Zinc Arts

Promoting young people's mental health
and wellbeing through participation in the arts

The evaluation of the
Zinc Arts ArtZone
programme 2012-2015

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Acknowledgements

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Summary

Introduction

Zinc Arts is a dynamic, leading arts and education charity that promotes inclusion through "arts without exception". Zinc Arts runs a wide range of creative courses (including music, sculpture, drama, spray painting, stop-frame animation, film, and visual arts) and is underpinned by the ethos that the arts can be a very positive and powerful force in individual's lives; awakening them creatively, inspiring future choices, providing a voice for self-expression, serving as a tool for learning, stimulating change, and resulting in a product which serves as an end in itself.

ArtZone, a three-year arts programme run by Zinc Arts, involved working with young people aged 11-25 with or at risk of mental ill health through engaging them with a wide range of arts activities. The programme enabled Zinc Arts to deliver a mixture of six-to-ten week outreach projects to an array of organisations who work with young people in both secure and non-secure mental health services. Anglia Ruskin University was commissioned to provide a service evaluation of the ArtZone project from August 2012 to July 2015.

Methods

The evaluation comprised both quantitative and qualitative methods. The quantitative strand comprised 122 ArtZone participants (across years one to three) completing measures of mental illness severity and mental wellbeing pre/post course completion, and completing a measure of course satisfaction at the end of their course. The qualitative strand comprised focus groups and semi-structured interviews with 34 ArtZone participants during years one and two of the programme.

Findings

ArtZone participants significantly decreased in mental illness severity and significantly increased in mental wellbeing from pre- to post-intervention. Furthermore, participants were highly satisfied with their courses, with 99.1% rating the quality of their course as good or excellent, 96.5% indicating that the course met most or almost all of their needs, 98.3% being mostly satisfied or very satisfied with the amount of help they received and 99.1% being mostly satisfied or very satisfied with the course as a whole. Of particular importance 92.9% said that the course had helped them deal with their problems better. Furthermore, the qualitative findings revealed that the project led to a number of social and emotional benefits to participants, most notably: decreased social isolation and increased social inclusion (through an increased sense of community and connection, the development of peer support networks and friendships, increased communication and understanding); and increased mental wellbeing (through the provision of an emotional outlet, distraction, motivation, relaxation, increased self-confidence, and increased self-esteem). In addition, the qualitative strand revealed that the project sparked imagination and creativity in the

participants, built new skills and competencies, and prompted thinking ahead and making future plans.

Conclusion

The present evaluation has found that the Zinc Arts ArtZone project has been hugely beneficial to its participants, and has achieved its aim of engaging young people with mental health problems in the arts, enabling them to use the arts to express themselves in a safe and secure setting. The findings also support Zinc Art's ethos that the arts can be a very positive and powerful force in individual's lives; awakening them creatively, inspiring future choices, providing a voice for self-expression, serving as a tool for learning, stimulating change, and resulting in a product which serves as an end in itself. The project has provided opportunities for over a hundred young people in both secure unit and community settings, and their engagement with and enjoyment of the project has been clearly evident. The evaluation has shown that the Zinc Arts ArtZone project has achieved important measurable outcomes, with statistically significant improvements in mental wellbeing and significant reductions in mental illness severity. Furthermore, the qualitative findings have revealed that the project has led to a number of social and emotional benefits to participants, having an impact at both an individual and community level. The evaluation results demonstrate the importance of sustaining the ArtZone programme, so that these benefits to young people with or at risk of mental ill health may continue. Further research exploring the longer-term benefits of the courses would be highly valuable.

Introduction

"It was an escape from normal life. You can be yourself, nobody was judgemental" [and you] *"felt more like family than friends".*

Young participant from community project

Policy context

Over the past 20 years there has been a developing arts and health agenda. In 1999 the Department for Culture, Media and Sport (DCMS) concluded that arts participation can improve community health, crime, employment and education, but identified that robust evidence on the cost and benefit of arts participation was required (DCMS, 1999). Arts Council England's (ACE) corporate plan 2003-2006 (ACE, 2003) later committed to developing strategies on arts and health, leading to the commissioning of a review of the medical literature (Staricoff, 2004). This was followed by ACE's national framework for arts, health and wellbeing (2007a) which stated that every day the arts are having a significant impact on people's health. In 2005 the Department of Health (DH) then commissioned a review of arts and health (DH, 2007) which concluded that the arts are integral to health, health provision and healthcare environments. The DH also commissioned '*A prospectus for arts in health*' in partnership with ACE, which asserted that the arts make a significant contribution to health and wellbeing (ACE, 2007b), with many arts and health initiatives contributing to important DH and DCMS objectives.

Despite this flurry of Government interest, concerns about a lack of Government action following these publications led to a House of Lords debate on 6th March 2008, in which Lord Howarth of Newport (Minister of the Arts 1998-2001) asked HM Government how they intended to develop their policies to link the arts with healthcare. In response to the Lords debate an internal "Arts/Health group" was established within the DH and Alan Johnson (former Secretary of State for Health and Social Services) endorsed the value of arts for health in September 2008:

> *"Music, poetry, dance, drama and the visual arts have always been important to our mental and physical wellbeing… active involvement in the arts… can have a profoundly positive effect on patients' wellbeing… through the Arts/Health group that's been set up in my department, we will be looking at what more we can do to provide guidance, where to go for advice on best practice and sources of funding for clinicians and arts professionals."*[1]

However, by 2009 Alan Johnson was no longer Secretary of State for Health and other priorities in thinking took over. Nevertheless, Lord Howarth set up an All Party Parliamentary Group for Arts, Health and Wellbeing which formally met for the first time in January 2014. The group aims to encourage the evaluation of arts and health work and the dissemination of evidence. Furthermore, the past year has also seen the

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[1] The full text of Alan Johnson's speech can be accessed at: http://www.artsforhealth.org/news/alan-johnson-speech.pdf [Accessed 12 June 2015]

publication of a number of research reports by the DCMS which have quantified the wellbeing and social impacts of arts engagement (DCMS, 2014; DCMS, 2015a; DCMS, 2015b).

In addition to the growing arts and health political agenda, there has also been a growing number of reports to Government seeking to address the many challenges of improving the lives of children and young people over recent years (e.g. HM Government, 2012; Department for Education, 2011; HM Government, 2011a; 2011b; HM Government, 2010a; 2010b). These reports contain a number of recommendations focused on either developing new resources or enhancing the quality of provision. Recent years have also seen specific promotion of the arts amongst young people in Government reports. In October 2013 the report of the Chief Medical Officer of Public Health England highlighted the need to prioritise and invest in mental health services for children and young people. The report contains case studies outlining the benefits of arts participation for the wellbeing of young people. In March 2015 the Department for Education and the Department of Health also published statutory guidance for local authorities, clinical commissioning groups and NHS England titled '*Promoting the health and wellbeing of looked-after children*' which emphasised the importance of ensuring that looked-after children have access to positive activities such as arts, in order to promote their wellbeing.

Literature review

The following section examines academic literature which assess how the arts (e.g. performing arts, visual arts, decorative arts, printing, short stories and poetry, and sculpting) are used as a therapeutic care strategy, and conceivably play a crucial role in strengthening social recovery among young people with mental health problems (Heenan, 2006). There is a considerable body of evidence that highlights the strength of association between art-based interventions and positive mental health and wellbeing (Heenan 2006; Odell-Miller, et al., 2006; Secker, et al., 2007). In the UK, there are a considerable amount of interventions and strategies in place to tackle mental health issues. Many of these are underpinned by the presumption that social

interaction is beneficial for mental health. For example, a recent UK mental health strategy 'No health without mental health' (DH, 2011) includes plans to improve mental health by reducing social isolation and enhancing social networks. A literature review by Greenberg et al. (2001) argues that the most effective strategies that address mental health problems among children are those that educate them as well as encourage positive changes across the school and home environment.

What is the role of the arts in psychological recovery?

A number of studies explain the impact of art on improving psychological recovery from mental illness by drawing on the notions of 'social exclusion' and 'individuals perceptions', in connection to subjective accounts of levels of wellness and illness. For instance, Naidu and Shabangu (2015) conceptualise the psychotherapeutic effect of poetry on anxiety. Using documented experience of an adolescent girl, they infer that writing poetry can encourage a better understanding of challenging problems which could help individuals manage anxiety. Howells and Zelnik (2009) also suggest that engaging in art could be self-validating which is crucial in recovery from mental illness (especially serious mental illnesses) as credible self-valuation is usually compromised by the onset mental ill health (Eriksen et al. 2012). This form of therapy 'improves self-esteem' which in turn encourages participation in positive social behaviour. Findings from Heenan (2006) explain art as being empowering, leading to an increase in independence and capacity building. Furthermore, 'self-expression' from art-making has been argued to provide a platform to release tension and unresolved feelings (Lloyd et al. 2007). This form of expression through communication of intimate and personal feelings can improve self-validation (Stacey and Stickley, 2010).

Additionally, some studies have reported that having a sense of purpose, derived from participation in art, gives individuals a focus beyond their mental ill health. The focus provides a distraction away from mental health symptoms particularly among those who are traditionally unable to focus (Spaniol 2001; Stacey & Stickley 2010; Van Lith et al. 2011).

What is the role of arts in social recovery?

The idea of art as a method of improving mental health recovery is well evidenced and underpinned by the concept of strengthening social networks and reciprocal interactions. A qualitative study by De Vecchi et al. (2015) explores the notion that art-based interventions support reciprocal interactions which provide a supportive environment for social interactions, which in turn helps to boost self-confidence. By discouraging social isolation, art groups encourage building of social skills and widening social capital through encouraging interaction among members of the group which improves social skills and develops the ability to interact and understand social norms (Green et al. 1987; Odell-Miller et al. 2006; Stickley et al. 2007). Social skills such as; supporting others, learning and gaining wisdom from others, camaraderie building and trying to maintain friendships provide opportunities for interpersonal development (Körlin et al. 2000; Stickley et al. 2007; Stacey & Stickley 2010; Stickley 2010; Van Lith et al. 2011).

Art-based interventions are shown to reduce social isolation by enhancing individual perception of acceptance and reducing social stigma. For example, Harris, (2007) and Pinniger et al. (2012) both report a significant association between dance therapy and self-esteem, depression and anxiety. Interaction among members of an art group often presents with a feeling of acceptance and reduces perception of social stigma and discriminatory beliefs (Parr 2006; Secker et al. 2007; Howells & Zelnik 2009; Stickley 2010). Spaniol (2001) suggested that by promoting themselves as artists, the development of a social identity beyond having a mental illness often occurred. When participants referred to themselves in this way it characterised a major positive shift in their recovery journey.

As a final point, this group of authors stress that there are personal as well as social benefits of involvement in art for young people in the promotion of self-care for mental health and wellbeing. We have cited therapeutic examples which centre on nurturing and building personal resilience and acceptance to aid recovery. They include: self-expression and self-validation; self-esteem and self-confidence; empowerment; social interaction and inclusion, and building trusting relationships and support networks. The next section discusses how the Zinc Arts ArtZone programme sets out to address these competencies.

Zinc Arts

Zinc Arts is a dynamic, leading arts and education charity that promotes inclusion through "arts without exception" (www.zincarts.org.uk). The organisation exists to advance and promote the creativity, culture and heritage of disabled young people and adults and socially excluded groups. Zinc Arts, formerly known as Theatre Resource, was initially set up in 1990. Throughout the past 25 years, the charity has expanded considerably and Zinc Arts now runs a wide range of creative courses (including music, sculpture, drama, spray painting, stop-frame animation, film, and visual arts). The Zinc Arts Centre, based in Chipping Ongar in Essex, includes a fully accessible theatre/studio space, and is now a centre of excellence in the development and provision of high quality and engaging art.

Although the charity works with people of all ages and abilities, Zinc Arts specialises in working with children, young people and adults who are physically disabled, learning disabled or mental health service users. Zinc Arts is underpinned by the ethos that the arts can be a very positive and powerful force in individual's lives; awakening them creatively, inspiring future choices, providing a voice for self-expression, serving as a tool for learning, stimulating change, and resulting in a product which serves as an end in itself. Zinc Arts aims to develop artists and showcase art from those with disabilities or from disadvantaged backgrounds. The Zinc Arts team comprises professional artists and trainers with a background and experience relevant to the groups with whom they work.

ArtZone

ArtZone is an arts programme that was run by Zinc Arts over three years, funded by Comic Relief, Essex County Council and Steel Trust. The programme involved working with young people aged 11-25 with or at risk of mental ill health through engaging them with a wide range of arts activities. 12-week arts programmes were run for young people using community mental health services at Zinc Art's premises and on secure units. The programme enabled Zinc Arts to deliver a mixture of six-to-ten week outreach projects to an array of organisations who work with young people in both secure and non-secure mental health services, including organisations working with young people at risk of mental ill health. ArtZone enabled young people to work alongside professional artists to create high quality art pieces, as individuals and groups. The sessions were designed so that young people could use the arts to express themselves in a safe and secure setting. Anglia Ruskin University was commissioned to provide a service evaluation of the three year ArtZone project from August 2012 to July 2015.

Evaluation Methods

Quantitative methods

The quantitative strand of the evaluation involved key workers completing questionnaires (at baseline and post-intervention) relating to participants' mental illness severity and mental wellbeing, and participants completing a measure of satisfaction after the course had ended. The chosen questionnaires were assessed for face validity and user acceptability via the South Essex Service User Research Group (SE-SURG). The most concise versions of the measures were selected to ensure minimal intrusion for service users.

The measure of mental illness severity was the Threshold Assessment Grid (TAG: Slade et al., 2000), a valid and brief assessment tool with higher scores indicating greater severity of mental illness. The measure comprises seven domains grouped into three categories: safety (intentional self-harm and unintentional self-harm); risk (risk from others and risk to others); and needs and disabilities (survival, psychological and social). For each domain a health professional ticks one of three or four statements that best applies to the person being assessed. Domains are scored either 0 ('None'), 1 ('Mild'), 2 ('Moderate'), 3 ('Severe'), or for some domains answers can be scored 4 ('Very Severe'). Scores can range from a minimum of 0 to a maximum of 24. The TAG has been shown to be reliable and valid (e.g. Slade et al., 2000; 2002).

The measure of mental wellbeing was the Warwick-Edinburgh Mental Wellbeing Scale-short version (WEMWBS: Stewart-Brown et al., 2009; Tennant et al., 2007). This measures positive affect, psychological functioning and interpersonal relationships. Mental wellbeing is more than the absence of mental illness, and the scale covers only positive aspects of mental health. The shortened version consists of seven positively phrased statements rated on Likert scales: 'None of the time' (0), 'Rarely' (1), 'Some of the time' (2), 'Often' (3) and 'All of the time' (4). The overall score is the sum of each item with a higher score reflecting higher mental wellbeing. Scores can range from a minimum of 0 to a maximum of 28. The WEMWBS has demonstrated high validity and reliability across a range of populations (e.g. Bartram et al., 2011; Clarke et al., 2011; Stewart-Brown et al., 2009; Tennant et al., 2007).

Participants also completed the Client Satisfaction Questionnaire (CSQ: Larsen et al., 1979) following course attendance. The CSQ comprises eight questions scored one to four, with a minimum possible score of eight and a maximum possible score of 32 (higher scores indicate greater satisfaction). This measure demonstrates high internal consistency (e.g. Larson et al., 1979).

In order for this evaluation to protect service user anonymity, the research team did not receive any personally identifying information. Sonia Cakebread (project co-ordinator) gave each participant a unique ID code which was retained throughout the duration of the evaluation. Sonia entered participant data (with accompanying ID codes) into a database which was passed on to Dr Ceri Wilson for analysis.

Participants

Participants who consented to providing information for the evaluation (*n*=122) were spread across locations/courses (see Table 1). Participants ranged in age from 12 to 25 (mean=16.89; *SD*=3.10). 41.3% were male (*n*=50) and 58.7% female (*n*=71): data was missing from one individual. The majority identified themselves as White British (*n*=101: 83.5%), four identified themselves as Black Caribbean (3.3%), four as Black African (3.3%), and four as Mixed (3.3%). Three identified themselves as White Irish (2.5%), two as Black British (1.7%), two as other (1.7%), and one as Asian British (0.8%). Ethnicity data was missing for one participant.

Table 1: Course participants

Course	Type of setting	Year	Number included in quantitative evaluation
Brockfield House Course 1	Secure unit	1	7
St Aubyns Adolescence Unit Course 1	Secure unit	1	11
St Aubyns Course 2	Secure unit	1	5
Brentwood Foyer Course 1	Community	1	11
The Priory Hospital Course 1	Secure unit	1	10
SexYouality	Community	1	13
Southend YMCA	Community	2	10
Brockfield House Course 2	Secure unit	2	2
St Aubyns Course 3	Secure unit	2	6
The Priory Hospital Course 2	Secure unit	2	12
Brentwood Foyer Course 2	Community	3	11
Brockfield House Course 3	Secure unit	3	1
Epping Forest College	Community	3	23

Qualitative methods

The qualitative strand to the evaluation adopted a mix of research methods to build rich micro-data on the different meaning and interpretation of participants' experience of the delivery of the intervention and their ideas in how it may have helped to change their behaviour or attitude towards achieving optimal self-care in mental health and wellbeing. Qualitative research does not ignore social contexts or the experiences of people as lived, rather than as constructed by theoretical categories. The presumption on which this qualitative strand of the evaluation rests is that most, if perhaps all social realities are social constructs and this study emphasises young people's subjective accounts in how the intervention positively impacted on their health and wellbeing.

The qualitative strand consisted of semi-structured interviews (see Ritchie & Lewis, 2003) and focus groups (see Patton, 2002) with ArtZone participants. The interviews and focus groups took place during the penultimate learning session of the intervention. In the semi-structured interviews (*n*=9) the interviewer used a paper-based interview guide that he followed. The semi-structured interviews contained

open-ended questions and discussions often diverged from the interview guide, it was therefore necessary with the permission of participants to tape-record interviews and later transcribe these tapes for analysis. The objective of the focus groups was to allow participants as a group to discuss, debate and share experiences on the delivery of the intervention and its merits. The focus groups were digitally recorded with the permission of the participants and then transcribed in full. The data then underwent content analysis to generate themes following the principles advocated by Miles and Huberman (1994). This involved repeated readings of the transcripts to gain familiarity with the content. Coding was used to identify key content relating to the objectives of the evaluation, recurring, similar and contrasting content, and links to the literature. The codes were then collapsed into central themes.

Table 2: Focus Group Sites

No.	Name of site	Type of site	No Participants	Gender split		Interview method
1.	Brockfield House	Secure unit	2	F2		1-2-1 interviews
2.	St Aubyns	Secure unit	7	F6	M1	Focus groups & 1-2-1 interview
3.	Brentwood Foyer	Community	5	F1	M4	Focus group
4.	Priory Hospital	Secure unit	7	F7		Focus group
5.	Southend-on-Sea YMCA	Community	7	F5	M2	Focus group
6.	Brockfield House	Secure unit	6		M6	1-2-1 interviews
			Total	**34**	**F21**	**M13**

Participants

In total, 34 participants took part in a combination of semi-structured interviews and focus groups during years one and two of the programme. The evaluation sites were selected by the ArtZone coordinator using a convenience sampling approach. This comprised all the programme sites in years one and two. Potential participants were approached to get involved in the qualitative strand of the evaluation on the basis of completing the quantitative measures. Potential participants were first approached by the learning moderator and provided with an oral description of the evaluation and asked if they would be willing to take part. The potential participants were later introduced to the interviewer who explained the purpose of the evaluation and their role in the interview and/or focus group before asking participants to consent. Participants were explained their rights to withdraw from the interview and/or focus group at any time without explaining why to the interviewer, what would happen to their information and how it would be stored and that a ten pound shopping voucher would be given to participants to say thank-you and remunerate their time.

A number of participants withdrew from the evaluation for personal or organisational reasons. They are not counted as part of the 34 completed encounters. Withdrawals typically occurred for the following reasons:
• Patients being transferred to non-participating wards in secure units.
• Patient's observation levels increasing leading to limited access off the ward and/or restrictions around sharp instruments and/or involvement in group work.
• Patients electing to do other structured activities (i.e. rambling) which ran at the same time as the ArtZone programme.
• Patients electing to drop out and no explanation given.

In the planning for the qualitative strand of the evaluation we focused in particular on literature related to Theory of Change (TOC) (See Sullivan & Gillanders, 2004). This approach seemed the most appropriate for meeting the overall aims and objectives of the evaluation. It values a 'bottom-up' approach to evaluation that has helped with the challenge of developing a strategy that accommodates multiple-perspectives and effectively measures small-scale, locally driven projects or programmes.

As Connell and Kubisch (1998) outline, TOC provides a dynamic framework for assessing change in conjunction with key stakeholders. Through a three-stage approach (i.e. development of a TOC; monitoring of achievement of intended outcomes; and analysis and interpretation of findings), the ArtZone would be able to use the findings to better assess the effectiveness of the participants development, according to internally-focused criteria. Further advantages of TOC, according to Connell and Kubisch (1998) and Sullivan and Gillanders (2004) are that key stakeholders, (i.e. health care team) will have a vital role to play in the discussion of the range of outcome measures that ought to be used, to ensure interventions are needs-led and key stakeholders are involved in defining impact.

The drawback to TOC evaluations are that they are necessarily labour and cost intensive, requiring a deep relationship between the researcher (who acts in the capacity of facilitator) and key stakeholders. They are also only viable if the evaluation is able to commence concurrently with or before the development activity begins, due to the initial planning activity that is central to TOC. As a consequence, this evaluation did not wholeheartedly adopt the TOC approach but applied very loosely the principles of TOC to capture children's changing views of the developed programme.

Findings

Quantitative findings

Mental illness severity

The mean TAG score at baseline (*n*=98) was 5.34 (*SD*=4.22) and at post-intervention (*n*=82) this had decreased to 4.57 (*SD*=3.77). Baseline and follow-up scores were non-normally distributed therefore a Wilcoxon Signed Ranks Test was carried out to compare scores. Only those participants for whom the TAG was completed at both baseline and follow-up were included in the analysis (*n*=82). The mean baseline TAG score for these 82 participants was 4.90 (*SD*=4.10). The decrease in scores from baseline to follow-up was statistically significant: *z*=-3.024, *p*=.002. There was no significant difference in change in TAG scores between males and females (*p*>.05). Age was not significantly related to change in scores (*p*>.05). A one-way ANOVA was conducted to explore whether change in mental illness severity differed between the years of the courses attended. This was not statistically significant: $F_{(2, 81)}$=1.27, *p*=.286. Due to small numbers from each individual course it was not feasible to statistically compare change in mental illness severity between individual courses. However, mean changes for each course for which both baseline and follow-up TAG scores were available are reported in Table 3. The greatest decrease in mental illness severity was seen at the second course at the Priory hospital, closely followed by the first course at St Aubyns Adolescence unit.

Table 3: Mental illness severity change for participants from each course

Course	Year of course	*n*	Change in mental illness severity M(SD)
St Aubyns 1	1	8	-1.13 (2.10)
Brentwood Foyer 1	1	10	-.10 (.32)
The Priory 1	1	10	.20 (.42)
SexYouality	1	13	.00 (.00)
Southend YMCA	2	10	.00 (00)
St Aubyns 3	2	5	.00 (.00)
Brockfield House 2	2	2	.00 (00)
The Priory 2	2	12	-1.33 (.99)
Brentwood Foyer 2	3	11	-.27 (.65)
Brockfield House 3	3	1	.00 (.00)

Mental wellbeing

The mean WEMWBS score at baseline (*n*=121) was 14.95 (*SD*=6.75), and at post-intervention (*n*=113) was 20.40 (*SD*=5.78). The data were non-normally distributed at follow-up; therefore, a Wilcoxon Signed Ranks Test was carried out in order to compare scores. Only those participants who had completed the WEMWBS at both baseline and follow-up could be included in the analysis. For the 112 participants who had completed measures at both time points, the mean score at baseline was 15.37 (*SD*=6.56) and at post-intervention was 20.47 (*SD*=5.75): a mean increase in wellbeing

scores of +5.10. This improvement in wellbeing was statistically significant: z=8.229, p<.001.

There was no significant difference in wellbeing change between males and females (p>.05). Age was not significantly related to wellbeing change (p>.05). A one-way ANOVA was conducted to explore whether wellbeing change differed between the years of the courses attended. This was statistically significant: F(2, 111)=9.49, p<.001. Follow-up Bonferroni comparisons revealed that the improvements in wellbeing for attenders of courses in year 2 were significantly greater than improvements for year 1 and year 3 course attenders (both p<.01: see Table 4 for means).

Table 4: Wellbeing change for participants from each year

Year of course	n	Wellbeing change M(SD)
1	47	+3.79 (3.79)
2	30	+7.87 (3.57)
3	35	+4.51 (4.92)

Due to small numbers from each individual course it was not feasible to statistically compare change in wellbeing between individual courses. However mean score changes for those courses for which baseline and follow-up WEMWBS scores were available are reported in Table 5. As can be seen in Table 5, all courses saw an increase in wellbeing. The third course at St Aubyns adolescence unit saw the greatest mean increase (+11.17).

Table 5: Wellbeing change for participants from each course

Course	Year of course	n	Wellbeing change M(SD)
Brockfield House 1	1	6	+2.00 (1.90)
St Aubyns 1	1	8	+3.13 (7.43)
Brentwood Foyer 1	1	10	+3.80 (1.87)
The Priory 1	1	10	+4.90 (4.07)
SexYouality	1	13	+4.15 (1.77)
Southend YMCA	2	10	+5.70 (3.56)
St Aubyns 3	2	6	+11.17 (1.72)
Brockfield House 2	2	2	+8.00 (1.41)
The Priory 2	2	12	+8.00 (3.38)
Brentwood Foyer 2	3	11	+3.91 (4.48)
Brockfield House 3	3	1	+3.00 (.00)
Epping Forest College	3	23	+4.87 (5.28)

Satisfaction

113 participants completed the CSQ following completion of their Zinc Arts course. The mean score was 29.46 (*SD*=3.13) indicating that participants were highly satisfied with their course. As can be seen in Table 6 the vast majority answered all of the questions favourably. Worthy of note, 99.1% of participants rated the quality of the course as good or excellent, 96.5% said that the course met most or almost all of their needs, 98.3% were either mostly satisfied or very satisfied with the amount of help

they received and 99.1% were either mostly satisfied or very satisfied with the course as a whole. Of particular importance 92.9% said that the course had helped them deal with their problems better (either 'a bit' or 'lots').

Table 6: CSQ response frequencies

Question	Poor (1) Frequency (%)	Fair (2) Frequency (%)	Good (3) Frequency (%)	Excellent (4) Frequency (%)
How would you rate the quality of the course?	-	1 (0.9%)	21 (18.6%)	**91 (80.5%)**
Question	**No, definitely not (1)** Frequency (%)	**No, not really (2)** Frequency (%)	**Yes, generally (3)** Frequency (%)	**Yes, definitely (4)** Frequency (%)
Did you get the kind of service you wanted?	2 (1.8%)	2 (1.8%)	27 (23.9%)	**82 (72.6%)**
Would you recommend the course to a friend?	1 (0.9%)	3 (2.7%)	15 (13.3%)	**94 (83.2%)**
Question	**No needs met (1)** Frequency (%)	**A few needs met (2)** Frequency (%)	**Most needs met (3)** Frequency (%)	**Almost all needs met (4)** Frequency (%)
To what extent did the course meet your needs?	2 (1.8%)	2 (1.8%)	49 (43.4%)	**60 (53.1%)**
Question	**Quite dissatisfied (1)** Frequency (%)	**Mildly dissatisfied (2)** Frequency (%)	**Mostly satisfied (3)** Frequency (%)	**Very satisfied (4)** Frequency (%)
How satisfied are you with the amount of help you received?	-	2 (1.8%)	16 (14.2%)	**95 (84.1%)**
Overall, how satisfied were you with the whole course?	1 (0.9%)	-	14 (12.4%)	**98 (86.7%)**
Question	**Not at all (1)** Frequency (%)	**Not much (2)** Frequency (%)	**Yes a bit (3)** Frequency (%)	**Yes lots (4)** Frequency (%)
Have the services you received helped you to deal with your problems better?	2 (1.8%)	6 (5.4%)	**55 (49.1%)**	49 (43.8%)
Question	**Definitely not (1)** Frequency (%)	**No, I don't think so (2)** Frequency (%)	**Yes, I think so (3)** Frequency (%)	**Yes definitely (4)** Frequency (%)
If you needed help again, would you come back to our course?	1 (0.9%)	2 (1.8%)	26 (23%)	**84 (74.3%)**

*The most frequent response for each question is in **Bold**.

Qualitative findings

From the participant's accounts the ArtZone programme has been a cause, effect or catalyst to changes in their behaviour and how they see themselves and cope with their mental wellbeing. Participants have spoken about three specific different types of change that have occurred since joining the art-based programme. They can be typified as 'emergent changes' (e.g. that were coming into being or just noticed at the time of being interviewed), 'transformative changes' (e.g. the participant's deeper understanding of the 'self)'; and finally, 'projected changes' (e.g. which were felt will have a significant impact on their future lives).

Exposure to the intervention reportedly provided a distraction and enabled participants to gain critical distance from the problems they were experiencing; it also provided a new avenue for self-expression and communication. They learnt new techniques that helped them to relax and self-soothe. Some participants reported an instant calmness which could still be experienced 24 hours following the end of the session. It also sparked in participant's their imagination and creativity (e.g. enabling them to reside in a different sphere of their brain and/or consciousness) and led to changes in behaviour exemplified by self-directed art work which often carried over into their free time (e.g. they could continue doing arts and crafts in their own time). It also provided participants with a sense of freedom and autonomy and served as a mechanism to self-validate and process their individual concerns.

Table 7 illustrates the short term indicators of change in behaviour and attitude that participants subjectively reported feeling or thinking as a result of exposure to the intervention.

Table 7: What's changed from the participant's perception short-term?

Types of change	Short terms indicators
Changes in status	Decrease in feelings of social isolation; a sense of community and connection, a switch from a controlled environment to community memberships.
Changes in circumstances	Space from hospital staff, developed friendships, appearance of peer support networks.
Changes in behaviour	Functioned as an emotional outlet, and new way to communicate, performed outside of the session, motivation to wake/get out of bed.
Change in attitude	Constructive distraction from condition and environment, an immediate form of relaxation which can last up to 24hrs, sparked imagination and creativity, increased communication and understanding.
Changes in preparation	Built self-confidence; self-esteem; and prompted episodes of improved wellbeing, thinking about educational career.
Changes in skills	Obtained formal and informal learning, building skills and new competencies particular to the project.

While Table 7 highlights indicators of personal change defined by participants as a direct result of involvement in the programme, there were other notable and reported changes which happened on the level of the community. Exposure to the intervention within a controlled environment provided a break from institutionalised routines and respite from the health care team; it also provided a reason and/or motivation to wake and get out of bed on days when the sessions were running. Significantly, it helped to re-establish a morning routine; prompted participants to talk to each other and build new relationships (e.g. friendships); and exposure to the intervention supported the development of trusting peer-to-peer and adult-to-youth relationships and support networks (e.g. camaraderie). Finally, it led to a willingness and ability to share concerns among peers and understand each other's idiosyncratic behaviours and idioms. These acts strengthened social bonds and broke down stigma and isolation.

We can observe in the participant's accounts how exposure to the intervention benefited their personal journeys of recovery. The participant's subjective accounts correlate with the quantitative measures which indicate that the majority of participants significantly increased in mental wellbeing from pre to post participation. Participant's personal accounts reveal how they exercised free will in the intervention, which helped their recovery. This is exemplified in how participants negotiated and navigated boundaries inside the learning sessions and learnt from others when necessary. Participants comment, *"they do not force you [ArtZone team] to do anything but at the same time they do not let you give-up" and "[we also] received constructive criticism from peers and others".*

Correspondingly, the intervention team listened to what participants had to say about the techniques and methods being deployed in the intervention. Based on the participants' suggestions, the techniques and methods were supplemented or adjusted to fit participants' expressed needs. For instance, this can be seen in how the coordinator addressed the availability of pre-course information for potential participants following concerns being raised on the lack of information. Again, information was shared about the workforce to alleviate any concerns held by participants who stated that they held back from telling ArtZone facilitators about their problems simply because they did not know their backgrounds and due to confusion over whether the purpose of the sessions would be classical art therapy. Admittedly, not all the participants expressed these concerns but enough did to warrant action being taken to ensure that the purpose of the intervention was accurately conveyed and timed to foster interest from the participants.

To foster interest from participants, information about the project was provided in different formats. In both secure and community settings information was given orally, normally in routine meetings and on occasion accompanied by notices placed on the wall. A significant amount of participants commented that they would have liked a leaflet or information sheet to take away with them after hearing about the project, and in their own time read and consider if this opportunity was something that they would be interested in doing. In a few instances, participants were directed to the programme without prior knowledge of what to expect or gaining their explicit consent to take part.

Linked to the participant's request for project background information, a few of the participants questioned the mental health knowledge and experience of the ArtZone delivery team. They felt suspicious and were cautious to not reveal too much about their mental health problems in an attempt to not undermine the building of relationships or keep relationships going. By the end of the programme they became aware that the ArtZone team are artists with expertise in mental health problems. ArtZone addressed this concern by letting future participants know from the outset that they are skilled in supporting individuals with mental health problems so participants could take what they wanted from the relationship and also permission to engage in self-soothing and calming-down exercises/techniques without the fear of being judged or risking damaging relationships.

Due to the initial lack of information about the programme early on in the ArtZone project a few of the participants thought they would be doing classical art therapy, which was not the case. A small number of participants expressed a resistance to engaging in more therapies. This revealed a tension and reluctance to engage in tried and tested treatments when participants really wanted to have a laugh and an opportunity to develop their interest or talents. The intervention provided a way to engage in the arts and the by-product would be therapeutic support through an art-based process.

As we have noted, following conversations with the participants and gatekeepers adjustments were also made to the delivery of the evaluation. This was done when a) there were not enough participants to constitute a focus group, and b) where changes in care plans meant participant's observation levels had been increased (e.g. due to risk to self and others) and they could not leave the ward and/or get involved in whole group exercises. As a direct result, the interviewer came prepared to run a focus group, interview or to use both methods dependent upon the site briefing on the day. Qualitative research is well suited to these challenges and the research design was flexible enough to respond to the emerging needs of participants and gatekeepers. Thus, the qualitative strand was responsive, fluid and able to successfully generate reliable data to answer the evaluation question.

Discussion

The present evaluation has found that the Zinc Arts ArtZone project has been hugely beneficial to its participants, and has achieved its aim of engaging young people with or at risk of mental ill health in the arts, enabling them to use the arts to express themselves in a safe and secure setting. The findings also support Zinc Art's ethos that the arts can be a very positive and powerful force in individual's lives; awakening them creatively, inspiring future choices, providing a voice for self-expression, serving as a tool for learning, stimulating change, and resulting in a product which serves as an end in itself. The project has provided opportunities for over a hundred young people in both secure unit and community settings, and their engagement with and enjoyment of the project has been clearly evident. A staggering 99.1% of participants rated the quality of their course as good or excellent, 96.5% said that their course met most or almost all of their needs, 99.1% were either mostly satisfied or very satisfied with their course as a whole, and 92.9% said that their course had helped them deal with their problems better.

The evaluation has shown that the Zinc Arts ArtZone project has achieved important measurable outcomes, with statistically significant improvements in mental wellbeing and significant reductions in mental illness severity. Furthermore, the qualitative findings have revealed that the project has led to a number of social and emotional benefits to participants, most notably: decreased social isolation and increased social inclusion (through an increased sense of community and connection, the development of peer support networks and friendships, increased communication and understanding); and increased mental wellbeing (through the provision of an emotional outlet, distraction, motivation, relaxation, increased self-confidence, and increased self-esteem). In addition, the qualitative strand of the evaluation revealed that the project sparked imagination and creativity in the participants, built new skills and competencies, and prompted thinking ahead and making future plans.

The principles behind the ArtZone intervention did not focus on a deficit model of care but an asset based approach where recovery is seen as a cause, effect or catalyst from exposure to the intervention. The prevailing 'deficit model' (Kretzmann & McKnight, 1993 and Foot & Hopkins, 2010) of assessing health needs, puts participants on the defensive while ignoring their potential strengths. The asset model approach fostered in this intervention offers a necessary complement to the problem-focused framework by considering multiple levels of health-promoting aspects in participant's treatment and promoting joint solutions between participants and their health care team inside and outside of the art-based activities. The ArtZone intervention provided not only an interactive, fun and deliberative methodology (e.g. performing arts, visual arts, decorative arts, printing, short stories and poetry and sculpting) but also provided a concrete example of how asset-based work can positively promote behavioural changes and impact on individual and community to evaluate their relative level of wellness and illness. Participant's commented, *"It helped me with my confidence", "you feel the need to talk", "we tell each other problems", "It is a support", "people do not judge others on the project" and "it is like a family".* A tangible and frequently

reported indicator of this asset model has been the telling of reciprocal relationships connected to the journey of recovery. This is reciprocal relationships with the health care team, with fellow participants and most importantly with themselves (or diagnoses). The intervention has visibly helped in the redistribution of power by helping participants acquire the confidence and knowledge for self-care. The health care team have been both driving and blocking forces in such change as a result of the deficit model which takes on a significant existence in secure accommodation.

Conceivably, the strength of the intervention has been in the co-design process to establish the content of the sessions, stable participating groups to allow for the building of trusting relationships and a supportive atmosphere. Paradoxically, the personal and collective interest have had to be periodically and/or momentarily negotiated which has shown to offer greater opportunity for collaboration and boosted support among participants. The collaborations have united strangers and allowed common bonds to emerge around single arts and crafts activities. Holding all of this together is the exercise of free will to be in the room and collaborating in a common project. If attendance was compulsory and activities perceived as a traditional therapeutic intervention participants would have most likely responded to activities less eagerly and fallen back on pre-existing behaviours. The time length enabled young people in secure units to participate from arrival to departure avoiding the need of repetition within the programme.

Unlocking personal assets in participants to aid self-care was a vital ingredient provided by the programme. By using their imaginations and creativity participants felt empowered to problem-solve and in the process some reconnected with their own biographies. Whether playing an instrument, painting, drawing or writing poetry these enactments evoked a sense of happiness and belonging and tapped into good influence and ideas for the future.

In line with abovementioned points, reciprocal relationships are shown to underpin the success of the intervention. Whether we view participants at a personal or community level, new and emerging relationships have shown to be a key feature in the participant's journey of recovery. You can hope to achieve trusting and mutually beneficial relations however the success of such relations are dependent upon the dynamics of the individuals involved and the environment in which they meet.

Recommendations

Zinc Arts
- The ArtZone programme has demonstrated significant benefits to young people with, or at risk of, mental ill health. The key now is to ensure sustainability of the ArtZone programme in order for the work to continue and for longer-term outcomes to be assessed.

Future Research
- Consider building indicators of long term changes experienced by participants who take part in the intervention. This should be done by the design of a follow-up research strategy which captures health and wellbeing measures 3 months, 6 months and 12 months following completion of the programme.
- Compare between an intervention group who receive the intervention along with other therapies and a control group who receive traditional therapies only. This is to better isolate and measure the impact of the programme on improving health and wellbeing.

Policy
- Consider how the art-based approach could be used in training to help practitioners and heath care teams to be mindful of what might be going on for a particular child or young person who comes to their attention because of their mental ill health.
- Local Health and Wellbeing Boards should be made aware of the programme and how education and promotion of the arts can be used as a prevention and promotion tool for good mental health and wellbeing among children and young people.
- Consider the impact of cuts to pastoral support and youth services on the most vulnerable young people in the community, who may be thus denied an important avenue of support. Opportunities for young people to participate in art-based activities should be encouraged.

Practice
- Provide information via websites and social media about how young people can access the programme themselves, and/or support friends who disclose that they are experiencing mental health issues.
- Consider ways in which young people could be encouraged to self-refer to the programme and track the outcomes of these referrals.

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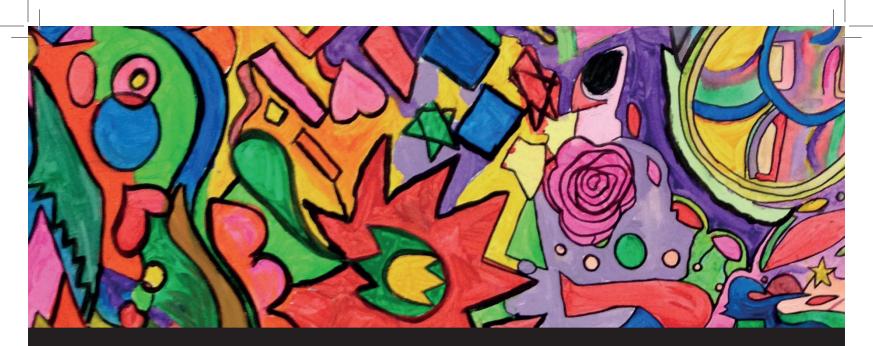
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