

**Visions of Reality Event
29 April 2010**

Questions

Is there a way of capturing the implicit value of arts and health work that will please all stakeholders ie. commissioners, commissioned and participants?

Karen: To 'please' all stakeholders there needs to be ownership of a project / process and for them to feel passionate about it. If everyone is signed up to a set of realistic targets, then the implicit value of the work will already be agreed and captured in any evaluation.

Max: Narrow the margin of possible outcomes by joint agreement on what can be achieved with the project, and tailor evidence gathered to different partners' needs. However, there is a real challenge in gathering evidence and no amount of it will convince the NHS to publicly support the arts!

Karen: Do not neglect participants – their views are paramount and they must agree to methods of evaluation being used.

Is there room for failure? Is failure being documented?

The Panel agreed that yes there is room for failure, but it can lead to a development of further practice and new challenges (we all learn from our mistakes...). Some examples were given of projects where research did not achieve what was really needed. It was noted that journals do not like printing 'failure stories' and we often feel we are not allowed to admit failure in our evaluation documents.

Please would the panel define (in their opinion) the difference(s) between Arts in Health and ArtsTherapies. Is there a continuing process from one to the other?

Kate: Diana Waller (President of the British Association of Art Therapists) as an example of investigating opportunities for working together.

Damien: Divisions have changed and we are now working to develop a common language. We are part of one big arts and health field, but with different skill sets, areas of practice and application.

How do you perceive 'arts and health' taking place in the community where neither arts or health organisations or services are the lead?

Damien: An increasingly prominent role being played by social care service users and greater engagement of them, which is very important. This type of work tends to lead to a more organic creation of projects.

Clive: Highlighted the [Voluntary Arts Network](#) and [University of the Third Age](#) as other areas of participant-led practice.

Karen: Mentioned artist-led projects as well as prolific arts work within the Youth service, particularly tackling mental health issues. All agreed that enthusiasm needs to be harnessed professionally and projects presented honestly.

What impact do you anticipate there will be on arts funding in the health sector after the election, regardless of who wins? Do you anticipate creatively managing budget reductions without a loss of artistic input within your services?

Michael: Compiling evidence of the value of arts and health is key. On the editorial panel of '[Arts & Health: An International Journal for Research, Policy and Practice](#)'. Also mentioned the '[Journal of Applied Arts and Health](#)' edited at The University of Northampton. There are likely to be significant cuts to NHS and Higher Education budgets (10-15%), and certainly no avalanche of resources to act on, which means any evidence will probably be insufficient to effect change.

Karen: There are key individuals within the health sector who will still remain as quiet but effective arts and health supporters, despite the financial climate – these are the people we need to continue to engage. It is difficult for PCTs to publicise their support of the arts, as the public response would be negative, with a misconception that resources were being diverted from elsewhere.

Max: Dance is possibly the only artform that does not need to be negotiated 'underground'. It is inextricably linked to the 2012 Olympics. Stressed the importance of local and national networking – together we can offer and achieve more.

Kate: Collaboration of services is the key.