking the iceberg, rather than attacking its tip, is a better basis for public policy.²

Moving from ice to fire – and hopefully not mixing metaphors like Derek of *Spinal Tap* – we offer an example of an arts in health project tackling social inclusion in *The Happy Hearts Lanterns* event in Wrekenton. This event brings together arts, health, education, the voluntary sector and local people and demonstrates how individual involvement in collective creativity can lead to communal change.

Wrekenton is a corner of the borough of Gateshead in North-east England. It has an unenviable and undeserved reputation as a blackspot. It has a poor health profile, in a borough with one of the highest morbidity rates in coronary heart disease in England.

Education results are poor too, and there is a high percentage of teenage pregnancies in the locality.

A large heart lantern is the centrepiece of an annual procession of 500 or so local people carrying lanterns they have made over the previous fortnight. At the end of the walk it is hoisted up a hill for all to see. Then, it is seen from a distance, as part of that landscape under a night sky. There it becomes what it has come to be called by the locals – ‘the heart of the community lantern.’

This sense of metaphor is important. For at the core of this event as of much arts in health work is the nurturing of emotional intelligence and informal learning. As a nine year old commented: “When the lanterns light up everyone turns into my friend.”

This association of good times and positive self image with an ephemeral arts event and its processes is a potent one. It is the after image, the one of the heart on the hill, that is left in the mind’s eye. That is why great hulking 16 year old lads come to lantern workshops of their own volition and don’t think that making beautiful objects and talking about how you feel is cissy. The congenial space of the lantern-making workshops consists of a spirit of high energy, laughter, purposeful creative activity and the beginnings of trust, credibility and confidence.

These lanterns are made from willow sticks, tissue paper and are lit by candles. As dusk falls, they are revealed as having delicate, lacy structures, glowing amber, bobbing along on an incoming tide of darkness, each individual effort finding its place in the collective stream; none is dispensable. This is a rite of transformation, not just for the people involved but of the streets as well.

As a local woman pointed out “Some of us don’t get on. But at lanterns we put all that to one side. You see each other different at Lanterns”

This year saw the tenth lantern procession. Developments have occurred that couldn’t have been planned. Every lantern has the image of a heart secreted in it by its maker. Lanterns are made in memory of those who have died and for those newly born. It continues to develop beyond an annual event, spawning activities that will take place throughout the year. Participants have gained confidence for themselves and for where they come from.

This is the space from which latent talents can emerge. It isn’t only the usual suspects who show an aptitude for civic participation. This year, interest came from regeneration schemes in Newcastle and Sunderland. *Happy Hearts* will be passing on the skills to other communities who have realised that this can hit spots that other methods can’t and will be using it to deal with more complex intercultural scenarios.

Happy Hearts isn’t the only celebratory lanterns event with a health focus. Another is *Zindaagi Kai Noor* (Light up our lives) centred in a school in Manningham, inner city Bradford. Initial evidence following the first event shows a persistent increase in attendance in the targeted year group and much improved communication between school and parents.

We have identified several others and are planning a longitudinal research programme that will look into their potential influence on public health. This will mean new participative methodologies, ones that involve participants not merely as data collectors but as analysts alongside a research team.

All involved feel that the strong, collective and good-time nature of the event feeds individual and communal health needs. Indeed, it is now a very particular tradition. Ali Magee, a *Happy Hearts* participant from the very beginning, put it like this; “In Wrekenton, there’s Christmas and there’s lanterns... It’s definitely made me think about my health and my kids’ health, and given me the confidence to do something about it - we can choose to be healthier.”

Wrekenton provides an example of how collective creativity can make a committed expression of public health. This is what distinguishes arts in health work from art therapy and connects it into social inclusion work. On the setting up of the NHS in 1948 Aneurin Bevan observed that “the maintenance of public health requires a collective commitment”, and the Chancellor of the Exchequer re-affirmed Bevan’s view in February last year in his speech on future funding arrangements for the NHS.

The lanterns event shows how health awareness can become a felt experience and even have a commonly owned iconography. Grounded in local arts development the project joins up theory, strategy and practice. We could build on this with some longitudinal research to examine the therapeutic benefits and communal change that the arts activity helps motivate. The delivery partners behind projects like this enter into social relationships with the community. This challenges the way we ourselves work – and let’s face it, for some of us participation in the arts can seem a fate worse than death. The point is, however, that it is a learning process for all involved, illuminated by what the arts do best in turning complexity into revelation. Arts activity can also address an underlying concern in the NHS to maintain trust between healthcare professionals and the public. As the Health Secretary said to us at a conference we held two years ago “the arts can play a very important role in ensuring that messages about healthy lifestyle and about engagement between the service and the communities they serve can be enhanced.”³

The arts in health field is now so diverse we are starting to see some emerging ‘specialisms’ in differing approaches.⁴ There is presently a window of opportunity for arts development to realise a social model of health. The move to multi-agency working is new to the NHS and arts can have both an integral and a catalytic role in this. What used to be understood as the preventative approach to healthcare is increasingly about building capacity for change, externally in developing social capital and internally in improved training and holistic approaches - approaches that the arts can help define and contextualise. The thinking that informs this work is becoming ‘mainstream’, though the very diversity of funding partnerships that support it may mitigate against it being taken on as a mainstream financial commitment by any one sector.

To demonstrate their effectiveness in tackling exclusion arts in health practitioners want to share their practice more as a basis for undertaking collaborative research programmes. This could then prise out the evidence base that we know is already implicit in the qualitative testimony of participants in these projects. Networking of

well-founded community based arts in health projects is necessary to take the research agenda forward. At present, if we were to place the case for arts in health on the *Treasury Green Book's*⁵ appraisal cycle it would be somewhere between the initial rationale and the setting of objectives. But an improving dialogue between arts, health, medical and education sectors is helping us see the way forward. A welcome development is the growing interest in this area of research shown by the Arts and Humanities Research Board.

The call for such dialogue is not coming solely from the arts. A BMJ editorial last December advocated a half percent shift of the health budget to be diverted to the arts because “if health is about adaptation, understanding and acceptance, then the arts may be more potent than anything medicine has to offer”.⁶ That half per cent would increase Arts Councils’ funding by 70%!

CAHHM has recently set up a national advisory group for the evaluation of community-based arts in health supported by the Health Development Agency and Nuffield Trust. It proposes to conduct a survey of arts in health organisations and NHS trusts to determine what each sector expects of the other with regard to research and evaluation. The results of this will be published along with an agreed lexicon of terms and definitions guided by the question 'What would constitute useful and valid evidence, and how should it be obtained?'

A GP in the Midlands who long ago embraced the contribution the arts could make to his practice said recently “My 24 years as a family doctor have convinced me that many of the medical complaints reported by patients are in fact the physical manifestations of social, psychological and emotional problems. To create a healthier nation we must start by encouraging inclusive and harmonious relationships in a society where so many find themselves socially excluded. The principal killers are not cancer and heart disease but lack of social support, poor education and stagnant local economies.”⁷ We are now testing the validity of that viewpoint through community-based arts in health.

Many arts in health projects are attempting to establish a continuum of support for people to improve both their well-being and creative skills. Much of the practice and learning going on in this field can usefully contribute to wider health promotion strategies and the development of participatory arts with the general public. They need not be seen simply as specialist services for an excluded minority, but rather as core applications of the arts to encourage a healthy culture in a healthier nation.

¹ Williams R. *Towards 2000*. Chatto and Windus 1983

² Watt G. *Policies To Tackle Social Exclusion*. BMJ 323. July 2001

³ Alan Milburn MP in Smith T. *The Six Hour Coffee Break*. CAHHM. Durham. 2001

⁴ Smith T. *The Common Knowledge Interim Evaluation*. CAHHM. Durham. 2001

⁵ *HM Treasury Green Book*. Stationery Office. 2003

⁶ Smith R. *Spend (Slightly) Less on Health and More on the Arts*. BMJ 325. Dec. 2002

⁷ Rigler M. *Art in Health in Dudley*. Unpublished conference paper. 2002