

available it is likely that staffing costs are similar since many of those working at STH projects have similar health and social care backgrounds. NHS day centre expenditure on 'equipment and durables' is costed at nil, however, STH projects need to spend money on tools, seeds and other consumables. Either this takes place at the expense of the salary budget or staffing costs are offset by taking on unpaid volunteer staff.

Interestingly, the data obtained in the survey reported here also show a difference in costs between services for people with MHP (£38.92 per client placement) and those with learning difficulties (£56.57). Again this may reflect salary costs since the mean number of staff at STH projects which provide a service only for people with learning difficulties was greater (2.5) than that for projects providing services for people with mental health problems (1.6). Placement costs are in proportion to staffing levels.

Conclusions

This survey shows that there has been a growth in the provision of care through projects using social and therapeutic horticulture, particularly since the mid 1980s. Prior to the 1980s projects were implemented in the main by charitable organisations. Subsequently there has been an increased involvement of health trust and local authority social services. The number of respondents to the survey is likely to be an underestimate of the total number of projects operating in the UK since the method of distribution of the questionnaire relied upon the known network. Projects operating outside of the network would not have been aware of the survey, although a handful of new projects were identified as a result of the surrounding publicity. Additionally, some horticulture projects known to the researchers did not respond to the questionnaire.

Many different client groups benefit from STH although the main ones are people with mental health problems and those with learning difficulties. The reasons for the specific involvement of these two groups may be historical since gardens were once an important feature of many mental health institutions.

A comparison of the costs of STH projects and local authority and NHS day care shows that the costs of providing STH are similar to those of day care. The benefits of STH are currently under investigation, however, if they are effective at promoting well-being and social inclusion their cost effectiveness would appear to be a further justification for their continued use and expansion.

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Social and Therapeutic Horticulture: the state of practice in the UK

A summary of the main findings from a survey of horticulture projects for vulnerable adults in the UK

This Evidence Paper describes the main findings of a survey of 836 horticulture projects for vulnerable adults in the UK carried out by Thrive in partnership with the Centre for Child and Family Research (CCFR) as part of the Growing Together study.

Horticulture, in many different guises has been used as a form of treatment or therapy for both physical and mental health problems. It has also been used in an organised form as a recreational or leisure activity for these and other vulnerable groups, including people with learning difficulties, asylum seekers, refugees, victims of torture and many others. The structured use of horticulture and gardening has developed from rehabilitation and occupational therapy and is known variously as 'horticultural therapy', 'therapeutic horticulture' and 'social and therapeutic horticulture' (STH) (see Sempik, Aldridge and Becker, 2003).

In 1998 Thrive carried out a survey of known horticulture projects practising STH for vulnerable adults. Around 1,500 'projects' were identified and became part of a network for the dissemination of information regarding training, meetings, new developments etc. It is through this network that Thrive has been able to provide support for those projects. However, it soon became clear that some of the entries in the database classified as 'projects' were not active ones. Some were individuals with an interest in starting new projects while others were projects that had closed down. In summer 2003 a new survey form was designed and distributed to the 1,500 named individuals within the Thrive network newsletter.

Non-respondents were followed up with an additional form and then a telephone call.

The Responses to the Survey

A total of 836 active projects responded to the survey. Their responses showed that the area of social and therapeutic horticulture as a source of service provision for vulnerable people has been steadily building for the last twenty years. The first project still active in the network started in 1955 and by 1985 78 new projects were added.¹ However, the following years showed a sharp rise in the number of projects which reached its peak in 2002 with 58 new ones in that year.

While up to 1985 projects were started predominantly by charities, after that year local authorities, health care trusts and social services were involved in setting up many new projects. For example, in the period 1956 – 1980 only six of the thirty new projects were associated

with local authorities or the NHS, but in the period 1996 – 2000 this had risen to 112 of the 209 new projects. The association of gardens with hospitals is not new and the use of gardening as a therapeutic process has a long history. At one time many hospitals, particularly mental health units had gardens which provided the patients with an opportunity for exercise, rehabilitation and leisure and which were a valuable source of fresh produce for the institutions. As hospitals have closed these gardens have been replaced by gardening and horticulture projects. Some of these are also now associated with hospitals or set in their grounds – 14% of garden projects are connected with hospitals (the largest single grouping), 4.3% with rehabilitation centres and 3% with secure units.

¹ 602 projects were able to provide the year in which they had started.

However, 34% are independent with no direct links to other institutions. The remaining projects are connected to colleges, schools, residential homes, commercial enterprises with a small number associated with prisons and hospices.

Clients attend projects on a regular basis and most projects were active on four days of the week or more (64.1%). Information from interviews with project managers shows that limits on the number of days of attendance are often set in an attempt to distribute resources fairly. Additionally, funding is not always available for client placements and this limits attendance. Extra capacity, therefore, appears to be available for clients but may remain unused because of a lack of funding.

Projects varied in size and capacity and 77.7%² had 30 or fewer clients per week but 7.2% reported more than 50 clients attending. The mean number of users was calculated as 25.3/project/week and extrapolating this figure to the total number of respondents in the survey suggests that around 21,000 clients attend STH projects each week. In short, the projects provide approximately one million client placements per year (assuming an activity of 48 weeks per year which appears reasonable in the light of knowledge of individual projects). It is likely that the total number of individuals using STH projects per year is close to the weekly figure of 21,000 since the pattern of use is that of regular attendance and data from interviews suggest that client turnover is low.

The Clients

The published literature on STH reports participation by a range of vulnerable groups and many projects appear to provide a service to clients from more than one group. Of the respondents in this survey only 35.5% worked with one client group the rest had multiple client groups and almost half (46.4%) worked with 3 groups or more (with at least 20% of their clients coming from each of those groups). Table 1 lists the main groups attending horticulture projects. Almost half of the projects provided a service for people with learning difficulties (48.7% of projects) and mental health needs (40.6%), this is perhaps unsurprising since these two groups represent the historical core of gardening projects.

² 609 projects supplied information as to the number of clients using their facilities.

³ UK 2001 Census data available from National Statistics: <http://www.statistics.gov.uk/>

Table 1.
Main client groups attending gardening projects

Group (making up at least 20% of the total number of clients at the project)	Percent of Projects Providing Service to that Group
Learning difficulties	48.7
Mental health needs	40.6
Challenging behaviours	17.2
Physical disabilities	16.9
Unemployed	13.9
Multiple disabilities	11.7
Young people	10.9
Older people	10.6
Low income	9.3
Drug and alcohol misuse	8.9
Rehabilitation	7.2
Accident/illness	6.0
Visually impaired	5.4
Offenders	5.1
Hearing impaired	4.7
Black and ethnic minorities	4.3
Ex-offenders	3.7
Major illness	3.6
Homeless and vulnerable housed	2.4
Women only groups	2.4
Refugees/asylum seekers	1.1

Women and Ethnic Minorities

Around 30% of the total users of STH projects are women and 20 projects in the network catered for women-only groups. It is unclear why women are under represented. Data from interviews shows that the gender distribution of project workers and volunteers is equal. Further research is necessary to discover why so few women attend the projects as clients.

It was estimated that around 6.2% of clients came from black and ethnic minorities. This is greater than the estimate produced by Naidoo, de Viggiani and Jones (2001) who surveyed the same project network. However, their response rate (113 projects) was much lower than that in the present study. The 2001 Census³ reported that 7.9% (4.6 million people) of the total population of the UK was from black and ethnic minorities although the distribution varied significantly across the country. These data suggest that ethnic minorities are slightly under-represented at STH projects if the comparison is made purely in terms of percentages of the population. However, the projects provide a service for vulnerable people and those at risk of social exclusion. If these risks are greater among black and ethnic minorities then the degree of under-representation is also greater in real terms. Naidoo, de Viggiani and Jones (2001) have suggested a strategy for increasing participation by black and ethnic minority groups in STH projects. They identified the barriers to involvement in the projects as being both cultural and organisational, for example:

‘Cultural barriers included gender roles, especially the presumed reluctance of South Asian women to engage in activities outside the home, and a lack of interest in horticulture, which might be viewed as unimportant or unpaid work rather than a leisure pursuit’

(Naidoo, de Viggiani and Jones, 2001, p. 15).

‘The most commonly cited barrier in the questionnaires, the lack of BMEGs [Black and Minority Ethnic Groups] living locally, may also be viewed as an organisational barrier, in that the relative invisibility of BMEGs is a perception rather than reality’.

(Naidoo, de Viggiani and Jones, 2001, p. 18).

Clearly, assumptions regarding the views of ethnic minorities on horticulture and those relating to the perceptions of service providers about black and ethnic minority representation in local communities need to be addressed.

Services and Activities Provided by the Projects

Garden projects provide an opportunity for clients to work together outdoors in an activity that is widely perceived to be enjoyable. Within this context projects offer a range of structured activities and training, some with fixed time constraints and formal qualifications and others informal. The stated aim of many of the projects is to enable clients to resume or find paid employment and with this in mind they offer training in a variety of skills related to horticulture and the opportunity to obtain formal qualifications such as National Vocational Qualifications (NVQ) or National Proficiency Tests Council (NPTC) awards, although the results of the survey show that only 25.7% of projects provide such accredited training. In general this training is offered more frequently to people with learning difficulties. This is also true for work skills training. The most commonly provided services relate to social skills development, followed closely by basic skills training and day care/leisure provision.

Funding of Projects

Projects used many different sources of funding and only 38% relied on a single source. The main sources were Central Government (10.3% of the total annual budget of all projects), local government (10.9%) and health trusts (17.1%). These figures exclude client fees which accounted for 20.4% of the annual budget. These were mostly paid by local authorities and health trusts although a small proportion of clients were responsible for their own fees. Where a charge was made⁴ (either to the client

or authority) the mean fee was £27 per session although this varied from as little as fifty pence to £137. However, 86% of projects charged between £10 and £60.

The majority⁵ of projects operated on a budget of less than £10,000 and 71.7% on a budget of less than £50,000. Projects with larger annual budgets supported more clients but the relationship between mean client numbers and budget size was not linear (see Table 2). If the number of clients is doubled it is necessary to increase the size of the budget by up to tenfold. It is interesting to consider why the economies of scale appear to work in the reverse for STH projects. It may be that as projects expand they are able to offer more, and more expensive services or that staffing needs grow disproportionately to client numbers. Further data needs to be collected in order to elucidate this point.

Table 2:
Project budget and number of clients at projects.

Total Annual Budget	Mean number of clients
Less than £10,000	15.1
£10,000 - £50,000	26.6
£50,000 - £100,000	32.6
£100,000 - £500,000	41.5
Over £500,000	50.0

(Data from 546 projects)

⁴ 120 projects reported that they levied a client fee.

⁵ 590 projects supplied details of their total annual running costs.

Having produced an estimate of the number of annual client placements and with the knowledge of projects' expenditure it is possible to estimate both the mean cost of an individual client placement (£53.68) and the total budget for this sector of care (£54.5 million per year). In general, a session at a STH project lasts a whole day, although typically work commences around ten o'clock in the morning and ends between three and four in the afternoon. The length of an average working day is 5.5 hours (data from interviews). Services in the NHS and provided by local authority social services are generally costed per half-day session so it is possible to compare costs between those and STH projects on a reasonably equal basis. NHS trust day care costs approximately £54 per day (two sessions) for people with mental health problems (MHP). Day care provided by local authority social services costs around £36 per day for people with MHP and £54 for people with learning difficulties (see Netten, Rees and Harrison, 2001, pp. 57, 58, 73 and 74). It can be seen that the costs of STH projects and NHS day care facilities are remarkably similar. This may be due to similar salary costs which account for the greatest part of local authority and NHS day care costs. Although a detailed breakdown of the project budgets is not