Collaborative local governance for arts in health: Learning from an arts programme for hospital-based stroke patients

ABSTRACT
The issue of training, supervision of artists and governance of arts and health practice is a major area requiring resolution for the development of arts-in-health practice. Moss and O’Neill posit that arts and health practice should be regulated and professionalized, whilst Mike White argues that arts practice should be the collective responsibility of local agencies and individuals working together to establish arts and health programmes. There has been limited discussion and debate within and between leading arts and health organizations. This article contributes to and raises the profile of this issue, by describing the development of a substantive arts programme for stroke patients, focusing on how artists were sensitized, prepared and supported to work with stroke patients in the specific setting of an arts programme.

KEYWORDS
arts and health
stroke patients
training
supervision of artists
governance
programme
development
for hospital-based stroke patients. It suggests that professional artists can be supported locally to deliver valued arts programmes. The article also outlines how the materials developed for the programme could be used in a number of ways to help support the development of flexible, local, professional arts practice in health contexts in other areas.

BACKGROUND

The training, development and governance of art therapists has been thoroughly addressed in healthcare literature and in art therapy practice. Art therapy is an established professional discipline for clinicians with a clear career pathway. The approach to training, development and supervision of ‘arts-in-health’ practitioners on the other hand has received relatively limited attention. The route into and practice of artists who work with patients or citizens for health benefit is much less clear. One study (Moss and O’Neill 2009) searched the literature for publications about arts and health training (using OVID, Google, Google Scholar and the healthcare library of the Society for the Arts) and found publications on training for art therapy but none for training of artists for work in the health sector.

Nor have national arts organizations (e.g. National Network for Arts and Health, Arts Council England) sought to address the issue. A. Raw et al. (2012) argue the focus of leading organizations has been on the empirical evidence base into health outcomes for the sector, to the detriment of work to develop a theoretical and practice framework for arts and health activities.

Moss and O’Neill (2009) and White (2010) have outlined polarized positions on where responsibility should lie for training, practice development and governance of arts in health, and whether or not practice should be accredited, professionalized and regulated in the way arts therapy is.

Moss and O’Neill (2009) argue that the relatively ad hoc training and support for professional artists working in health settings has implications for the quality and safety of practice with patients. In some cases, they say, artists working in healthcare environments are ‘unable to cope with the complexity of the environment’ and ‘make unrealistic requests, misunderstand issues relating to confidentiality, [and do] not relay important information about patients to members of the MDT’ (2009: 104).

Moss, Director of Arts and Health at the National Centre for Arts in Health (Dublin), publishing on the Arts and Health Ireland website (2010) emphasized the need for standards, accredited training and professional regulation. She argues that artists are the only professionals working with patients who are not regulated by a professional association that oversees and sets standards of provision, enforces continuous professional development and professional supervision: ‘artists working directly with patients or interacting with them at any level within healthcare organizations need to ensure the quality of the service provided and that the standards of practice are high. An accredited professional qualification would meet these needs …’.

According to Moss and O’Neill (2009), who have also set up a post-graduate training programme for artists, the key skills required by artists working with patients in health care environments include clinical training, management and methodological training. The report also mentions an extensive list of suggested topics for training, based on training of arts therapists including: ethics, person-centred care, knowledge of health systems, the
role of different professionals and clinical teams, health and safety, infection control, prioritizing patients and medical needs, self-awareness; standards and best practice in delivering arts in health settings, placements, mentors and supervision, the nature of diseases, facilitation/group work skills, collaborative practice and relationships; research, communication and project planning.

An alternative view, previously set out in this journal by Mike White, argues against training artists to become quasi-health professionals. White, a senior researcher specializing in arts-in-health based at the Centre for Medical Humanities, Durham University argues that participatory arts-in-health is a ‘collective’ enterprise delivered by professional artists alongside and with the active support and engagement of health professionals. He argues that induction, training and governance of arts and health activity can and should be organized by health organizations locally, in line with and in proportion to local requirements.

For White the focus of national arts and health organizations should be on improving the capacity of organizations both to recruit professional artists and develop appropriate local governance systems and arrangements to support their safe and effective practice. White’s ‘Guidelines for good practice’ are, as a consequence, targeted at ‘skills partnerships’ of ‘people who come together in their distinctive roles to [design and deliver practice that] engage the public in creative activities that aim to improve health and wellbeing’ (Waterford Healing Arts 2009: 4). The guidelines emphasize the collective responsibility of all those involved in commissioning, delivering or supporting arts and health enterprise (see Table 1).

For White, the professionalization of arts and health along a bio-medical model of health, introduction of codes of practice (e.g. Greater Manchester Arts in Health Network (GMAHN) 2005; Jabadao 2007; Teall 2004) and a requirement for accredited training and regulation (Moss and O’Neill 2009) would be detrimental to the viability of arts in health practice, as they ‘supplement … the requirements for a boldly competent arts practitioner with a whole raft of extra responsibilities relating to governance, research skills and partnership management’ (White 2010: 146). It could risk exclusion from arts in health activities, of a good number of professional artists because the time and resource commitment required to undertake comprehensive training and development, and conform to enhanced governance

Participants come first (the well-being of participants is paramount)
A responsive approach to arts practice is taken, (drawing out the creative response of participants whilst exercising professional judgement on what is reasonable to expect)
Values are upheld (the importance of developing a relationship of trust through offering high quality, enjoyable activities that are delivered sensitively, protecting the dignity of participants, and promoting inclusiveness)
Feedback and evaluation are collected and used (importance of engaging with evaluation and self-evaluation and to practice improvement)
Good management and governance are arranged (providing artists with policies, protocols and ethical procedures to provide a framework for good practice)

Table 1: Summary of guidelines for good practice, Waterford Healing Arts.
and standards of practice, would make continued work as a professional artist unworkable.

Professionalization might also undermine the quality of the work delivered by artists. The informality and artistic freedom that professional artists can bring to arts in health work could be damaged by a system that placed broad constraints on practice and delivery of arts projects and standardized elements of practice, and as a result the value and benefits of the work itself could be diminished (Moss and O’Neill 2009; White 2010). Artists think and work outside the box bringing a different perspective to bear on situations and this is one of the characteristics which marks them out from being ‘activities coordinators’.

However, if professionalization, standardized training and regulation are not the solution, is White’s model of local collective and collaborative responsibility for nurturing and supporting artists workable? Can local agencies establish adequate governance arrangements, organize training and induction of artists independently and achieve the sustained multi-agency and multi-professional commitment to arts and health projects that is necessary to ensure safety and quality of practice?

This article addresses these questions and contributes to the debate, by describing the development and implementation of an arts and health programme for stroke patients in a hospital in the South East of England. It sets out how a five-step process for programme development and evaluation was used to sensitize, prepare and support artists and clinicians to work together to provide long-stay stroke patients with the opportunity of engaging in personalized arts activities. It demonstrates that the local collective responsibility model is workable and should not be overlooked as a way of ensuring professional artists can work effectively in clinical settings with vulnerable patients.

The development of the programme presented here is a narrative account based on observations and perspectives of the authors who were all involved in a major evaluation of the programme focusing on the meaning and value of the programme to stroke patients, published elsewhere (Baumann et al. 2013) and the evaluation of programme processes (Matrix Insight 2010).

No formal assessment of safety or quality of practice was undertaken as part of the evaluation as the focus was on understanding patients’ perspectives and experiences of participation. However each patient’s involvement in the programme was discussed with members of the multi-disciplinary team (MDT), the artists involved and patients and relatives and the few issues relating to the safety of practice that emerged from the evaluation are presented in the final part of the findings section.

DEVELOPING AN ARTS ‘PROGRAMME’ FOR VULNERABLE PATIENTS FROM SCRATCH

Healing Arts is an arts service that manages all the arts and arts related activity for the Isle of Wight NHS. It regularly employs freelance professional artists to deliver participatory arts projects with patients. In 2006 the service received funding from HM Treasury, to implement a programme of research and development to support arts and health practice in areas of health priority. The funding supported the development and evaluation of arts programmes targeting three health conditions: one with stroke patients, one with children at risk of or experiencing obesity, and one with adults of working age suffering
from depression. The results of the research associated with each of these can be found on the Healing Arts website (2014a).

The programme for stroke patients was developed and delivered by freelance artists in partnership with members of the MDT on the Stroke Unit at the Trust, and its development supported by a research agency. It aimed to provide long-stay hospital-based stroke patients with an opportunity to explore their artistic or cultural interests, in a series of one-to-one sessions with professional artists through arts activities they had chosen (or chosen with an artists’ help). It offered opportunities for participants to engage in creative and collaborative activities that relate directly to their own lives and interests, with an empathic and encouraging artist at a time when they face many sources of distress and discomfort.

The aim was to promote mental and emotional well-being and counter some of the immediate emotional and psychological consequences of stroke such as anxiety, sadness, anger and distress. The theory was that as a result of taking part in art activities with supervision, encouragement and the undivided attention of a sensitive and enabling artist, patients might experience pleasure, distraction, comfort and renewed optimism. Participation in the programme was available to all medically stable patients who were expected to remain in hospital for two or more weeks; only patients with a previous diagnosis of cognitive impairment were excluded at the request of the ethics committee.

A multi-disciplinary Steering Group was established to guide the development of the programme. The group included three of the authors, a Stroke Consultant, a Senior Specialist Nurse, Chief Speech and Language Therapist, the Director of Research and Development at the Trust, a Senior Physiotherapist, a Health Commissioner, a representative from the Stroke Association, a stroke patient who had been an in-patient on the stroke unit at the hospital, and a senior stroke rehabilitation academic to advise on the research.

A multi-disciplinary Project Delivery Team involving staff at operational levels representing occupational therapy, speech and language therapy, physiotherapy, nursing and all five of the artists met on a monthly basis to undertake the work to develop the programme and work through the implementation issues.

The Arts Team comprised five freelance artists working in different artistic disciplines – visual arts, dance, music and written word. Whilst continuing to work as professional artists, members of the arts team had worked in an applied arts and health setting for several years as part of a continuing health programme. Each member had varying degrees of experience of working with emotionally vulnerable people. Two of the artists had been involved in provision of arts for patients or in health settings for almost twenty years – including in acute mental health and prison settings, as well as in the community. One of the artists had just over a decade’s experience, whilst the remaining two artists had been working in arts and health for fewer than eight years. Whilst one of the artists had experience as a social worker, none of the artists had formal clinical or psychotherapeutic training, or experience of working on a one-to-one basis as part of an arts service for stroke patients.

The research team consisted of four of the authors of this article (MB, SP, GE, CC) who developed and implemented the arrangements set out in the research protocol.
The preparation of artists for working with stroke patients – the focus for this article – was embedded within the five-step model for programme development:

1. Development of a research protocol
2. Preparation and programme design
3. Piloting the programme
4. Programme refinement
5. Delivery of main programme

These phases of development and the learning from each of them are discussed in turn.

**Step 1: Development of a research protocol**

The programme was developed in the context of a research project that aimed to explore the meaning and value to hospital-based stroke patients, of taking part in one-to-one person-centred arts activity. A research protocol was developed over several months with support from the steering group and operational working groups.

The work to develop the protocol included the activities summarized in Table 2. The research protocol and all tools and materials received NHS research ethics approval from the Isle of Wight, Portsmouth and South East Hampshire Research Ethics Committee in October 2008. The study was also registered on the United Kingdom Clinical Research Network Portfolio database (ID 7392).

The work to develop the research protocol was extensive, time consuming and involved numerous ‘learning loops’ before everything was agreed and approved. Research programmes in the NHS always require governance and ethical issues to be considered in detail, and the arrangements for this programme were complicated because of the involvement of patients with

- Research team undertook a literature review: Policy literature, healthcare literature on the experience of stroke and its impacts, and arts and health literature on the value and impacts of arts and health activity
- Research team, artists and clinicians worked together to establish a realistic rationale for undertaking the programme and how it fits into stroke rehabilitation, and to scope out the outline programme design
- The Research team and the Director of Healing Arts agreed the governance arrangements for the programme and research – including the roles and responsibilities of the research team, advisory group, delivery group, project manager, local lead investigator and additional oversight to be provided by the local research governance team
- Research team developed information sheets and consent forms for participants informing them about the programme and associated research
- Research team, Director of Healing Arts and clinicians developed eligibility criteria for inclusion in the research, and a process and flow chart for recruitment and assessment of eligibility
• Research team and Director of Healing arts reviewed the requirements and implications of the Mental Capacity Act for the project and consulted clinicians on the special provisions needed to be made to allow for the recruitment and participation of patients with communication or cognitive impairment. This included involving speech and language therapy in artists’ introductory meetings with patients to facilitate communication, involving relatives in discussions about participation and encouraging them to participate in arts sessions to facilitate communication and mutual understanding.

• Research team and clinicians developed a process and form for referring participating patients to artists for an introductory meeting about the arts programme.

• Research team developed a system, and form (Patient Activity Planning and Monitoring Form) to support planning and inter-artist communication relating to arts sessions, and for capturing artists’ reflections on the response of patients to each sessions’ activities.

• Research team, clinicians and artists developed the arrangements to support communication between artists, and between MDT and artists about specific patients.

• Research team established the research design that would be used to address the research objectives of the project and specified the research methods.

• Research team developed research ‘topic guides’ for use in semi-structured interviews with patients and staff and the analytical framework.

• Research team assessed the risks and issues associated with all aspects of the project – including risks to patients and staff as well as project delivery risks.

• Research team specified the detailed arrangements for the flow, management and protection of data.

• Research team drew up a timetable and plan for the further development and piloting of the programme prior to the ‘main phase’ of delivery.

Table 2: Activities undertaken in the development of a protocol.

reduced mental capacity. Whilst most participatory arts projects would not be required to develop a research protocol, we believe its development and the process of gaining involvement and approval of all the relevant stakeholders were necessary and sufficient to build the foundations for safe, high quality arts practice for a completely new programme working with vulnerable patients.

Step 2: Preparation and programme design

The second step in the development involved extensive engagement with the MDT by the local lead investigator, the development of ideas for arts activities that might be suitable for the programme and practical aspects of delivery, and the training of arts and health staff involved in the implementation of the programme. The project delivery team met three times during this step to discuss the progress of the work and address the emergent delivery issues.
Engaging the MDT

The initial purpose of engaging the MDT that included stroke consultants, nursing staff, physiotherapists, and speech and language therapy, was to explore the organizational and service delivery context of the Stroke Unit and to identify and resolve any risks and issues associated with implementing the arts programme. A further aim of this activity was to increase the MDT’s awareness of and engagement with the proposed programme in order to develop a partnership with them in the development of the programme. A range of issues were addressed during this period including those relating to communication (what to communicate about patients, to whom and when), managing risks to patients (e.g. artists working alone with vulnerable patients and how to manage the risks of a deterioration in health during an arts session), staff training needs (around stroke and aphasia) and practical delivery arrangements (e.g. venues and storage of materials). Each of these issues was subsequently addressed through the development of specific processes, training and/or guidance.

Developing the arts activities

The development work for a menu of arts activities was undertaken by the arts team through a series of planning workshops. Because the five artists who constituted the team were professional artists, they each worked on the project on a part time basis. Each provided sessions on one day each week. This meant that patients would work with at least one artist (as they would often receive input more than once a week), and that artists would have to work in which ever art form the patients chose (regardless of the artists own art specialty). The artists considered how they would communicate with each other regarding their work with each patient; sourced materials for use in the programme, and devised systems for transporting materials from the Arts office to the stroke unit. The programme that evolved during this stage aimed to offer patients:

- Participation in a private room on the ward, in a series of one-to-one ‘person-centred’ arts sessions with professional artists
- Choice of five art forms to choose from: music and singing; creative writing / being read to; movement; 2D visual art; 3D visual art. Patients would select one art form to focus on during the programme
- Choice of a range of arts activities including relatively passive and more active choices to suit patients with varying abilities and impairments.

Training of arts and health professionals

A three-day training programme was organized for the Arts team and members of the MDT. The training days were facilitated by staff from Connect – the communication disability network.1 On Day 1 artists and MDT staff were given an introductory presentation covering the symptoms, psychological aspects, communication, social issues and physical impairments associated with a stroke. On Day 2, clinicians were given an introduction to the role and value of arts practice in health contexts. The final (third) day provided an opportunity for the artists to make a presentation to the clinical team outlining the range of activities they intended to offer to patients and to obtain feedback on these. The artists involved staff in hands-on practical work in each art form to help them get a feel for what would be on offer.
The training days provided artists with a basic introduction to the medical presentation of stroke, impairments, hospitalization and the perspectives of stroke patients. They familiarized clinical staff with the nature of the proposed ‘arts in health’ practice; who were also able to develop a greater understanding and appreciation for the contribution of professional artists and arts to stroke rehabilitation and recovery. Through providing the opportunity for mutual understanding and shared learning, fostered the development of good professional relationships between the artists and MDT.

The activities undertaken during Step 2 (preparation and development) were essential to the sharing of ideas and concerns about collaborative work between the disparate professional worlds of clinical care and professional arts practice in health settings.

**Step 3: Piloting the programme**

The programme was piloted over two-and-a-half months. The pilot provided an opportunity for artists and the MDT to test out the delivery of the programme, the effectiveness of their methods and collaborative working processes and arrangements. In addition to the day-to-day involvement and observation of the programme in operation, the Research Team facilitated focus groups with staff and undertook semi-structured interviews with patients and staff to explore implementation issues and to understand patient experiences. In total nine patients took part in the programme during the pilot stage and all nine were interviewed. The project delivery group continued to meet to discuss and address issues that emerged during the pilot.

At the end of the pilot, the Research Team analysed interviews and focus groups data and presented the findings to a Joint Project Advisory and Project Delivery Team meeting outlining the main issues and recommendations for further refinement of the programme prior to the main stage of delivery. The findings were organized under two main headings: ‘what patients valued’ and ‘delivery issues’.

**What patients valued**

Most patients reported a range of positive responses to the activities. These included pleasure, enhanced mood; peace of mind, relaxation, reconnection with pre-stroke identity; reconnecting with existing arts interests; normalization, re-invigoration and improved motivation to engage with rehabilitation, reconnection to the past through reminiscence, escape from the ward; happiness arising from a sense of being befriended; enjoyment of the one-to-one attention and absorption.

There was however some variation in the level of satisfaction with the programme, and this related most commonly to the dynamic in the relationship between artists and patients. Analysis sought to identify the features of the relationship that were most consistently valued:

Patients valued being treated and respected as individuals. This meant treating patients as people first, rather than patients, and ‘being real’ – with artists being themselves and not ‘acting’ the role of a service provider.

Patients valued being engaged in activities that were personally relevant to them. This meant being engaged in what was familiar and/or
provided a sense of continuity with aspects of their lives prior to hospitalisation, and being something that they had chosen.

Patients valued engagement with artists who were empathic, friendly, and who demonstrated that they thought about the patient and their needs carefully. When artists produced CDs of patients’ favourite music this was appreciated by patients because they felt that their feelings and interests had been sincerely considered between sessions.

Patients valued artists’ sensitivity and flexibility – particularly when artists took into account how they felt from moment to moment, and what they felt up to doing, and adapted the session accordingly. Some participants wished to talk in the sessions rather than doing arts, and others wanted to change their art form or combine several genres into a session or series of sessions.

**Delivery issues**

In terms of delivery, the findings from the pilot indicated that for the most part processes and procedures worked effectively. However, a number of delivery issues that required attention were identified:

There was a lack of consistency in the way art forms and activities were decided. Sometimes decision-making was artist-led rather than ‘person-centred’ or ‘collaborative’ i.e. it was based on a pre-planned art activity rather than tailored to the emergent elicited interests and preferences of participants;

Artists reported that the requirement for patients to select a single art form for the duration of the programme was restrictive and incongruent with a person-centred approach;

Some participants were confused about what the programme was about and what was required of them. Some had negative expectations of the programme, perceiving it to be about painting or drawing, and some patients and staff assumed the activities were ‘art therapy’ and intended as ‘psychological treatment’;

Artists encountered a number of challenging practice situations that they found difficult to manage (e.g. working with patients who were confused, fatigued, distressed or who wanted to talk about personal issues or make disclosures about their care); and

Communication systems and joint working between the artists and MDT worked well overall but clinical staff felt that they did not receive sufficient feedback from the artists about how patients were responding to the arts activities.

The pilot of the programme provided an opportunity for the Arts Team and the Project Delivery Group to diligently review and address issues of quality and safety in the design and delivery of the arts activities prior to main stage of delivery. Recommendations to build on what was valued and address the delivery issues were approved at a joint meeting of the Advisory and Project Delivery Groups. Further work to refine the programme prior was undertaken during Step 4.
Step 4: Programme refinement

The detailed learning from the pilot was discussed in a number of workshops with the artists. The main focus was on how to make the arts programme more person-centred, and how to address the practical issues of delivery to ensure artists were capable of managing work with patients with different needs. In addition the group developed plans for the further integration of artists into clinical care routines. The design of the programme was finalized during this step, and written up in the programme documentation.

Making it person-centred

The nature and purpose of the arts programme, its underlying values and guiding principles were further clarified amongst the Arts Team over a period of two months. Particular consideration was given to how the arts team could more consistently deliver an arts programme based on person-centred values of individual choice, empowerment, respect and personal relevance. A number of changes to the programme were made so that the refined programme would provide participants with an opportunity to explore their individual interests by engaging in arts activities that were personally relevant to them – which they had directly chosen or decided with the artists:

There would be no fixed plan for the sessions and no requirement for the participant to choose only one art form to focus on (as was previously the case). Sessions would be flexible so as to be responsive to the patients’ changing circumstances, priorities and wishes;

There would be a stronger emphasis on assisting participants to make choices about how they would use their sessions by developing a shared understanding of their personal interests and preferences;

Artists would only suggest activities that were clearly in line with participants’ expressed interests and preferences. They would avoid suggesting activities that they believed would achieve a specific rehabilitative outcome (unless this was what the participant wanted to do) or suggesting activities that they themselves were more familiar or expert in;

It was agreed that the term ‘participant’ rather than ‘patient’ would be used consistently in the programme as a result of placing a ‘person-centred’ philosophical approach at the heart of the programme.

As a result of the finding that participants attached in some cases, great importance to the quality of the relationship they developed with the artists, it was decided that further consideration be given to the closure of this relationship, and in particular, the final session. A specific exercise ‘A Letter to Myself’ was designed to be used by the artist in this session to help the participant reflect on their experience of the arts programme and to look at how they could integrate what they had learnt and valued into their lives.

Addressing practical delivery issues

The issues identified in the pilot relating to disclosure and confidentiality, and the challenges of working with participants with different capacities were discussed in detail at the artists’ workshops. Strategies for coping with
situations where participants become unwell, require nursing intervention, become distressed, confused or fatigued, were developed. Comprehensive guidance (outlined below) was drafted by the Lead Investigator with input from the MDT and the artists, to ensure artists felt confident to deliver to participants with different, dynamic needs. Readers are encouraged to access this guidance to understand how these issues were addressed.

Further integration of artists into clinical care

In order to further integrate and support artists to work with the MDT, arrangements were made for the lead investigator (from the Research Team) to hand over coordination of the delivery of the arts programme and liaising with the MDT to the Arts Team. It was agreed that artists would attend early morning ‘handover’ meetings on the Stroke Unit and a lead artist was identified to attend the main MDT meeting each week.

The arrangements and refinements to the programme were documented in a ‘Stroke programme delivery guide’ (Healing Arts 2014b), which was written and developed by the artists and the local lead investigator. The guide incorporated:

- A summary of the main learning from the pilot
- A description of the programme aims, focus and rationale, and intervention
- Discussion of the principles that should guide practice
- Guidance on the role of the artist
- A description of the participant’s pathway through the programme
- Guidance on specific practice issues – such as disclosure and confidentiality, participants becoming unwell or requires nursing intervention, distress, confusion and fatigue, communicating with participants with speech or language or cognitive difficulties
- Integration and communication with the MDT
- Programme management and supervision of artists.

The main benefit of the activities during this step is that key delivery and design issues and problems that emerged during the pilot stage were addressed and resolved and the solutions were generated and owned by the artists themselves. It also allowed artists to demonstrate to the Clinical Team, that they worked reflectively and acted upon the feedback from participants.

Step 5: Delivery and evaluation of main programme

Artists delivered the programme for seven months, and worked with eighteen participants who were long-stay hospital patients. They delivered a total of 98 45-minute arts sessions. Each participant received between 4 and 6 sessions. The findings of the evaluation about the meaning and value of the programme to stroke patients, based on semi-structured interviews with participants during the main phase delivery of the programme have been published elsewhere (Baumann et al. 2013).
However, whilst many of the key delivery and practice issues had been effectively addressed during the pilot stages, artists described some outstanding challenges they faced during the main stage of delivery.

Managing the emotional aspects of the work
Artists found sessions with participants who lacked mental capacity demanding. They found the work tiring and in particular, they found that trying to assess whether the work was of value to the participant or not was difficult. They found working with depressed participants, those close to death and those with cognitive impairments was demanding – it required considerable concentration and was emotionally draining.

Emotional aspects of this work were addressed in three ways. First, individual reflection-on-practice was encouraged through the use of ‘Patient Activity Planning and Monitoring Forms’, which artists completed after each session and shared with each other. Second, discussion of concerns was available in monthly supervision (as a group) provided by a trained counsellor. Third, artists consulted with one of the authors (SP) on specific clinical issues.

The monthly supervision was particularly valued by the artists, but they agreed that this should have been more frequent. The supervision itself was based on a psychotherapeutic model but it may have been more productive and suitable for the model of supervision to be based on a person-centred approach to mirror the model for the programme itself.

Accountability
Due to the informal/ad hoc nature of the employment of the artists, the line management and responsibilities for individual team members and managers were not fully clarified during the programme. There were no issues resulting from this but this should be addressed carefully in any future programmes.

Adapting the work to suit participant capabilities and preferences
Patient discomfort or pain was a relatively common experience, which meant that participants struggled to concentrate fully on activities although in most cases the MDT was able to help by repositioning participants or providing medication. Participants’ pre-occupations meant that it was sometimes very difficult to engage them in artistic activity at all. Participants would sometimes rather talk about their stroke condition, life on the ward, quality of food, being with other patients, their discharge arrangements, and experiences of treatment and care that they took up much of the sessions talking about this rather than in activity. In these cases, it was difficult for artists, to know whether to try to go with the flow of a participant’s discourse (in pursuit of a person-centred approach) or to try to engage them in arts activities as a way of distracting them from their pre-occupations. Finally, whilst sometimes participants wanted sessions to be longer, others were affected by tiredness – on a few occasions participants were asleep when their sessions were due to start, others became tired quickly during sessions. Tiredness was thought to be more of a problem amongst participants who had lost sleep at night, or who had already had a busy day (e.g. rehabilitation activities or visits) prior to taking part in an arts session.
The need for training on medical equipment

Artists did not always feel confident using some of the equipment that participants needed (wheelchairs, drips). Whilst the MDT always responded when artists requested advice, artists felt that a briefing from members of the MDT regarding key pieces of equipment and their use prior to the programme would have been helpful.

Supporting participants in decision-making

Each participant had different impairments, which sometimes affected their ability to undertake some of the activities that they had expressed interest in. Artists found it difficult to tread the careful path between allowing participants to try against the odds to complete an activity risking a sense of failure if not completed and, on the other hand, taking over the activity and doing it for the participant (e.g. replacing lids on tubes of paint, cutting pictures out of magazines or drawing for them).

The above issues did not result in any major difficulties with delivery but in any future programme of this sort these issues should be addressed.

CONCLUSION

This article sets out how local arrangements for developing and delivering an arts programme for hospital-based stroke patients incorporated preparation, training and supervision of professional artists. It provided them with the orientation, systems and support required to deliver the programme to stroke patients with varying conditions.

A five-step process was used to develop the programme that included embedded training opportunities for artists and clinical staff, opportunities for good practice and practice dilemmas to be identified and addressed, and for collaborative work between artist and clinicians to be established. We have also highlighted the centrality and importance of supervision, accountability and support for artists and clinicians in decision-making. Evaluation was integrated into the programme to ensure feedback and refinement of the programme as it was developed.

The ‘collective’ of artists and clinicians who developed and delivered the programme believe that safety and quality issues were managed effectively. However, the practice of arts and health was not assessed objectively against quality or safety criteria and so it is not possible to draw firm conclusions in this regard. Formal assessment of the quality of arts practice and the safety of patients and artists should be integrated into service evaluations of arts and health programmes in future to ensure safe practice and identify areas for ongoing practice development.

Our experience from implementing this programme suggests that professional artists – albeit with existing arts in health practice experience – can be supported to work with some of the most vulnerable patients in medical environments without the need for accredited training and professional regulation. It shows that professional artists can be enabled through local collective governance arrangements to make a significant contribution to healthcare and patient experience without undertaking formal accredited training and development, and suggests that wholesale professionalization and national regulation practice as outlined by Moss and O’Neill (2009) is not a necessary next step for arts and health practice. It shows the arts and health can be
supported to develop in a spirit that is in keeping with its artistic (rather than bio-medical) origins.

This research and the development of the programme was funded by a substantial grant from HM Treasury. It was intended to support the development of materials to support the case for arts and health and joint working across professional disciplines. Whilst local arts and health practice is unlikely to benefit from the level of funding that was available to the development of this programme the materials from this project including this article, the ‘Stroke programme guide’ (Healing Arts 2014b) and the evidence on the meaning and value of the programme (Baumann et al. 2013) provide a framework, including learning and materials, for what needs to be in place locally to support artists to deliver a similar one to one arts programme with long-stay stroke patients. This could be used, and adapted to suit local circumstances, by arts coordinators and local arts and health ‘collectives’ to set up and safely manage arts and health services with stroke patients.

Furthermore the five-step research-based model of programme development used here provides an example of an approach that could be taken to developing other flexible frameworks (including guidance, evidence and learning approaches) for other patients groups. National organizations such as the National Alliance for Arts and Health or the Arts Council should be encouraged to provide support for this kind of activity to support the development of arts and health practice. This would go some way to addressing the ‘hole in the heart’ of arts and health practice outlined by Raw et al. (2012) and provide the basis for the more locally tailored, flexible, and nurturing support for arts practice outlined by White (2010).

By contributing the account of the development of the programme discussed in this article, we hope to stimulate and provoke further research and debate on the topic of training and development within arts and health.

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