

Address to Culture, Health and Wellbeing International Conference
Bristol, 25 June 2013

Arts, Health and Wellbeing – Personal Reflections and Political
Perspectives

It's a privilege and delight for me to have the opportunity to speak to you this morning. I congratulate the National Alliance, the Royal Society of Public Health for bringing so many people together from across the world for such a remarkable agenda, and I particularly congratulate Alex Coulter and Arts and Health South-West; not only is Alex a great conference organizer, but her own work in arts and health at Dorchester District General Hospital is highly regarded.

The arts in health have a long history. The Hospital of St Cross, near Winchester where I grew up, is the oldest charitable institution in England. Founded in 1133, it has wonderful mediaeval wall paintings and an exquisitely beautiful sculpture of the Virgin Mary. At Bart's in 1733, William Hogarth, shocked that the hospital was considering commissioning art from Italian painters, insisted on painting his murals - including The Pool of Bethesda, illustrating Christ healing the sick - for no charge. At the Foundling Hospital both Hogarth and Handel were governors – the governance of the institution may have been more harmonious then than now - and Gainsborough and Reynolds presented work to the hospital.

More modern milestones have been the foundation of Music in Hospitals in 1948 and Paintings in Hospitals in 1959. In the 1970s Peter Senior pioneered Arts for Health Manchester and LIME; in the 1980s came the work of Mike White and Dr Malcolm Rigley in Dudley; in the 1990s Poems in the Waiting Room was the most widely read poetry publication in the UK; Stockport's pioneering Arts on Prescription, Susan Loppert's achievement at Chelsea and Westminster, the Windsor Declaration, Manchester Metropolitan University's Culture, Health and the Arts World Symposium followed; in 2000 the King's Fund's Enhancing the Healing Environment programme was launched; and in 2008 the Royal Society of Public Health was formed.

I myself, as Minister of the Arts in 1998-2001, initiated a programme of joint work between DCMS and the Department of Health. We were

too late to influence the first round of PFI-funded hospitals, but NHS Estates were responsive and by the middle of the decade the value of designing a life-enhancing natural and built environment was increasingly understood. The Department of Health set up its Review of Arts and Health Working Group, led by Harry Cayton; this was followed by the *Prospectus for Arts and Health* published jointly by the Department and the Arts Council. The establishment at long last seemed committed. Following a debate in the House of Lords in March 2008, with some people who are here today I went to see Alan Johnson to ask him to use the authority of his office as Secretary of State for Health and Social Services to make it clear that it was legitimate for commissioners, clinicians and managers to mobilise the arts in the mainstream of NHS and social services delivery. Alan, whose real ambition in life had been to be a rock musician, took no persuading and in September of that year he made his speech at the Wallace Collection, in which he said:

“Music, poetry, dance, drama and the visual arts have always been important to our mental and physical wellbeing... The arts certainly have a key role to play in healthcare – its therapeutic value cannot be underestimated... those hospitals and other care settings that pay close attention to the overall physical environment for patients... achieve real improvements in the health of patients... in the community, research shows that active involvement in the arts – whether by volunteering, taking a painting class or joining a music group – can have a profoundly positive effect on patients’ wellbeing... I would like to see the benefits of participation in the arts recognized more widely by health and social care professionals, particularly those involved in commissioning services for people with mental health problems. This is not some kind of eccentric add-on – it should be part of the mainstream in both health and social care.”

But by 2009 Alan Johnson was no longer Secretary of State for Health. The global financial crisis now dominated policy thinking. Austerity and defensiveness had supplanted that earlier optimism and willingness to venture along more imaginative and humane paths.

And so it has continued. A huge reorganization of the NHS has caused people to be more preoccupied with systems than with therapies. The search for £20bn of economies has caused many to be

preoccupied with hanging on to what they have rather than with improvement.

However you, and colleagues across this country and the world, are continuing to carry the torch. In these difficult times you have established the National Alliance for Arts, Health and Wellbeing. Local practitioners are being brought together in an alliance across English regions and your networking and advocacy are UK-wide and international. Your National Charter is a fine statement of principles and mission. Dedicated experts from twenty-two countries are learning from each other at this conference.

What the Alliance and its international partners are engaged with is of the most profound importance. We are at a moment when western societies face an existential choice. Your mission to mobilise the arts in the service of health and wellbeing symbolizes and illuminates that choice. Are we, in our society and in our public services, to embrace the values of creativity, humanity, empathy and reciprocity? Or are we to continue with the barrenness of materialism, competitive self-seeking, anomie and bureaucratic crassness?

The malaise so extensive in our health and social care systems is born of a political culture, in the UK and US at any rate, which has destroyed social capital and devalued the public realm. Monetary and competitive values have been implanted in our public services. Most extremely in the USA, but also insidiously in the UK, healthcare is commercialized; powerful business interests, subsidized by governments, influence health policy; suffering is commodified and exploited for profit; and the poor are excluded or made to put up with inferior service.

The view of human nature taken by so-called classical economics, the economics of the free market, that people are all self-seeking utility maximisers, is false and degrading. After forty years of that intellectual hegemony we have brought into being societies, and indeed a world, riven by inequalities, as seen in health and morbidity statistics. One in three people in our society experiences mental illness. The new Diagnostic and Statistical Manual catalogues a vast variety of mental disorders, but proposes that these are more biological than psychosocial in origin – a proposition rightly disputed by the British Psychological Association. In Britain more than 9000

people with mental illness are detained each year in police custody and treated as suspected criminals.

The banalities of the media and the ubiquity of porn and violence in entertainment coarsen relationships. Societies infatuated with technology and wealth neglect traditional wisdom and disrespect their elderly. The politics of money has issued in disastrous economic mismanagement. The poorest are bearing the heaviest burden of that failure, with immediate consequences for their health. Vast expenditures on the military and weapons have left ravaged conflict zones, injury and disease across the world. Gross disrespect for nature has jeopardized even the survival of human societies.

A less apocalyptic account of the last forty years would assert the achievements of the social democratic state. Public services have at least endured. Many people enjoy incomparably better education and healthcare than they previously did. Physical comfort and ease are far more widespread. New technologies offer amazing opportunities. We live in a culture in which disabled people are treated with greater respect and discrimination is no longer officially condoned. The arts are enjoyed by more and more people. The Angel of the North, research shows, makes people feel good about themselves and proud of their community. Liverpool as European Capital of Culture in 2008 integrated culture and health in a fantastic programme. Now we have UK Cities of Culture. Derry/Londonderry are honouring us and being honoured at this conference.

I have spoken about the pathology of the west, not because I think arts in health practitioners can solve all the problems of the west, but because this is the context of political culture and still-prevailing values into which you make your interventions. You, no doubt, in your day-to-day work take a less grandiose and more pragmatic view of what you are about, and I applaud you for that. Nonetheless, what you are about expresses a choice of values as well as techniques. You, as heretics and radicals, are challenging the dominant values and conventional policies. What are the prospects of you succeeding?

There is an important opportunity with the recent new recognition by government, imported into this country from France and Canada, of the significance of wellbeing. The Office of National Statistics has been tasked to develop and monitor new measures of national wellbeing. Its findings are not particularly encouraging – just under

20% of all people in Britain suffer from anxiety or depression - but that government no longer seeks to measure our collective achievement exclusively in terms of GDP is an advance.

In Parliament, Lord Layard has established an APPG on Wellbeing Economics. With the National Alliance, I am now working towards setting up another APPG, on The Arts, Health and Wellbeing. The terms of reference of the Group would be: to enable backbench parliamentarians, of all parties and in both Houses, to be informed about significant practice and developments in the field of the arts, health and wellbeing; to examine and discuss relevant government and opposition policies; to enable Ministers and others in significant decision-making roles to make presentations and be questioned; to provide a forum for regular discussion between politicians and practitioners; and to provide a springboard for parliamentary action, such as debates and questions.

There is, I believe, in our society a profound desire not to go back to business as usual before the crash of 2008. Nor, I also believe, do the great majority of people want to continue along the trajectory we have taken since then, with the dominance of finance unchecked, sharply rising inequality and the exclusion of young people from social opportunity. We want to make a different choice. But if we are to do so we'll need political leadership. Will governments know how to do different? How to back away from the free market paradigm, moralise capitalism, humanize public administration and renew professionalism? Dare we hope for a new politics of healing? I hope so, of course.

Whatever the answer to that, you meanwhile will get on as best you can with the job in hand. Better, without a doubt, not to rely on politics. What we can all do is make that small part of the world where we happen to be a somewhat better place. We need to engage in what George Eliot in *Middlemarch* called "the slow preparation of effects."

Let me therefore talk about practicalities.

Last year's Health and Social Care Act remains deeply contentious. Opportunities arise from it, however. It reconfigures public health delivery and gives it new emphasis. From this April Public Health England – with Richard Parish a newly appointed member of the

board - is supposed to support local government in local public health strategies. Health and Wellbeing Boards are to link the NHS and local government services for housing, children and young people and older people. A joint strategic needs assessment should guide the planning of services. The theory is that local discretion and innovation are to be encouraged. The causes of poor health are to be identified and tackled through cost-effective solutions. Very substantial funds - £2.7bn in 2013-14 - are being applied here - to set against other huge reductions in social services and arts budgets. There is clearly a major opportunity in this recasting of public health provision for organisations committed to the arts, health and wellbeing. The processes involved and the requirement for evidence-based practice will be demanding for small organisations, but potential is there.

Earl Howe, Health Minister in the House of Lords, last month introduced the Care Bill, speaking of the Government's "vision for a system that promotes people's well-being and focuses on the person, not the service."

With no prospect of overall increases in public spending, the search is on, as it should always have been, to address social problems at their origins. The search is also on to find cheaper ways of mending problems when they have developed. All this means opportunity for you.

I'd like to say something about research and evaluation. Extensive, high quality, convincing research is essential to build the reputation of arts in health and to gain credibility in funding bids. Much progress has been achieved, notably by distinguished academics present at this conference. There are now a number of academic centres - medical humanities departments and others, with many working on an interdisciplinary basis - in English universities which have strongly established research programmes and are respected worldwide. Respected academic journals have also been established in recent years, helping to improve the dissemination of research findings. The Arts and Humanities Research Council and other Research Councils are now willing to allocate serious funding in the field of art, health and wellbeing. DCMS, notwithstanding major cuts to its budget, has provided money to pull together research findings in relation to health and literature, music and the visual arts. The research arm of the Department of Health, the NIHR, which disposes

of almost £300m in grants for research programmes and development of research capability, is emphatic that arts and health projects are eligible for funding, particularly where they may show the way to practical impacts. If funding from that source remains hard to obtain, it's worth bearing in mind that 80% of all applications are turned down. The competition is very tough against medical disciplines based on hard science and advanced technology, and in fields where government, supported by the public, places its own priorities: cardiology, cancer, obesity, diabetes.

In evaluation, what is frustrating is that so often – after all the jargon and the form filling and the box ticking - notwithstanding all the evidence that skilled deployment of the arts in health reduces drugs bills and other expensive treatments, assists anaesthesia, shortens hospital stays and reduces staff loss, and in community settings reduces isolation, builds trust and eases stress, the system too often hardly wants to know. Nonetheless the developing evidence base will be increasingly convincing.

You have to contend also with the obsession with the measurable. Large samples may be needed for statistical analysis, whereas often your projects are on a small scale. How actually can you demonstrate causal links between the arts and health and wellbeing? Will functional magnetic resonance imagery reveal all? Qualitative research is essential in many areas of your work, but qualitative research risks being dismissed as anecdotal. Wellbeing, although it can properly be distinguished from health and all of us know how important it is, may be scorned as subjective and vague.

Other sources, however, besides public funds have been forthcoming for research funding. The Wellcome Trust and the magnificent Lankelly Chase Foundation are supporting important work by the Public Engagement Foundation and the UK Arts and Health Research Network. We have to be most grateful to those funders, as well as to other foundations which support various kinds of arts, health and wellbeing work, including Nuffield, Clore, Hamlyn, Baring and Rayne.

I wonder if I could presume, as a vulgar politician, to make a suggestion about research. May I venture to suggest that you don't wait for the discovery of the Holy Grail of a definitive methodology or a conclusive demonstration of effects? Academics will continue to go round and round the mulberry bush refining research

methodologies. It's quite right that they should. But I'd like to suggest that the time has come for leaders of research to form up and present a manifesto in which they set out where they've got to and say these are our methods, they are robust and productive, they demonstrate clear and substantial value of work in arts, health and wellbeing, and those in a position to fund work in the field have no excuse for not doing so. Practice should push forward without feeling it must wait for theory to lumber along behind. I think I sense a willingness to do something like that.

Meanwhile, under the auspices of the RSPH and, for example, the Sidney de Haan Research Centre, crucially important training resources and professional development opportunities are becoming more widely available.

One area where practical progress has been dramatic is architecture. In this city, where the Mayor himself is an eminent architect, the Bristol Heart Institute, by local architects CODA, has won admiration, perhaps especially for the integration of artwork in its design. The most remarkable series of buildings has been the Maggie's Centres, designed by some of the world's leading architects: Murphy, Gehry, Page and Park, Cullinan, MacCormac, Rogers Stirk Harbour, Kisho Kurakawa, Zaha Hadid. Landscape, gardens and artwork have all been intrinsic to their designs, which have sensitively facilitated professional help and community support in cancer care, elevating the standard for new healthcare settings.

Recognition of the contribution that the arts can make to health and wellbeing is occurring in unexpected places. The army is now using its bandsmen to assist the rehabilitation at Headley Court of soldiers traumatised in Afghanistan. Musicians are working with healthcare professionals and gaining deep personal satisfaction as they do so. A conference on the project is to be part of the forthcoming City of London Festival.

Across the country good practice is all the time developing, as the RSPH *Beyond the Millennium* Report documents. The marginalization of art and design in the school curriculum threatens to take our culture backwards, yet I believe that the arts have become so strong in our society that periodic idiocies on the part of government won't undo this. Writers and artists such as A.L.Kennedy, Quentin Blake, Cornelia Parker and Grayson Perry have publicly and memorably

affirmed the creative power of arts in health. Museums, art galleries, theatres, choirs, opera companies, orchestras and heritage sites are developing their own health and wellbeing agendas. We saw the amazing array of work showcased last week in London Creativity and Wellbeing Week. I would like to mention two hugely impressive projects which I've had the opportunity to observe closely myself.

Dulwich Picture Gallery's Good Times project is part of its community engagement programme, developed over more than twenty-five years, now working on over eighty community partner sites. Using its great collection the Gallery offers art to older people, combating their loneliness, inactivity and depression, as well as mitigating clinically diagnosed conditions such as Alzheimer's and psychosis. Successive evaluations by the New Economics Foundation, Canterbury Christchurch University and the Oxford Institute of Ageing have found measurable impacts on blood pressure, speech and cognitive abilities. The Gallery uses the arts to bring elderly people together with young people from deprived estates in Southwark. A few days ago old and young together were performing Indian dance, with many of the staff of the Gallery joining in and, as one of the participants said to me, creating pure joy.

The Reader Organisation, based on Merseyside, enables a shared experience of reading great literature aloud, in settings such as drug-rehabilitation centres, prisons, dementia care homes, daycare centres, supermarkets and schools. I have attended two groups, each of which, as it happened, was reading a Shakespeare play. Everyone in the Brixton group found that Hamlet's feelings about the death of his father and his troubled relationship with his mother chimed with something important in their own experience. In Chester, alcoholics and drug users recognized in Act 1 of *The Winter's Tale* that Leontes, in allowing himself to be possessed by jealousy, was taking a fateful wrong turning that was going to screw up his life. The complexity of Shakespeare's syntax, so far from being a barrier, with guidance of a facilitator, was gateway to an experience of beauty and a stimulus to emotion and insight. The dynamics within the groups were mutually supportive and sustaining. The continuing evaluation of TRO at the Centre for Research into Reading, Information and Linguistic Systems at the University of Liverpool, by Eng Lit academics, psychologists, health professionals, sociologists and statisticians, using questionnaires, interviews, transcripts, recording, filming, brain-imaging and control trials, will, I expect, cast light on how it is that

shared reading aloud of literature, which Professor Philip Davis describes as “an exploratory and meditative holding-ground for human meaning”, benefits wellbeing. TRO are creating an international centre for reading and wellbeing.

These sorts of successful practice will cumulatively make their impact. Clinical Commissioning Groups, another product of last year’s legislation, also offer you important opportunities. By patiently, persistently, reasonably explaining to clinicians, commissioners and managers, as well as to social workers and local authority officers across the country, that what you offer works, is inexpensive and cost-effective, is loved by patients and by frail elderly people, is loved too by staff, you will increasingly succeed in changing practice, improving the culture, developing a new wisdom. It will be a long march through the NHS and Social Services, but you will increasingly find acceptance.

If Andy Burnham’s proposal for integration of physical and mental health services and social care services into a single budget and single service to provide “whole person care” comes to pass, that will be a further opportunity for you.

Gradualism may, however, be overtaken by events. There is a crisis of confidence in the establishment. The horrors of the Mid-Staffordshire Hospital Trust and the shame of the Care Quality Commission could – should – be a turning point.

In his letter to the Secretary of State, printed at the opening of his Report on Mid-Staffs, Robert Francis writes of the “appalling suffering of many patients...an insidious negative culture involving a tolerance of poor standards and a disengagement from...responsibilities...in part the consequence of...a focus on...targets...financial balance and...status...at the cost of delivering acceptable standards of care...systemic failure” by “a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies...for years...A culture focused on doing the system’s business – not that of the patients...Standards and methods of measuring compliance which did not focus on the effect of a service on patients.” “A fundamental culture change is needed.”

The appalling failures at Morecambe Bay Hospitals are compounded by the nihilism of the CQC. In these institutions organizational culture

seems to have drained people of humanity. The CQC, responsible for upholding the quality of care, became a dystopian body that condoned abject failure of care and censored criticism of both hospitals and itself.

We are facing here more than malaise; we are facing crisis. This is the moment of choice.

The Secretary of State spoke last Friday of the need for “a different culture...where the system never trumps the individual.” He saw remedies in greater transparency, a new Duty of Candour, publication of success rates, breaking down hierarchies, “substantive use of the NHS staff survey”, strengthening accountability, ensuring that commissioning, regulatory and inspection systems give adequate weight to patient safety issues, improved contracts and incentives, “a better understanding of how proper measurement works” and “other changes made possible by technology.” In no way do I impugn the Secretary of State’s good intentions and no doubt all these things are necessary and will help. He was right above all to say “we need to harness the passion, dedication and commitment to safety that already exists in those who work in the NHS.” Absolutely we must recognize all those skilled and truly caring people who work in the NHS. Yet I cannot but feel that more is needed than the Secretary of State’s language expressed.

The remedies for the crisis of the NHS will not be bureaucratic or mechanistic. They will be about the spirit of the NHS, its ethos, the morality and the morale of the people who work in the NHS; about the quality of human relationships, mutuality, reciprocity and trust within this vast structure; about reimbuing care with true humanity. They will be about seeing the patient as a human being, not as a case or a statistic. The values and the practice of the arts in health movement point the way. You understand what is needed to bring healing and wholeness to wounded, suffering lives. You have the passion, the self-belief, the commitment. Your work embodies kindness, whether you are preventing, easing, sustaining, curing, mitigating, palliating, comforting. You go beyond technical healthcare to supporting healthy lives, lives of wellbeing, and - when the time comes - good deaths.

The crisis now besetting us is the greatest challenge and the greatest opportunity for you.

