# The Benefits and Challenges of Interdisciplinary Collaborations in Arts and Health Practice


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## ABSTRACT

Arts and health[1] are international fields of practice with stakeholders from various disciplines. It is known that the UK has an established practice of collaboration in the form of interdisciplinary partnerships in arts and health (Clift et al., 2009, White, 2009), whereas in Denmark initiatives exist ad-hoc and there is no such established field (Jensen and Wille, 2015).

This thesis is a qualitative study investigating the interdisciplinary relationships between stakeholders engaged in arts and health practice in the UK and in Denmark. The identified stakeholders in the study are: health professionals, museum educators and mental health service users.

Semi-structured interviews were conducted with 36 participants including health professionals, museum educators and service users. Data were collected in Denmark and in the UK. A thematic approach was used to analyse the data and theoretical lenses of sociological theories of professions and institutional logics were employed to explore the findings.

There were two stages to the data collection in Denmark; the first was a small-scale pilot study where the findings identified that arts engagement have health and wellbeing benefits for mental health service users. These benefits are perceived to include empowerment and meaning in life, which are two of the core principles of recovery; arts engagement can therefore be a useful tool in recovery and although this was a small-scale pilot study, the findings are not dissimilar to findings from other studies examining this issue. However, the


[1] Arts and health is to be understood to cover arts and cultural activities that are focused on some level of health and wellbeing outcomes for the participants.

pilot study also highlighted some further issues with the interaction between museum educators and service users that had unintended negative effects.

The larger scale study was then conducted in Denmark to explore the interaction between service users and museum educators. The findings illustrate, similarly to the pilot study, that arts engagement is perceived to be beneficial for service users. The findings also show that the experience of visiting a museum was not always positive and depended upon the interaction with the museum educators.

The service users identified points about the museum educators as a professional group which gave the idea that if museums in Denmark want to engage positively with people with mental health problems, then the training of staff and the improvement of institutional approaches to support working with vulnerable people are essential.

In order to further understand and explore the professionals in arts and health practice and what contributes to an effective partnership, the next part of the study took place in the more established arts and health field in the UK. In this way, this part of the study was conducted in the UK and was chosen in order to explore a setting with health professionals and museum educators working together in an interdisciplinary collaboration. This stage of the study reveals that interdisciplinary work in arts and health is complex, given the different disciplines and institutions involved. However, findings throughout the study (in Denmark and in the UK) illustrate that competing institutional logics play a vital and ambiguous part in the work of the professions involved in arts and health practice and that this presents a challenge for interdisciplinary working in the field.

The UK part of the study also illustrates that aspects of practice, such as risk management, are approached from different perspectives depending on the profession involved and are interpreted in various ways according to the disciplinary background. Working in unfamiliar settings creates professional vulnerability and ambiguity and the interdisciplinary setting

illustrates that professionals have territories that they want to uphold. However, the study also shows that there is an agreement among the professionals that an interdisciplinary approach to the field is necessary.

The conclusion of the study has, from the perspectives of the participants, served to highlight some benefits and challenges in the interdisciplinary field of arts and health practice. The study suggests that an awareness of the existing complexities of logics, a pragmatic framework in which multiple and competing logics can co-exist and that recognising the differences between disciplines and institutions could benefit practice in the field.

In addition, offering various arts activities in diverse health settings and for different health issues, including health promotion, treatments and recovery, can strengthen a patient-centred approach of healthcare that both the UK and Denmark strive to achieve. Furthermore, the study makes recommendations for the field of practice.

## PUBLICATIONS ASSOCIATED WITH THIS THESIS

**Publications (peer reviewed)**

Jensen, A, Stickley, T, Torrisen, W & Stigmar, K. (2016) ***Arts on prescription in Scandinavia: a review of current practice and future possibilities.*** Perspectives in Public Health.

Jensen, A, Stickley, T & Edgley, A. (2016) ***The perspectives of people who use mental health services engaging with arts and cultural activities***. Journal of Mental Health and Social Inclusion, 20:3, 180-186.

Jensen, A. & Wille, G. (2015) ***A Danish perspective of culture and health – towards an interdisciplinary approach.*** Journal of Applied Arts and Health, 6:2, 129-138.

Jensen, A. (2014) ***Considering 'first, do no harm' in Arts and Health Practice***. Journal of Applied Arts and Health, 5:3, 331-339.

Jensen, A. (2014) ***Kunstneriske aktiviteter fremmer sundheden.*** Ugeskrift for læger, 176:VO8130521.

**Other publications**

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Jensen, A. (2016) ***Kunst og kultur som sundhedsfremme blandt ældre***. Årsberetning ÆldreForum, side 7- 12.

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## GLOSSARY OF TERMS USED

**ABBREVIATIONS**

| | |
|---|---|
| ACE | Arts Council England |
| ACI | Arts Council Ireland |
| AHRC | Arts and Humanities Research Council |
| AoP | Arts on Prescription |
| APPG | All Party Parliamentary Group |
| BMA | British Medical Association |
| BSL | British Sign Language |
| CAG | Clinical Academic Group |
| CMHT | Community Mental Health Teams |
| DH | Department of Health |
| DK | Denmark |
| ESRC | Economic and Social Research Council |
| GP | General Practitioner |
| HCPC | Health and Care Professions Council |
| HKI | Hans Knudsen Instituttet |
| ICOM | International Council of Museums |
| JOAP | Journeys of Appreciation Programme |
| NEF | New Economic Foundation |
| NHS | National Health Service |
| ONS | Office of National Statistics |
| OT | Occupational therapist |
| ONS | Office for National Statistics |
| PhD | Philosophiae Doctor |
| PHE | Public Health England |
| UK | United Kingdom |
| RCT | Randomised Controlled Trail |

| | |
|---|---|
| R&D | Research and Development |
| RSPH | Royal Society of Public Health |
| RCMG | Research Centre for Museum and Galleries (Leicester University) |
| SIG | Special Interest Group |
| SLaM | South London and Maudsley NHS Trust |
| WHO | World Health Organization |

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# CHAPTER ONE: Introduction

## 1.1 Introduction

My work in the UK with mental health service users started during my BA-degree in the late 1990s, when I studied Arts in the Community combined with Art History. As part of my course it was obligatory to do a placement. I found a placement in a National Health Service (NHS) Mental Health Centre in North London which included arts and creative activities among the services provided to the service users.

Developing projects in this context of arts and health helped me make sense of why I was doing my BA and I began to understand the value of engaging in arts activities for mental health service users. The value went beyond merely being involved in an activity, although the benefits varied: for some it was the social element only, for others it was the creative process itself, or gaining a new means of communication, while for others it helped in developing a new identity. I experienced how some individuals spent all day, every day in the art room which added to the meaning of their lives. Being able to contribute to this positive development and witnessing the service users' improved wellbeing became a driving force in my work and the beginning of many years of working in arts and health settings. I later wrote my MA dissertation on community arts and their influence on the mental health benefits of individuals and communities. However, at that time there was very little literature about the subject and it was mainly 'grey literature'.

Simultaneously, my interest in Outsider Art developed. Outsider Art is defined as spontaneous expression that is raw and untrained (Cardinal, 1972). This expression has had little external influence and can be considered a manifestation of work coming from the soul. Outsider Art is the chaos of raw thoughts that are transferred, uncensored, into visual imagery or made into sculptural objects (Rhodes, 2000). The work of Outsider artist Carlo Zinelli (1916-1974) illustrates the power of this artistic method, giving meaning to practice. In 1957, after

spending almost a decade in total isolation in a psychiatric hospital in Verona, Zinelli was introduced to painting. Traumatised and muted by his experience as a volunteer in the Spanish Civil War (1936-1939), he created narratives about his experiences of the war as well as his childhood. He represents how an individual placed in an asylum developed a language through the use of art which created a channel for his feelings and thoughts. Like other Outsider artists such as Adolf Wölfi (1864-1930), Henry Darger (1892-1973), Scottie Wilson (1888-1972) and Madge Gill (1882-1961), who also created large volumes of work. Zinelli was captured by his work and he drew for eight hours a day creating over 3,000 artworks in his lifetime (Azzola, 1999). I have seen similar tendencies of the need to create large volumes of work and the benefits of the use of visual arts as way of channeling an otherwise unspoken state of mind through my time working with mental health service users.

As well as working with mental health service users I have fulfilled the roles of project manager, fundraiser and researcher for various organisations; the focus was always on the use of arts/cultural activities as a tool for improving mental health wellbeing and inclusion. This work also involved collaborations with social care, health professionals and arts professionals. While some of the interdisciplinary collaborations worked better than others, a focus on positive outcomes for the service users was my main motivation in continuing to work in the arts and health field. To develop my work at the Mental Health Centre in London I had employed freelance artists to collaborate on specific projects where their knowledge and skills of specific art forms and techniques were needed. Some of those projects worked better than others, depending on the artist and the service users involved; however, with the light of hindsight it becomes clear that some of the problems that occurred were probably because the artists did not have enough mental health awareness training. The experience encouraged me to manage a partnership between Tate Modern, Shape Arts and the City Lit Institute, where deaf artists trained to become British Sign Language (BSL) guides at museums in London. This collaboration between education, health and the arts sector was challenging as it brought

together a variety of professions and disciplines that had not worked together before. My work evolved in complexity and scope and I later managed an art gallery for mental health service users, working in partnership with 20 other organisations, charities and institutions. The collaborations with the partners comprised different agendas and approaches of the institutions as well as expectations from the service users and my role was often more focused on addressing those aspects than on the development of the profile of the art work produced by service users. Additionally, I also managed the UK part of an EU-project which entailed the collaboration of art and health organisations in the UK, Germany and Denmark in developing an arts project aimed at improving inclusion and wellbeing for service users with mental health and physical health problems.

The experience and knowledge I have gained in arts and health collaborations has been focused on the management of projects with tasks including fundraising, administration and strategy. Those tasks, such as the demands of the stakeholders including the institutions, the service users, the partners in the collaboration, the funding bodies and so on, necessitated an emphasis on delivery and never allowed adequate time to explore or evaluate projects in detail. My frustration at not being able to gain a better and deeper understanding of the layers within the interdisciplinary collaborations is the main motivating factor for beginning this PhD.

Other motivating factors are the need to create a dialogue about the challenges of interdisciplinary work in arts and health and to bring a focus onto the untapped potentials of this field, for which there is no tradition in Denmark.

I returned to Denmark in 2011, after two decades of working abroad and discovered that the field of arts and health was not well established in the country; there were no traditions for using arts in the health systems or their application for health benefits[2]. I decided to make a

[2] Although the use of music therapy available in Denmark and Aalborg University offer Master and Doctoral Studies in music therapy it is not mainstream practice.

contribution towards this dialogue so that this development could begin. Although my professional experience had primarily focused on arts and mental health and arts in a community context, I became interested in the broader field of practice, research and policy across the arts and health disciplines.

However, I soon realised that I did not know how to penetrate the Danish system or how to identify the gatekeepers, let alone how to create a dialogue with them. My strategy of talking to professionals in the arts sector about potential projects was insufficient and I needed to develop a different approach. In order for me to transfer my knowledge and experiences from a UK to a Danish context I began the process of applying for funding for a PhD, as well as convincing various stakeholders about the benefits of the interdisciplinary field of arts and health. I wanted to combine my working experience and knowledge from the UK with academic knowledge and find a way to make this useful in a Danish context. My conviction and motivation for pursuing this study was strong and I made the choice to start the study without having the finance in place, giving me a fundraising task while studying.

Before venturing onto the PhD journey, I considered my identity in the work and I have continued this throughout. In addition, I have questioned my personal agendas. These are difficult questions with multiple answers; however, the question about my personal agenda can partly be answered by my conviction that using arts in health and community settings has the potential to benefit the health and wellbeing of individuals. I want to use my professional experiences to bring arts and health practice into a Danish context. This leads to the identity in my work which is formed by my values and experiences. Thus, in this study I have various identities: I am partly the storyteller, partly the researcher, partly my own history and partly the future. The storyteller conveys the story of the arts and health and presents the stakeholders; the researcher gathers data, examines, analyses and theorises in order to understand; my own history is the underpinning foundation of everything; and the purpose of the study is to make a contribution to the field of interdisciplinary work of arts and health.

I believe that the benefits of arts engagement can be found through the social relations, the act of doing and making and by getting in touch with a part of the creative self. I consider that providing a space for people to engage in arts activities, with no other purpose other than to participate in a creative activity is a significant factor in the health and wellbeing benefits that this study is also considering. These are my values and they are the motivating energy and the foundation for choosing my methodologies. In this way, my values are associated with motives, intentions, feelings, passions and interests. Without values the world would be cold, without feelings and with no incitement for development and making changes in organisations or in other social practice (Jørgensen, 2006). It is through values that contexts such as right or wrong, good or bad, appropriate or inappropriate are understood. Values are, however, also problematic as they are also unconscious and silent and can be found everywhere. They are communicated through the techniques and instruments that we use and through our language. As well as being productive and a tool for development, values can also be restricting as they are embedded in social interaction (Jørgensen, 2006) and this study is invariably value-based. The focus in my work in arts and health has been on the process of doing and making and is the participatory aspect of projects which differs from that of an art therapy approach which is offered in a clinical framework and is focused on therapeutic techniques.

My drive is an aspiration to produce knowledge that can benefit the health and wellbeing of individuals and communities and will be useful, particularly to the health sector, but also to the cultural sector wanting to engage with participants with health issues. It is based on a belief that everyone has something to contribute and that this cannot be assessed by a value judgment or an aesthetic judgment alone. No individual has more value than another and living in a society that is organised with the focus on valuing a contribution that is in monetary form makes it difficult to take part if your contribution cannot easily be valued through an Excel spreadsheet. Knowledge is permeated with values, passions and intentions and can therefore not be value-free. Foucault (1980) states that in the production of knowledge there is

violence, blood, conflicts and dominance, which I understand to be about the creation of knowledge boundaries. This knowledge production becomes an act of power and can contribute to shaping how things are seen; in this way knowledge has power and the knowledge that I strive to create is therefore not neutral and comes with a certain amount of responsibility to society. This study is my attempt to illustrate and create knowledge about arts participation as an instrument for delivering health and wellbeing benefits, specifically in mental health recovery. To do so, it is necessary to get under the layers of the interdisciplinary practice to begin to understand what happens between the stakeholders – the professions involved and the services users.

Everyone has a value-ridden story that can make a contribution and find their own unique way towards meaning for them. Carlo Zinelli's art practice is a testimony to the impact that art activity can have on an individual. There are many more examples of how arts activities can be used to find meaning, both for empowerment and to improve mental wellbeing. Zinelli is also an example of a mental health service user who had been treated by a health system whose focus was more on pacifying the service user than supporting their recovery though making sense of their own mental health and supporting their ability to live with mental health difficulties. However, regardless of this he later found his expression through art practice and was given a place to produce and develop his work. Some individuals who participate in arts and health projects will, like Zinelli, find their own expression and will experience increased wellbeing and better mental health.

My paradigm for this study is framed by a qualitative approach, used for constructing knowledge from interviews with those working within this field about their interdisciplinary work in arts and health as well as users of their services. Being able to contribute to the health and wellbeing of individuals and communities is a driving force in my work. My experience in arts and health has consolidated my ontological position which takes as a starting point the idea that people's experiences of social practices can tell us something about the way in which

social practices can both constrain and free humans to make changes and interact with the world around them. In order to make changes an understanding of the rich texture of the human condition is significant. Through the social constructions that I explore, the interaction between the health professionals, the museum educators and the service users will help me understand both the challenges and the benefits in arts and health collaborations.

## 1.2 The political framework of arts and health practice

Arts and health is the generic term that embraces a range of art practices primarily within social care, healthcare and community settings bringing the skills and knowledge of both arts and health professionals together. It aims to promote health and wellbeing by improving quality of life and access to arts/cultural activities in social care, healthcare and community settings. Arts and health initiatives may range from one-off events to long term programmes and strive to reflect the equal partnership of skills necessary to ensure good practice (ACI, 2010).

The field of arts and health practices has developed over the past 30 years in the UK (RSPH, 2013). In the last 15 years, the evidence-based effectiveness for arts and health interventions has grown rapidly and has involved the health sector, the cultural sector, the voluntary sector and commitment from academic departments A succession of UK government reports acknowledges the relationship between social circumstances and health and mental health (Marmot, 2010, DH, 2006, Social Exclusion Unit, 2004, Ashton and Seymour, 1988).

The Royal Society for Public Health (RSPH) has been a vehicle in support of this field with, among other things, its publication: *Arts, Health and Wellbeing: Beyond the Millennium: How far have we come in 15 years?* Summarising the achievements in the field, as well as organising the Arts and Health awards, the RSPH drives a campaign for creative arts to gain an equal footing with mental and physical health in health policy commitment (RSPH, 2013).

The RSPH is currently hosting the International Special Interest Group (SIG), which is a membership group comprising stakeholders for the arts and health field.

One of the key stages of the development of the arts and health field that had significant political impact was the Windsor Conferences in 1998 and 1999 organised by the Nuffield Trust. The conferences explored the potential of the arts in contributing to healthcare and therapy, health professional training, hospital design, and the promotion of healthy communities (Clift, 2005). Another significant stage was the development of The National Network for the Arts and Health which was founded in 2000; prior to this date there was no national focal point for those involved in the arts and health (Dose, 2006).

Furthermore, a significant stage of development can be traced back to a seminar in 2003 organised by the Institute for Public Policy Research (IPPR) and hosted by the Department for Culture, Media and Sport (DCMS) which brought together Estelle Morris, Minister for the Arts and Rosie Winterton, Minister of State for the Department of Health. The arts and mental health social inclusion agenda was given a mandate for action on that day (Stickley, 2007).

In 2006 the Department of Health's Review on Arts and Health Working Group examined the role that the arts can play in health; one key finding illustrated that arts and health programmes have measurable benefits that could enable The department of Health (DH) and National Health Service (NHS) to contributing to wider Government health initiatives. Another key finding in the review was that the DH had a leadership role in developing and creating an environment for arts and health practice (DH, 2006).

The publication *Arts, Health and Well-being* was introduced as a framework rather than a strategy (ACE, 2007) and coincided with the DH publication that endorsed the arts in the health agenda.

The Arts Council England (ACE) has had arts and health on the agenda for over a decade that commenced with Peter Hewitt, being appointed as the Chief Executive in 1998. Hewitt was

responsible for the publication of *A prospectus for arts and health* in collaboration with the Health Department (ACE, 2007). The Arts Council's commitment to arts and health was instrumental in the development of the area, making funding available for arts and health initiatives and publications of research (Mowlah et al., 2014, Ings et al., 2012, Staricoff, 2004) as well as political lobbying.

However, the global financial crisis of 2008 subsequently led to austerity measures and we have seen reductions in public health grants and arts and cultural budget cuts, which has left support and funding of arts and health somewhat in jeopardy. With the change of the UK Government in 2010 there was a shift away from the social inclusion agenda towards a focus on wellbeing. This shift in focus meant that arts and health projects that gained funding from social inclusion grants were no longer able to access such streams of funding.

With this new focus, a drive to measure and improve people's wellbeing and health emerged and wellbeing boards were established around the UK as an attempt to recognise the wider determinates of health on health and wellbeing. Funding for arts and health practice was subsequently reduced in the light of government imposed austerity measures on all government departments.

Several regional and national networks in arts and health are active and play a big part in disseminating information, sharing research results and promoting funding opportunities. These networks host events, seminars and conferences. Members of these networks are organisations and practitioners from the health and the arts sectors as well as academics. In 2012, the National Alliance for Art, Health and Wellbeing was launched to provide a focused voice to articulate the role creativity can play in health and wellbeing and it was this Alliance that set up the All Parliament Party Group for Arts, Health and Wellbeing (APPG).

From an academic perspective, several universities have centres dedicated to research in the arts and health field: *Art for Health* at Manchester Metropolitan University specialises in

research, advocacy and development; at the department for *Medical Humanities* at Durham University an emerging field of enquiry within humanities and social science exploring the human experiences of medicine that incorporates arts and health is addressed; at Canterbury Christchurch University, the *Sidney Haan Centre* researches the value of arts and music for wellbeing and health; the University of Nottingham led on a series of arts and health seminars from 2012-2014, funded by the Economic and Social Research Council (ESRC) (Stickley et al., 2016); at the University of Winchester, the *Centre for Art as Wellbeing* explores the role of the arts on wellbeing through research. During the same period the Arts & Humanities Research Council (AHRC) also introduced the Cultural Value Project, examining why arts and culture matter to society (Crossick and Kaszynska, 2016). This coincided with the Arts and Humanities Research Council (AHRC) programme "Connected Communities" (AHRC, 2016) that funded six PhD projects directly related to arts and creative practice (successful grant holders: Crawford, Daykin, Froggett, Wakeford, Williams and Windle).

The voluntary sector also plays a contributing factor to the field and projects and programmes have been delivered by charities, both nationally and regionally, such as MIND, the Mental Health Foundation, Arts 4 Dementia, SANE, and Shape Arts, as well as smaller local charities that recognise the links between arts participation, health and wellbeing. Such work involves liaising with service users with health issues using cultural and creative activity to improve wellbeing.

With the development of the All Party Parliamentary Group for Arts, Health and Wellbeing (APPG), launched in 2014, a forum for stakeholders and members of parliament who meet regularly to discuss relevant developments in policy priorities, the field benefits from further political support. The APPG is working on an Arts, Health and Wellbeing Inquiry exploring themes in the field and identifying policy objectives to make recommendations for future policies. While taking into account ongoing developments at Public Health England (PHE), including the evaluation framework for arts and public health (Daykin with Joss, 2016), the

Inquiry is exploring a coherent framework for commissioning, delivering and evaluating of arts interventions that contributes to specific NHS and PHE priorities within recognised care pathways. The Inquiry is due to be published and presented in 2017.

Although the political support and commitment for the field has grown within recent years, the UK lacks a national framework for delivering arts and health initiatives. In Australia, for example, a National Arts and Health Framework was developed to enhance the profile of arts and health and to promote greater integration of arts and health practice and approaches. A ministerial working group was tasked with developing the framework which was endorsed in November 2013 by Ministers of Health and Ministers of the Arts in every Australian state and territory (Davies et al., 2016).

In Denmark there is no political framework for developing art and health practice and the initiatives that exist are ad-hoc and not considered to be part of the mainstream political agenda. However, the government has recently funded a three-year pilot project for Arts on Prescription (AoP), managed by the Danish Health Agency. Nevertheless, the funding comes from a particular source of funding supporting initiatives for marginalised groups and often projects that are supported through this funding structure do not have a life beyond the funding period. Developing a field for arts and health in Denmark requires more than pilot projects and restricted funding resources. It also requires political support, institutional awareness of the potentials and allocated funds for project delivery and allied research.

This study explores some of the challenges and benefits from arts and health practice. I envisage that some of the findings can support the development of the field in Denmark by providing data relevant for political lobbying, creating arguments for supporting this field of practice and research, and in doing so, helping to create a robust yet flexible platform from which practitioners can work.

*The systematic neglect of culture in health is the single biggest barrier to advancing the highest attainable standard of health worldwide (Napier el al. 2014).*

## 1.3 The focus of study

Given the mounting interest and evidence for arts and health, and yet accepting that these practices are relatively novel and without a long history, the question of how they work becomes of interest. The purpose of this study therefore is to explore and gain a better understanding of the relationship between the stakeholders in arts and health collaborations in order to make the field of practice more transparent.

Studies across an international arena suggest that engagement in arts and cultural activities can have a significant positive effect for people with a range of mental health and physical health problems and is widely used in a variety of settings in the UK, Ireland, Australia, Canada and the USA (ACI, 2010, Cox et al., 2010, Wreford, 2010, Sonke et al., 2009, Wikoff, 2004). Over the past two decades, positive outcomes have supported developing trends towards using arts and culture in the wider health sector. In the countries mentioned, it is now commonplace to find art programmes both within hospital settings and embedded into other healthcare settings such as day-care centres, outpatients, hospices and homes for the elderly and community public health promotion (Clift and Camic, 2016, RSPH, 2013, Stickley and Hui, 2012, ACI, 2010, Cox et al., 2010, Wreford, 2010, Sonke et al., 2009, Wikoff, 2004). In 2004, almost half of US hospitals had established arts programmes (Wikoff, 2004) and in the UK a large

proportion of hospitals have ad-hoc art activities as well as art strategies (Art for Health, 2011). Moreover, numerous studies show that supplementing medicine with art and cultural activity can improve the health and wellbeing of people with mental and/or physical health problems (Sigurdson, 2015, Stickley and Hui, 2012, White, 2009, Daykin et al., 2007, Spandler et al., 2007, Camic, 1999) emphasising a growing body of evidence supporting the contribution of arts to healthcare. And yet this practice remains on the 'fringe' in relation to the bio-medical model of treatment. The focus of this study is on the relationships between the stakeholders in the field.

I approached this study with the aim of exploring the roles that professions play in arts and health collaborations. This aim emerged as a result of reflecting on my own experience of working in the arts and health field and how my own role and those of other professionals have contributed positively or negatively to the delivery of projects. I acknowledged the range of different professionals and the significance of the professions represented in the field as well as my understanding of the literature from the field, which led to this study being organised around the research question:

*How do collaborations in arts and health practice work?*

Objectives:

- To explore the relationship between stakeholders in arts and health projects (health professionals, museum educators and mental health service users);
- To examine the professional groups and practices involved;
- To study the interdisciplinary work involved.

Having presented my background and motivation for pursuing this study as well as the overall research question, I present the structure of the thesis below.

## 1.4 Thesis structure

I present this thesis as a series of chapters. Chapter one provides the introduction to the study and the overall research question. In chapter two, I contextualise the study by presenting the literature review, which includes aspects of the field of arts and health and the growing importance of being able to provide evidence that shows cost effective benefits. I also consider the arts in terms of its use in society. I focus on the concept of health and how it means different things in different contexts and health inequalities are highlighted through the literature. As it is difficult to discuss health without considering wellbeing as a closely linked concept, I explore the literature for meanings of wellbeing. The chapter also considers museums in terms of places for wellbeing and how mental health, like the concept of health, is considered to be a contested concept. Through the literature review, I also explore literature that considers how community arts and Arts on Prescription (AoP)[3] programmes can contribute to the health and wellbeing of individuals and communities. In addition, the chapter considers the interdisciplinary working in arts and health and considers various projects and some issues in interdisciplinary practice in the field. Finally, having reviewed the literature, the chapter presents the rationale for the study.

Chapter three provides the underpinning philosophical considerations for the study. The theories introduced are considered to guide the inquiry by interrogating the practice and these are the theories of professions and theories of institutions and institutional logics. After conducting the data collection, I recognised a variety of possible theories, however, as one part of my study considers different professions working together, I decided that the theory of professions, (Abbott, 1988) would be most useful in making sense of those findings. I was also alert to the fact that more than one institution was involved in my study, and therefore I turned to the sociological theories of institutional logics (Thornton et al., 2012). However, I was also

[3] Arts on prescription (AoP) is a feature of the disconnected social prescribing programmes which have been delivered in different forms across the UK over the past 20 years.

interested in what Foucault (1975) could add to the study in terms of his thoughts on institutions and how these theories could be effective in the light of my data.

In chapter four, I introduce the methodology including my position in the study and why I have chosen a qualitative approach. I describe the methodological framework for the small-scale pilot study that I conducted in Denmark that included six participants. I describe the methods used for gathering data in Denmark and in the UK, including the recruitment of participants, ethics approval, method of conducting the interviews and I consider the role of the analyst. The instrument for analysis is introduced and I explain step-by-step, how I undertook the data analysis and which decisions I made during the process.

In chapter five, the three themes of the findings from the small-scale pilot study are presented. The chapter also provides the findings from the 30 participants from Denmark and from the UK. These are presented in five overarching themes: *1. Disconnecting dialogues between service users and museum educators; 2. Being self-experts in arts and health; 3.A risky business for professionals in arts and health; 4. Competing logics in arts and health practice; 5. Hierarchy of experts in arts and health collaborations.* The themes present the health professionals' and museum educators' experiences of interdisciplinary delivery in arts and health and service users' experiences of arts engagement.

Chapter six provides the discussion of the findings and in this section, I draw on the sociological theories of professions and institutional logics theories as well as relevant literature from the field of arts, culture and health in order to make sense of the data that were collected.

Finally, I present the closing chapter seven, which gives an overview of the study, concluding the thoughts drawn from the key themes identified and the implications for arts and health practice. I also reflect on my personal journey, identify the strengths and limitations of the study and make suggestions for further research.

Having provided an overview of the structure involved in the thesis, chapter two presents a review of the literature that provides a background to this study and informs my rationale for the study.

# CHAPTER TWO: Literature Review

## 2.1 Introduction

The field of arts and health practice encompasses different disciplines from across the arts and health professions. A range of literature is significant in understanding the concept of professions in interdisciplinary collaborations in arts and health and exploring the relationship between the health professionals, the arts professionals (which in this study are museum educators) and the service users (which in this study are individuals using mental health services). To address the aim of this study, the focus of the review is on the concepts that are central to this study including arts, health, wellbeing, mental health and 'interdisciplinarity', aiming to contextualise the field considering background, concepts and definitions that are carried forward in this study. The review considers the relationship between arts and health and how it can impact on the health and wellbeing of service users, health staff and on communities. Furthermore, in order to provide a comprehensive backdrop for the study, the review aims to explore some of the challenges faced by the arts and health field.

The review will examine themes and critically analyse the literature of each concept, as well as consider ways in which they might interconnect and, although the literature considers these concepts in a variety of contexts, this review will focus on their application to the collaborative nature of arts and health with a primary focus on mental health.

The literature in this section presents the themes in different contexts and will primarily focus on their application to arts and health within a wider socio-political context, as the interdisciplinary work in arts and health is to be understood in relation to health and wellbeing. I seek to answer questions about the challenges and benefits of arts engagement for health and wellbeing in a wider context, in order to provide a background for where I position my study.

I have adapted a critical review approach to the literature review as it is "… *concerned with normative questions which explicitly concern themselves with evaluative judgments about how things should be to further support our understanding of how things are*." (Edgley et al., 2014: 5). Through this approach I aim to produce knowledge that can create a level of change as the methodology is designed to keep options open and thereby possibilities (Grant and Booth, 2009). Without strict inclusion or exclusion criteria it is possible to explore outside literature on the subject and to bring novel and critical perspectives which I seek to do in this literature review.

## 2.2 Arts and health

The arts and health literature presents a broad variety of case studies, research, reviews and books. This literature is primarily associated with research, policy and practice illustrating the benefits of arts engagement for the health and wellbeing of a wide variety of participants. The reviewed literature covers a spectrum of the past 20 years in arts and health, starting with Matarasso's (1997) report on arts participation and the community, followed by Staricoff 's (2004) review on medical literature on arts and health; both publications are among the first significant contributions to the field. Other arts and health literature contributions are discussed in terms of their role in arts and health discourses and how they can make a contribution to the health and wellbeing of individuals and communities. A body of literature from across the world has been published in English language journals such as *Arts and Health: An International Journal for Research, Policy and Practice* and *Applied Arts and Health* and the book *Oxford Textbook of Creative Arts, Health and Wellbeing* (2016), providing the field with perspectives from around the world sharing different methods, policies and practices. Evidence of these contributions illustrates a growing interest in the arts and health fields from different national and international perspectives and is discussed below.

The arts and health literature includes areas of practice, policy and research relating to hospitals, health settings and communities with the focus on how the arts can have health and wellbeing benefits. Art forms in arts and health include: dance, music, performance arts, visual arts, literature and so on in both practice and research-related publications. The literature in arts and health includes peer reviewed articles, reports, reviews, 'grey literature' and books that have argued and provided evidence (qualitative and quantitative) for the impact that engaging in arts activities has on the health and wellbeing of individuals and communities. The reviews are mainly conducted by academic researchers, while reports and other 'grey literature' are often written by staff running the various projects and occasionally by professional evaluators. The research-related publications cover: art dance with Parkinson's patients (Broderick, 2011, Burns et al., 2011); arts activities for people with dementia (ACE, 2014, Fujiwara et al., 2014); music and song for wellbeing (Stigmar et al., 2016, Leicht, 2014, Napier et al., 2014); community arts for wellbeing (Jensen, 2013, Ings et al., 2012, White, 2009, Putland, 2008, Matarasso, 1997); mental health service users engaging in arts (Jensen et al., 2016, Stacey and Stickley, 2010, Hackney and Earhart, 2009); arts in healthcare (Hallqvist, 2015, Jensen and Wille, 2015, Sonke et al., 2009); arts in hospital settings (de Dreu et al., 2015, Vaag et al., 2013); art therapies (Zeilig et al., 2014, Lounsbury and Boxenbaum, 2013); public health (Cuypers et al., 2011, Warne and McAndrew, 2009); arts activities for older people (Daykin and Joss, 2016, Barry et al., 2008); roles of arts coordinators in hospitals (Aston, 2011, Moss and O'Neill, 2009, Parsons, 2007); and the use of theatre (Hamilton et al., 2015) to specifically focus on qualitative research in arts and health (Stickley, 2012b, Cohen et al., 2006). Such a variety of literature, illustrating different art forms used in different settings, verifies the growing interest and practice in the field and how the benefits of arts and health have emerged.

In 1997, the independent research organisation, Comedia, published the report *Use or Ornament? The Social Impact of Participation in the Arts* by François Matarasso (Matarasso,

1997). While earlier publications on the social impact of the arts had attracted relatively little attention, this publication played an important role in establishing a near-consensus among cultural policy-makers on the beneficial social impact of arts engagement in the UK and the publication was cited widely among culture- and policy-makers (Merli, 2002). It was the first major UK study of its kind, which included the mapping of personal development, community empowerment and social cohesion and developing the multifaceted theme of the social impact of the arts from a perspective linked to health and wellbeing and the contribution to the social fabric of society. Massarato draws attention to the impact that the arts have on health and wellbeing, contributing to the following: "positive feeling; effective means to health education, contribution to a relaxed environment in health centres; improve the quality of life for individuals with poor health; and a foundation for enjoyment" (1997: 68). Massarato (1997) illustrates that arts can have a positive impact on a variety of health- related issues which all are part of improving quality of life and wellbeing in general.

The principal findings in the publication are illustrated as personal development for participating individuals; social cohesion; community empowerment and self-determination; local image and identity; imagination and vision wellbeing (1997: vi-viii). Other findings included discussions about social policy and the economic impacts of arts practice in the community.

The report was later met with criticism, mainly for its methodological approaches (Belfiore, 2002, Merli, 2002). The cases and projects used in the report as evidence to support the impact appear randomly chosen and although the examples are supported by project evaluations, there is no clear indication about why these are selected, nor any explanation of the evaluation methods applied. Not providing a methodological account makes it difficult to determine rigour and without a selection criterion, clarification of why some projects are selected and some are left out does not exist. Furthermore, in the discussion of the projects and social impacts, Matarasso provides a somewhat limited account of arts and health projects

and their impacts and makes broad claims such as: “It [arts] produces social change which can be seen, evaluated and broadly planned” and, “It [arts] brings benefits in other areas such as environmental renewal and health promotion…” (1997: v), giving inadequate references to other literature and research to support his assertions.

In contrast to what was considered by some to be an unfocused publication which lacked rigour, the Staricoff systematic approach from 2004 provided a thorough and systematic review of the literature on arts in health; up to this point, the arts and health had lacked systematic evidence to support the clinical benefits. The review was commissioned by the Arts Council and covers publications from the period 1990 to 2004. Out of the 385 references to the literature, the key findings were themed into five main categories which are: *i)* the effect of arts on clinical outcomes; *ii)* the effect of arts and humanities on staff outcomes; *iii)* the effect of the arts and humanities on the education and training of practitioners; *iv)* the effect of the arts in mental healthcare; and *v)* the effect of different art forms and the mechanisms involved in the perception and processing of art (2004: 6-9). The selection criteria for the reviewed literature included RCTs and non-RCTs, peer reviewed papers or papers and studies that employed a ‘before and after’ method of analysis.

Some of the clinical outcomes illustrated that visual arts and music can reduce anxiety and depression in cancer care, that music is beneficial in pain management, and that the use of music in neonatal intensive care significantly reduces the length of stay in hospital. The review also analysed several studies relating to job satisfaction, which illustrates that the use of the arts in medical training and nursing improved problem-solving abilities in work-related situations and in communication with patients. Such findings are consistent with the findings from other studies using body painting and poetry in medical education, which also confirmed that students’ communication abilities improved. Professor John McLachlan, set out to explore the value of engaging in arts for students in medical education and in 2005, he led a programme of arts in the medical curriculum at the University of Peninsula (Collett and

McLachlan, 2006). Various workshops offering poetry, life drawing, sculpture, photography and body painting were offered to the medical students. The findings from the programme suggested improved communication between doctors and patients, as well as increased skills of observation and the ability of the doctors to reflect more on their practice. The art workshops presented an emotional outlet for the medical students and participating in the life drawing workshops helped the students improve their knowledge of anatomy. The action of painting created memory and was a useful tool for the students, crossing back and forth between the arts and the science (Kreutz, 2016, Collett and McLachlan, 2006, Collett and McLachlan, 2005).

The use of arts in medical education shows that an introduction to the arts can increase awareness in dealing with illness and bereavement, and strengthens confidence among student nurses (Staricoff, 2004). Using the arts and humanities in medical education and nursing shows an increased capacity among students for comprehension of illness, suffering and critical analysis; this encourages health practitioners to act in a more thoughtful manner to the medical, ethical and social needs of patients. Furthermore, a mixed method study evaluated the impact of arts activities on the empathy of 161 medical students in Hong Kong and showed that arts workshops can play a promising a role in competing clinical training of medical students as they increase emotional awareness and self-understanding. The study concludes that, although the quantitative findings show little difference in levels of empathy, the qualitative results illustrate benefits including developing a better 'self', better patient understanding and considerations about the role of a doctor (Potash et al., 2014).

The review by Professor Rosalia Staricoff (2004) also draws attention to how arts and humanities can impact on staff satisfaction and possibly contribute to a reduced staff turnover. This concurs with findings from a Finnish study that illustrates that more frequent use of cultural activities improves engagement and wellbeing among the health staff (Tuisku et al., 2010). A quantitative study of nurses participating in silk painting workshops once a week for

10 weeks showed that in the intervention group (n~56), there was a tendency for the activity to have a positive impact on the nurses' general health and mental wellbeing; there was a reduction in stress and fatigue as well as a contribution to increased creativity and a sense of work community. In the control group there was no improvement. Furthermore, from the intervention group, 93% reported enjoyment and 75% of those aspired to continue with art activities in the future. The study suggests that arts activities can be used to promote wellbeing as a workplace intervention for nurses (Tuisku et al. 2010). This is relevant to the study in terms of illustrating the health and wellbeing benefits for health professionals to participate in arts activities.

These studies illustrate how participating in arts activities can be beneficial for health professionals and medical students. Not only do these studies create background literature for the health professionals involved in this study, but they also stress the various benefits that engagement in the arts can have on health professionals which they can use in their professional work. Understanding the benefits on a personal level might encourage further use of arts and creative engagement in their professional work with patients and services users.

In addition to participatory arts activities, the use of music in operating theatres creates a less stressful environment and listening to self-selected music increases the mental task performance of surgeons (Staricoff, 2004). The use of music has also been implemented in ambulance services in parts of Denmark to reduce stress levels for the medics and the patients en route to the hospital (Thorgaard, 2014). However, using arts in medical settings is not always positive. The findings from a study in the USA, measuring the effects of arts-in-medicine programming on the medical-surgical work environment, pointed towards a need for developing practice protocols and policies for artists, as it was shown that the arts programme caused negative distraction and stress for a small but relevant percentage of the medical staff. Such distraction considered to have the potential to threaten patients' safety (Sonke et al., 2015). This concurs with an Italian study which showed that 5 of 20 (25%) medical staff that

were interviewed found music to be a negative element, and one doctor noted that it disturbed concentration (Petri and Welch, 2012).

Using arts in health settings for health and wellbeing benefits shows recognition of the potential role that arts can play in health environments which can be beneficial for both staff and service users. However, the implementation of the specific arts forms in health settings are significant and continuing research is essential to establish how environments and health professionals can benefit from such applications.

The Staricoff (2004) review concluded that there was a lack of research on the contribution of the various art forms to healthcare. The review found that science and technology are getting closer to understanding the mechanism involved with "perception, processing and the emotional responses elicited by the arts" (2004:9). The review was updated in 2011 in collaboration with Professor Stephen Clift and renamed *Arts and Music in healthcare: An overview of the medical literature* because of the additional focus on music.

In an attempt to describe some of the different mechanisms and how the brain responds to listening to or engaging in performance, a review was conducted by the Danish neurologist and musician, Peter Vuust, with a psychologist colleague. Gebauer and Vuust (2014) set out to collect the evidence of whether music application could be useful for a range of physical and psychiatric disorders. The review *Music interventions in health care* (2014) acknowledges that in studies about the effect of music a wide range of research questions and methodologies are employed; out of the 1939 publications that were identified in a search, however, the authors claimed only to use literature where quality of empirical evidence were included. The review identifies a range of illnesses for which music invention has proved to have a positive impact, including cancer: patients' pain, anxiety and mood; stroke patients' motor control and speech recovery; people with dementia: improved effective social, cognitive and physiological symptoms; and patients with Parkinson's disease: improved

motor function, speech and emotional symptoms. Listening to music can also decrease stress and anxiety and can be reductive for cortisol levels, blood pressure and heart rate for individuals of all ages; in this way music can be used as a tool to improve the general public health. The review by Gebauer and Vuust (2014) provides an introduction to music intervention in healthcare, with details of specific studies that document the effect that music has on the brain and how that, in turn, is useful to improve a range of illnesses and disorders, adding to the wellbeing of patients.

The Staricoff (2004) review shows strong evidence of the impact that arts can offer in terms of approaches, management of patients and training and education of health practitioners and it "identifies the relative contribution of different art forms to the final aim of creating a therapeutic healthcare environment" (Staricoff, 2004: 47). Furthermore, the review highlights the ability of the arts and humanities to reduce medicine consumption, shorten the length of stay in hospital, improve mental healthcare and promote better doctor-patient relationships, providing evidence of efficacy for the arts in healthcare. Other published reviews that concern specific art forms, or are relevant for certain groups of patients or health interventions, have added to the volume of reviewed literature and efficacy for arts engagement impacting on health and wellbeing (public health, see: Clift et al. (2010), Stuckey and Nobel (2010); older people, see: Daykin and Joss (2016); Alzheimer's and dementia, see: Theorell and Ullén (2016); mental health, see: Secker et al. (2007b); arts-based methods in health research, see: Nenonena et al. (2014)).

Almost a decade after the Staricoff (2004) review, 2013 the Royal Society of Public Health (RSPH) published the report: *Arts, Health and Wellbeing Beyond the Millennium: How far have we come and where do we want to go?* This provides a helpful summary of the arts and health field for the past 15 years and is a beneficial reference to understand the historical developments in the UK. The publication covers the field from its background development and public health policy to evidence and different areas of the field including professional

education, arts in therapy and healthcare settings, arts in community development and health to health activities in museums and galleries.

This summary is interesting in relation to this study as the overview provided by RSPH illustrates how many aspects of arts and health are interlinked. This study is concerned with several of the areas that are highlighted in the overview, including museums and galleries for health promotion and the professional education of practitioners. Furthermore, the publication confronts the issue of how to develop the field with suggestions which include economic modelling in arts and health in order to address the value of arts and health in society (RSPH, 2013). The quest for economic evidence in art and health is discussed in the section 2.3 below.

Arts and health initiatives are found across the world and in recent years, numerous articles and research have surfaced in English language publications. The international perspectives of the arts and health field are covered in *Arts and Health: An International Journal for Research, Policy and Practice,* with publications including: *The state of the arts in the UK* (Clift et al., 2009), *The state of the arts and health in the USA* (Sonke et al., 2009), *The state of the arts and health in Canada* (Cox et al., 2010) and in Australia (Wreford, 2010). These articles map out an overview of the current state of arts and health in the respective countries, including various infrastructures at local, regional and national levels, giving funding structures, programmes and projects, policies and methodologies, and providing an insight into practice and policies in the Anglo-Saxon countries. An updated account of the developments over the past six to seven years in the respective countries would provide an interesting read. Understanding how political support and local and national strategies for arts and health initiatives, as well as results from research from across the world, would make a significant contribution to the arts and health literature; it could highlight some of the examples of good practice and methodologies and shed light on whether the problems and barriers in arts and

health are universal and how lessons can be learned on an international scale beyond this study.

An overview of cultural activities and public health research in Scandinavia (Norway and Sweden) was published in 2011 by Cuypers et al., but did not include Denmark. However, in a special issue of the *Journal of Applied Arts and Health,* with a focus on Scandinavia, studies from all three Scandinavian countries were included (Brodzinski and Torrissen, 2015). The special issue includes the contributing authors considering a Danish perspective on arts and health (Jensen and Wille, 2015); multidisciplinary perspectives from Sweden (Sigurdson, 2015); theatre and health in Norway (Torrissen, 2015); as well as notes from the field involving practice from a museum (Overgaard and Sørensen, 2015); music therapy with asylum seekers (Enge, 2015); and theatre work used in dementia (Hallqvist, 2015). These are examples of studies from Scandinavia illustrating the benefit of using arts activities with service users and illustrate the current interest in the arts and health field in Scandinavia.

*The Oxford Textbook of Creative Arts, Health and Wellbeing* also covers an international perspective with the focus on practice, policy and research, edited by Clift and Camic (2016). This offers a significant contribution to the arts and health literature, with projects presenting young and older participants, case studies, education, public health, research methods and covers contexts from Brazil to India; the textbook provides a prominent context for understanding the scope of the field.

The Oxford Textbook covers the areas of: *i)* creative arts and human health and wellbeing *ii)* national and international development in practice, *iii)* creative arts and public health across the life-course and *iv)* creative arts and public health in different settings; there are 39 contributions from authors from across the world. The book presents an international outlook on the arts and health field and presents a significant contribution to the evidence base with a broad range of practices, political contexts and evidence of benefits for participants. An

example of a contribution to the textbook is that of Belfiore (2016), who introduces the arts and healing and connects it back to the Ancient Greeks, whose poetry was linked to the process of healing and recuperation of health. Aristotle's attention to the healing power of poetry and theatre is found in his writings, where he presents the idea of catharsis as an effect of tragic theatre. With his writings, 'Poetics', Aristotle wanted to communicate the cultural values of poetry and theatre for education, ethical development and catharsis. Belfiore (2016) argues that the history of how the arts have therapeutic effects is rooted back in the primary writings of Western Culture in Homer's poems and in the writing of the Greek philosophers; evidence of this connection is also found in the ancient shamanic rituals. Such links are useful connections to establish historical links for the usage of the arts in health.

Some of the significant political discourses from arts and health literature attempt to understand how the practices can be understood. An example of such discourse is the distinction between arts therapy and arts practice[4]. In the article *Arts practices in unreasonable doubt? Reflections on understandings of arts practices in healthcare contexts*, in which Broderick (2011) suggests that clinical evidence-based evaluations are appropriate for art therapy but not for arts practice for health. She argues that using a clinical measuring tool in non-clinical settings is not an appropriate method to measure outcomes and does not capture the whole picture and different motivations are behind the art practice. For example, a service user comes to the art therapy for a specific reason or concern and the art therapist has access to the service user's medical records, whereas the artist is primarily concerned with the art work and the process of the artistic development commenting on aesthetics and methods. One of the key aspects of arts and health is having access to participatory arts where participants can

[4] Broderick (2011) uses the distinction between art therapies and arts practice in health as that clarified by the Arts Council of Ireland (2003ACI 2003. Arts & Health Handbook: practical guide. Dublin: Arts Council Ireland.: 113): "*From the perspective of a therapist, the intension is primarily therapeutic in that art is used as a means of communication and expression. Positive enjoyment of the arts is a bonus added to the value of their work. For artists, on the other hand, the primary intention is artistic and therapeutic effect seen as a bonus".* Broderick further clarifies that art therapies are *"therapeutic intervention informed by practice of psychology, psychotherapy and psychiatry*" (2011: 96) and the work is done with other clinical staff as part of patients' care plans.

engage with a creative process that is not embedded in clinical outcomes. Arts and health practice have often been confused with art therapy and although the process-based element of arts engagement have been described as being therapeutic (Jensen et al., 2016), it is important to make a distinction between the two approaches to practice. This study is not concerned with the arts therapy approach.

The discourses of art and health practices that concern practicing evidence-based medicine draw attention to the different ways of understanding health, which will be discussed further in the section with a focus on health. In the medical model there is focus on measuring methods that create evidence- based outcomes and this medical hegemony has already had an impact on how work with and health concepts are perceived (Jensen, 2010). As a consequence of the medical hegemony, there is a standard that requires evidence behind new health initiatives and the reasons behind such an approach are to ensure that activities and interventions provide best "value for money" (Dybbroe and Land, 2012: 15). The evidence has become a tool to ensure that resources are distributed and used in the best possible way in healthcare, as well as in other areas of public spending. The concept of evidence comes from the English doctor, Archie Cochrane, who in the 1970s laid the foundation for an increased interest in evidence. The purpose was to ensure documentation of the therapeutic effects in the health sector; however, Cochrane's intention was not to promote the results of controlled clinical trials as the only medical evidence (Jensen, 2004). The outcome of the interest in evidence has, as a result, ensured that not only are illness and treatment-orientated interventions evaluated for their therapeutic effects and economic efficacy, but such methods are also used in health promotion where it often does not make sense to measure, based on evidence-based methods (Dybbroe and Land, 2012).

Broderick (2011) attempts to divert attention from the dominant practice of evidence based-medicine to an approach that addresses the complexity of health in tandem with the social model of health and illness; this is to draw attention to the difference between the practice of

evidence-based medicine and experiential approaches, where the decision is made from the experience of the practitioner, based on the individual patient and pathology. Such an approach is challenging in a system where Randomized Controlled Trails (RCTs) are ranked high in the hierarchy of evidence-based medicine (Burns et al., 2011). However, RCTs are expensive, time consuming, show only one or very few variables and rarely reflect the total picture of patients' complicated health histories i.e. psychosocial aspects (Yitschaky et al. 2011).

An example where inappropriate evaluation methods are used is illustrated by an arts project in a hospital helping patients dealing with isolation. The patients in the Bone Marrow Transplant Unit were subjected to a RTC with the aim of establishing whether the artworks had impacted on the patients' recovery. However, the initial research design did not include an RTC approach, resulting in artwork that was not suitable for such an evaluation method (Broderick, 2011). This situation further highlights the pressure to be able to produce positive evidence-based clinical outcomes when working in arts and health.

For the purpose of understanding the backdrop to this study, the above examination has provided the specific distinction between arts practice in health settings and art therapy as well as the tension of using evidence-based approaches that are appropriate for clinical work and less for work in arts and health projects.

The drive for evidence-based medicine is linked to the discourse about economic evidence in the arts and health field, which I consider in the section below.

## 2.3 Economic evidence

In recent years, funding for arts and health projects has been linked to the ability to present economically viable arguments. In this section, I seek to introduce this aspect of arts and health as it provides part of the socio-political backdrop for this study.

Like any other field of practice that relies mainly on public resources, there is pressure on arts and health to demonstrate the economic benefits of the project. However, literature evidencing these benefits is limited, primarily because it is a complex process to document and there are often no resources available to enable collaboration with experts who can document the economic benefits; furthermore, mental wellbeing and the arts are subjective and cannot easily be measured (Clift and Camic, 2016, Felce and Perry, 1995). The ongoing debate about economic evidence in arts and health is also linked to research methods and while some literature argues for building the evidence base and evaluation tools (Clift, 2012), it is also asserted that methodological arguments are damaging for the field (Sonke et al., 2009). The focus on evidence-based medicine is a dilemma for the arts and health field. Public spending is focused on cost effectiveness and RCTs are often not appropriate measuring tools for arts and health and the field has yet to produce an alternative method of evaluation in order to satisfy health commissioners' quest for cost-effective evidence and solutions.

Illustrating how promotion and prevention could impact the future costs of mental health disorders in the UK, the report *Mental Health promotion and mental illness prevention: The economic case* demonstrates estimated spending (Knapp et al., 2011). From 2007 to 2016 the estimated cost of depression in the UK is expected to increase from £7.5 billion to £12.2 billion, and the cost of dementia provision to increase to £19.9 billion. In Denmark, a report from the Ministry of Health (Sundhedsstyrelsen, 2015) shows that anxiety and depression are among the five most frequently diagnosed illnesses. The Ministry of Health points out that mental disorders and illnesses such as anxiety, depression and schizophrenia cost society approximately £17.4 mio. a year in days off work, early retirement and premature death. Visits to the emergency room at hospitals for anxiety and depression alone numbered 28,400 in 2014.

Some arts and health activities have proved to have outcomes that support and improve mental health wellbeing and illustrate the specific benefits for service users; arguably such a non-medical approach can be delivered at low cost and a shift from treatment to prevention/promotion could generate cost-efficiency savings. However, the focus on cost and efficacy in healthcare services will undoubtedly remain part of the neoliberal economic approach that is motivating public health systems in many parts of the world. If arts and health wants to be a player in the health system and be offered a seat at the health commissioners' table, then there is a need to produce models that not only focus on health outcomes but also embrace the economic arguments. Arguably arts and health interventions require a different evidence base to establish efficacy and arguably some studies already show that these interventions are efficacious (Coulton et al., 2015, Uttley et al., 2015).

There are, however, only a few examples in the literature that argue the economic benefits and impact of arts and culture for health and wellbeing. The most recent publication (Fujiwara et al., 2014), shows how cost savings are identified in various categories, for example, the estimated saving of GP visits or of seeing a psychotherapist by engaging as an audience in the arts are £396.6m, or visiting museums are estimated to be £105.1m. These savings are based on the assumption that an individual would have a health benefit from cultural engagement that would reduce the cost of seeing health professionals. The study illustrates how arts and health initiatives could contribute some of the economic savings to healthcare costs.

The publication, *The Value of Arts and Culture to People and Society* (2014), from the Arts Council England, concludes that there is a need for being "smarter about making a more relevant case, more nuanced and sophisticated" to develop arguments in favour of public investment (ACE, 2014: 46). Another report, *Understanding the Value of Arts and Culture* (Arts and Humanities Research Council (AHRC)) argues that while the economic impact analysis can be problematic, it is not a question of *if* cultural activity has wider economic impact, but instead of *how* it can best be understood and measured (Crossick and Kaszynska,

2016). The report illustrates how challenging it is to provide a formula that shows causality between arts and culture and the wider societal impacts such as health and wellbeing and how, in times of austerity, the question of cost effectiveness is continuously raised in politics and therefore also discussed in the arts and health discourses.

There are several reasons why arts and culture based programmes do not fit into quantitative measuring formulae, including the application of different art forms, the different structures, the particular settings, that different people respond to different interventions (which might be sport instead of arts) and so on. Some of the additional multiple factors that can contribute to individual health benefits include attending a group, socialising and building confidence, which makes concepts of health such as mental health wellbeing difficult to define and difficult to measure with quantitative methods. As this is variable in different populations and for different individuals, the 'mechanism' by which interventions can improve health is not straightforward. Time, resources and expertise are needed for quality evaluations; many individuals delivering arts and health programmes are not trained in evidence development and resources are often limited (Hamilton et al., 2015) and therefore the traditional measurement of efficacy associated with a RCT is not appropriate (Belfiore, 2016, White, 2009, Angus, 2002). Cohen (2009) suggests that the focus ought to be on the actual mechanisms in arts and health practice rather than on measuring the outcomes, as it provides a stronger platform for gathering evidenced-based results. The actual mechanisms in arts and health are rarely described, as pointed out by Cohen (2009), which provides an interesting point for several reasons: the field is broad and many art forms and approaches are used and there is little suggestion as to which approach or art form works best in the specific circumstances, and the practice is only as good as the practitioner(s) that deliver(s) the project(s). To measure outcomes that impact on health there is a need to research the actual processes that practitioners use and create a theoretical framework to match (Raw et al., 2012). Working within an approved theoretical framework would provide better conduits for

research, support inexperienced practitioners and provide connections between understanding and practice. Above all it would support the arts and health field's ability to be understood in terms of political agendas.

Within neo-liberal policies, measures are required to evidence the cost effectiveness of services and initiatives within public spending from the national budget. So far, the arts and health literature has not presented a method for measuring cost effectiveness in art and health activities. Although the *Evidence Dossier,* produced for Arts and Minds in Cambridge, makes the case for that Arts on Prescription (AoP) programmes can be cost-saving for the public sector (Hamilton et al., 2015: 35), developing the evidence base for arts and health remains challenging. Other economic effects of arts activities that have been measured include shorter stays in hospital (Staricoff, 2004) and a reduction of visits to the doctor (Bungay and Clift, 2010).

In an editorial in the British Medical Journal, Smith (2002) makes a controversial argument to spend more on the arts and less on the health budget. While Smith argues, as do the numerous authors, academics and practitioners working in arts and health, that the arts have the ability to address some of the processes and difficulties that medicine cannot and that this could improve health, he also recognises that it is an unpopular proposal (Smith, 2002). While the arts have the potential to improve health and wellbeing it is still controversial to suggest that some of the health budget should be allocated to art activities, partly because the health sector is still reluctant to recognise the evidence that already exists and partly because documentation of the benefits could still be improved through standard methodological approaches. However, it is also likely to have a great deal to do with the fact that health and arts belong to different paradigms and are not obvious partners in interdisciplinary work and therefore it can be difficult to identify the causal links.

However, the strength of the evidence-base for arts and health has grown in recent years and there has been an increase in academic research (Raw et al., 2012). Arts projects are currently working with researchers to ensure that programme designs are optimised and that research bodies and researchers are publishing evaluation guidelines and best practice for this purpose. Such programme designs ensure that research standards incorporate methods and ethical considerations as well as providing an alternative to RCTs (Daykin with Joss, 2016, Fancourt and Poon, 2016 and Daykin et al., 2016 for a description of evaluation practice with emphasis on co-production among stakeholders), making the future evidence base easier to assess for the purpose of measuring the value of arts and health in terms of economic benefits and make it possible to compare with other interventions in terms of cost-effectiveness. Public Health England also provides a certain quality stamp through their evaluation framework (Daykin with Joss, 2016) which might be useful in terms of attracting funding for projects. One of the challenges associated with developing an evidence base for arts and health is that evaluations not only take expertise, but also resources: having access to evaluation frameworks that are ready to use can strengthen the standard of evaluations and contribute knowledge to the field.

## 2.4 Arts

The engaging and participatory dimensions facts are central to this study. Therefore, the review of the arts will focus on meanings and the use of the arts for individuals and communities; the review considers the arts in themes associated with arts participation and collaboration as well as considering the need for making art. Dissanayake (1992b) argues that humans have a biological need to make art which is linked back to the purpose of cohesion making human bonds.

Every civilization has enjoyed artistic expression throughout history, and the health and wellbeing benefits of the arts have been acknowledged since the time of Aristotle. In pre-industrial societies, art extended through the whole community in the form of bodily

ornamentation using paints, amulets, tattoos and hair treatments, and music and dancing was apparently a universal artistic practice among early humans. However, once the word 'aesthetics', which is associated with beauty and taste, was applied in the mid-18th century, it became the preserve of a priestly standing (Carey, 2005).

This understanding of the arts and the preoccupation with aesthetics was further promulgated by Kant, who argued that art was good insofar as it accessed a 'supersensible' realm of beauty and truth and only certain artists (geniuses) were capable of that (Kant, 1951). Kant is to be understood in a historical perspective, where his theories about aesthetics gave independence to art and artists with the concept of; art for art's sake', i.e. free expression. Kant's view of art required that the audience for art (readers, spectators and concert-goers) was also exceptionally talented (Carey, 2005). In this way, art was removed from 'communities' and became associated with the elite who, it was said, were equipped with the necessary knowledge and expertise to understand the arts. Many still experience the arts as inaccessible and therefore using the arts in health and community settings can start with an initial struggle as participants may be sceptical.

In contrast to the beliefs of Kant, Peter Box, Leader of Wakefield Metropolitan District Council, asserted that art should be about people and communities and be relevant to people's daily experiences, hopes and aspirations (ACE, 2010). Such a position suggests that arts have the potential to make changes for people and communities. This concurs with other authors, recognising that the arts indeed can promote social capital, create the capacity for social acting, a community identity and can act as a catalyst for social interaction (Thomson et al., 2015, Parkinson and White, 2013, White, 2009). In this way, arts can be linked back to its origin and usage for the purpose of cohesion (Dissanayake, 2002).

Art has increasingly become a part of mainstream society and public life in the form of print, graphic arts software, film, advertising, socially engaged arts and so on, making it available to

all members of society. This availability has triggered debate over the requirements of arts in society and some suggest that art has the potential to make changes for people and for communities (White, 2009). Ellen Dissanayake (1992b) agrees and looks towards our biology, arguing that we should approach art from an ethological perspective, which suggests that it is part of the human search for meaning. Considering art as a general behaviour and therefore as pre-cultural, Dissanayake argues that artistic activity and its response is rooted in human prehistory, both in terms of phylogeny and ontogeny. In other words, it is part of the evolutionary history of the species and part of the process through which humans embody the history of their own making. It provides humans, Dissanayake (1992a) argues, with a way of 'making special' our existence and values; making life meaningful in random environments. If we accept participation in arts to be a biological need, then it is arguably something that everyone can engage with, either actively or as spectators, regardless of background, social position or an understanding of aesthetics.

Using participatory art (music, song, dance, literature/poetry, theatre and visual art) as a tool in the health sector is widely recognised as an innovative approach to health improvement and health promotion, with well-documented research demonstrating positive therapeutic outcomes for people with both physical and mental health problems (Chatterjee and Nobel, 2013, RSPH, 2013, Stickley, 2012b, Art for Health, 2011, Wolf and Wolf, 2011, White, 2009, Belfiore and Bennett, 2007, Staricoff, 2006). The arts present an opportunity for more than simply aesthetic pleasure and, whether it is a biological need or merely an ability to gain health benefits from participatory arts activities, the arts present a meaningful way of expression.

Throughout history people have used the arts to express, celebrate and understand part of their lives and considering that this engagement can have health benefits for both individuals and communities, the next section will consider the contested concept of health.

## 2.5 Health

In this section, I consider and examine different concepts of health through the literature so that it is clear how I intend interpreting health within this thesis. The review considers health as a contested concept and views aspects of health from a range of perspectives. To define the concept of health it is necessary to consider views of the medical model and the social model and consider various health theories, as the concept of health remains disputed.

To argue the possible health benefits of arts interventions is complicated by the fact that health is a contested concept and the range of academic disciplines, and academics within disciplines offer their own definition and ascribe meaning to the concept respectively. One dominant understanding of health is the way it has been defined within the framework of the medical model.

Over the past fifty years the medical dominance and the requirement of evidence has been challenged by, among other humanistic research, recognising that health is a social and cultural phenomenon (Jensen, 2010). Within such understanding is the idea that health is complex and can be negotiated. The criticism of the medical model has been focused on the separation of biology and culture and that the science tradition is constructed in such a way that it is possible for medical practices to work towards ultimate truths about illness and disease. However, this way of understanding is no longer favourable (Jensen, 2010). Changes in how we consider health and illness have led to health being defined in a much broader perspective and not merely as a medical condition.

The medical model is said to employ a scientific approach concerned with description, observation and differentiation, moving from identifying and treating symptoms to recognising disease etiologies and developing specialist treatments (Clare, 1980). In this way, health can be understood as the absence of disease and this is the most common notion of

health representing a default state and pathology, meaning that if an organism is not sick then it must be healthy (Marcum, 2011).

The epistemological assumptions of the medical model are founded on positivism. A positivist philosophy of science is based on the view that information originated from logical and visible mathematical proof and that valid truth must be based upon scientific knowledge. The Scottish philosopher, David Hume, argued that sciences of man (natural science) are the only solid foundations of other sciences, assuming experience and observation as the foundations of a logical argument (Atherton, 1999).

A different way of understanding health is through the social model that offers a more holistic definition. The social model of health goes beyond the limitations and reductionism associated with the medical model of health (Yuill et al., 2010). The epistemology of the social model recognises that people's health is dependent on many factors including psychological, physical and social needs that themselves may not be visible, but must all be acknowledged and understood as part of a whole. Health is defined by the World Health Organization (WHO) as "a state of complete physical, mental and social well-being and does not consist only of the absence of disease or infirmity" (WHO, 1948). However, this definition has not been amended since 1948 and an editorial article in the Lancet (2009) argued that such a definition will not do "in an era marked by new understandings of disease at molecular, individual and societal levels". The Lancet introduced an alternative definition of health articulated by the French doctor Canguilhem in 1943, who rejected the idea of normal and abnormal states of health and saw health as the ability to adapt to the environment in which the individual was situated. Canguilhem argued that health, like wellbeing, is not a 'fixed entity' but varies for each individual and cannot be defined by a doctor, but rather by the individual according to their functional and social needs (Lancet, 2009).

In Foucault's writing about the notion of health, he described the practice of medicine from the nineteenth century as being more concerned with normality than health, and Foucault understood it as a steady move from regarding health as qualities of potency, flexibility and fluidity to being seen as a state of biological normality which could be realised by external intervention (Foucault, 1973). This helps to create an understanding of the breadth of meaning associated with the concept of health and draws attention to the move from health which requires personal action, to health which can be imposed or acquired, to health as a commodity; however it also points to a political aspect of ideologies associated with health (Seedhouse, 2001). According to Jensen (2006), health and disease are general human living conditions, as are life and death. Therefore, both the concepts and practices of health, at all times and in all cultures, are at the focus of discussions and negotiations. It can therefore be said that health concepts continue to place the body in long and repeated battles of understanding, definition and practice between health professionals, politicians and communities (Jensen, 2006).

The health paradigm presented in the Brunner and Marmot (2006) model depicts the way in which the organisation of society impacts upon the living and working situations that humans experience, which then operate to form health experiences. The model shows that strong social and political influences upon health can manifest themselves through genetic and cultural factors at all stages of life. Wilkinson and Marcum (2003), in their publication for WHO, *Social Determinants of Health, 2nd Edition,* identify six key causes including: social gradient, stress (anxiety, insecurity, low self-esteem and social isolation), good start to early life, social exclusion (poverty, deprivation), and stress at work and unemployment (causing more illness and premature death). These causes illustrate why social determinants should be considered when discussing health, and health in general ought to be viewed through a holistic lens as health is not just the absence or presence of diseases. Other models have also been used to illustrate recent social epidemiologic approaches to understanding the social determinants of

health and health disparities (House, 2002, Kaplan et al., 2000, Lynch, 2000). The models have several commonalities, the most noticeable being an emphasis on multilevel understandings, and an array of paths and possibilities for mutual influences (Kaplan, 2004). In summary, the social determinants of health are described as the conditions in which people are born, grow, live, work and age (Marmot, 2010) and not merely the absence or the physical presence of disease.

Health means a variety of different things to different authors, institutions and sectors. Health is difficult to define but it is important to acknowledge the different views of health and that it is a complex and contested concept which is often used as an umbrella term covering wellbeing as well as physical and mental health. The word 'health' is used with a variety of meanings in different disciplines and is ascribed value depending on the priorities and beliefs of the respective discipline (Seedhouse, 2001). Health needs to be considered in a much broader perspective than just the medical model (Seedhouse, 2001, Gannik, 2005). Health is not only a matter of lifestyle; however, social and cultural considerations are also involved (Antonovsky, 1979). In his theory of health and illness, Antonovsky developed the term 'salutogenesis', helping to understand the relationship between health and illness. Health and disease is not a question of either/or, in the case of a continuum, where one pole is the health and the other pole is the disease; Antonovsky (1979) argued that the subject may lie somewhere in between or close to one of the poles. His notion was to move the focus away from the perspective pathology to a 'salutogenesis' perspective and an understanding that it is how we handle the stress factors that we are subjected to that determines whether we become sick or not, and that even with a chronic condition you might consider yourself to have a good life quality and to consider yourself in good health. Being able to handle and reduce stress makes us more robust and able to deal with illness and this may be achieved through arts engagement.

There are various theories of health, including that health is an ideal state; health is the physical and mental fitness to undertake daily social tasks (i.e. to function normally in a person's own society); that health is a commodity which can be brought or given; a group of theories which hold that health is a personal strength or ability – either physical, metaphysical or intellectual; inequality in terms of socio-economics, political, environmental, personal and biological factors; the approach of medical science (emphasis on clinics, biology and measurements) and the humanist approach (disease and illness can co-exist with health) (Seedhouse, 2001). The notion that health is equivalent to a set of conditions that enables individuals to achieve their realistic, chosen and biological potential acknowledges that health is in flux and the importance of these conditions depends on the individual's context. Seedhouse (2001) sees health as a flexible concept and the level of health that an individual holds will vary depending on a person's social, economic and political circumstances. Health can be discussed and understood from a situational perspective which considers how a persons' notion of health is closely related to their social position and their competence to act within a societal context.

Health theories can apply a lens to understand the various concepts of health and help place health in a broad context, which includes social factors such as inequalities in health. For the purpose of this thesis, health refers to Seedhouse's (2001) understanding, as a concept that includes biological aspects and social determinants and is constantly in flux depending on the context of an individual.

### 2.5.1 Health inequalities

It is difficult to discuss health without drawing attention to health inequalities and to the fact that social exclusion can lead to health inequalities (Silver and Miller, 2003). Inequalities in health can be understood as different status in health caused by different socio-economic

positions; the lower individuals are ranked by socio-economic measurements, the higher their risk for poor health is. These groups of people are often those who are already on the margins of society (Secker et al. 2009). However this is not a simple issue, arts and health are arguably practices with the ability to be inclusive and create social relationships for marginalised people in order to combat aspects of health inequalities (Wright and Stickley, 2013, Secker et al., 2009, La Bonte, 2004).

Inequalities in health are growing, not only in the UK, but also in Denmark and other parts of the Western world (Dybbroe et al., 2012, Mackenbach et al., 2008, Wilkinson, 1996). In the report, *Health Inequalities: Europe in Profile*, focusing on the widening inequalities in mortality in Western Europe, it is revealed that relative inequality in mortality has increased in all countries. Relative inequality is to be understood as a regression based on an index summarising the scale of socio-economic status as the cause of inequality of health (Masseria and Allin, 2008). In this way, people from groups with a low socio-economic index are more likely to experience health inequality. The explanation for this phenomenon is only partly acknowledged and identified as being a result of the widening gap between socio-economic groups (Mackenbach, 2006).

Health inequalities can be statistically demonstrated, but their effects are also causally associated with social inclusion and exclusion. European researchers examined aspects in civic life that included: "poor future prospects, inability to participate in customary family and community activities, social crisis points in depressed regions and large cities, poor health, education, literacy/numeracy, housing and homelessness" (Silver and Miller, 2003: 11). American researchers, by contrast, seem to focus on the more tangible aspects such as the economic facets of social exclusion i.e. the financial impacts for a country to deal with people who are socially excluded (Silver and Miller, 2003). A global lens to consider health inequalities could be useful and the concern ought to be focused on the "socio-economic rules and political power that create excluded groups and conditions" (La Bonte, 2004: 120). Other

authors agree that it is not a simple issue whereby social exclusion and social inclusion are at each end of a scale but rather the gap between the rich and the poor is becoming greater with the growth of global capitalism (Secker et al., 2009, Wright and Stickley, 2013).

Groups of individuals that are experiencing high levels of health inequalities often include those with mental health problems (Stickley and Hui, 2012, White, 2009, Spandler et al., 2007) and, arguably, better social relationships could be achieved by integrating the arts and culture into an international movement for public health and wellbeing. This could be enabled in a way whereby artists are critically engaged in wider health issues including: ageing population; social isolation; addictive behaviours; obesity; substance use and mental ill health, which are all believed to be underpinned by inequality (Parkinson and White, 2013) and could support Lang and Rayner's (2012: 5) call for change:

> *Public health success is as much about imagination as evidence: challenging what is accepted as the so called normal … public health must regain the capacity and will to address complexity and care to confront power*.

Using arts and cultural engagement in public health could help build relationships, create social capital and improve social bonds, creating healthier communities, and it may impact positively on the wellbeing of communities and the individual (Putland, 2008, White, 2009). This study seeks to identify some of the positive aspects of arts engagement for mental health services users, and how these are facilitated through an interdisciplinary collaboration between stakeholders in health and cultural sectors.

## 2.6 Wellbeing

If we accept that health is more than the absence of disease then the concept of wellbeing become important and it is central to the study as a concept that is referred to in connection with individuals and communities; therefore, it is necessary to provide a definition and explore the notion of wellbeing and what it might mean to people and communities.

While seeking to understand wellbeing as a concept, with all its confusion and frequently contradictory understandings, it seems logical to start with the WHO description from 1948 that states, "health is not the mere absence of diseases but a state of wellbeing" (1948:100). The description offered by the WHO does not consider a more complex and contemporary understanding whereby wellbeing is defined as a concept that can be assessed in both objective and subjective terms (McNaught, 2011). The objective approach holds the view that wellbeing can be effectively measured through finite economic and social indicators such as income, housing and work (Diener et al., 2009) and, while these measures may indicate aspects of wellbeing, they cannot operate as proxy. The subjective approach relies upon individual, emotional and psychological interpretations of wellbeing (Felce and Perry, 1995). In other words, wellbeing to one person may not be wellbeing to another. An early attempt to define wellbeing was made by Branburn (1969) in his research on psychological wellbeing, moving away from diagnosis of psychiatric conditions to the study of the psychology of ordinary people in their daily lives (Dodge et al., 2012). Branburn (1969) examined how individuals coped with daily life and connected psychological wellbeing to Aristotle's idea of Eudaimonia. Eudaimonia can be defined as: "the good composed of all goods; an ability which suffices for living well; perfection in respect of virtue; resources sufficient for a living creature" (Cooper, 1975: 69). While Aristotle's idea of Eudaimonia might be considered to be the ancient Greeks' way of thinking about and considering wellbeing, a more contemporary consideration of wellbeing might be a stable/good/satisfactory state of being.

Specific friction occurs in attempting to understand wellbeing in the interchange between utilitarian and individualistic values (Tesh, 1988). A utilitarian approach to wellbeing centres around wellbeing for the greater good, where social levels of wellbeing within a society might be measurable, versus individualistic wellbeing, which is associated with personal wellbeing and the self. Seedhouse (1995: 63) argues, however, that "the nature of wellbeing remains mysterious and elusive". While there are various ways of understanding wellbeing, distinctions need to be made between physical, spiritual and psychological wellbeing, it is the aspect of psychological wellbeing that has generated interest among researchers associated with the movement of positive psychology. Psychology has not always been about working on personal 'weakness' and 'damaged minds'. Seligman and Cisikszentmihalyi (2000) claim that prior to the Second World War psychology had "three distinct missions: curing mental illness, making the lives of all people more productive and fulfilling, and identifying and nurturing high talent" (2000), which is a utilitarian perspective. Positive psychology focuses on a variety of perspectives including flow, happiness, wisdom, wellbeing, creativity, personal strengths and imagination (Hefferon and Boniwell, 2011). According to Hefferon and Boniwell, positive psychology is the science of wellbeing and optimal functioning. Critiquing positive psychology, the American author, feminist and political activist, Barbara Ehrenreich (2009), built on Max Weber's insight into the relationship between Calvinism and capitalism. Weber's thoughts on the link between capitalism and Calvinism were founded on the argument that capitalism, certainly in Northern Europe, evolved from the protestant (particularly Calvinist) ethic that prompted numerous people to engage in work, develop their own enterprises, trade and accumulate wealth for investment. In this way, the protestant work ethic was significantly influential in the unintentional development of modern capitalism (McKinnon, 2010). Linking capitalism to positive thinking and rooting the susceptibility to the philosophy of positive thinking in America's Calvinist past, Ehrenreich's critique of positive psychology considers the practice of hedonism and points towards the negative

impact it has on collective responsibility. Ehrenreich (2009) argues that there is a place for so-called negative emotions and that they cannot simply be erased by positive thinking.

A framework illustrating wellbeing as a macro concept, or a field concerned with both objective and subjective assessment of wellbeing as a desirable human state of being, was developed by McNaught (2011: 7). He explains wellbeing as:

> *…a dynamic process that gives people a sense of where their lives are going, through the interaction between their circumstances, activities and psychological resources and includes their interpersonal interaction and significant social formations (the family and their community) with society.*

The question of how to define wellbeing, or indeed how it should be spelled, still remains largely unresolved (Dodge et al., 2012). Defining the concept has "given rise to blurred and overly broad definitions of wellbeing" (Forgeard et al., 2011: 81). Limited epidemiological evidence examining measures and determinants of wellbeing means that it can be difficult to confidently assert causality (Aked and Thompson, 2009). The emergence of wellbeing on the political agenda has not helped attempts to define wellbeing as a concept. The current UK Government is committed to measuring people's individual and psychological wellbeing (Stratton, 2010, ONS, 2011). Wellbeing might be seen as a ubiquitous term that occurs frequently and extensively in public and political discourse. However, the mechanisms for measuring wellbeing are unclear and how it is defined remains unspecified in these discourses (La Placa et al., 2013).

It is argued that a clearer and more holistic framework which works with philosophical underpinnings is needed in order to develop a robust wellbeing policy (La Placa et al., 2013).

However, wellbeing will always be an essentially contested concept that will have a variety of meanings for individuals. In terms of this study, using a qualitative approach helps for a better understanding of the specific meaning of wellbeing in relation to the outcomes of arts engagement and how it is not just about the absence of disease, and that it may be relative and that inclusion and a sense of identity may also be aspects that are considered in the meaning of wellbeing.

Having considered wellbeing as both subjective and objective concepts, I consider the disputed concept of mental health and other issues associated with the concept of mental health including models of treatment. This is central for this study in order to provide a background for the context which mental health is subjected to through literature, models of health, systems and policies.

## 2.7 Mental health

Mental health is also a contested concept and it is often the WHO definition of mental health that is referred to as the conventional view. Mental health is also regularly referred to in terms of 'good' or 'bad' mental health, or by defining various neurological disorders or psychosocial problems through the medical model or the social model of health. The mental health of individuals, professionals and communities is central to the study and in this section I present these various views of mental health through the literature, with current mental health literature discussed in the light of recovery, which is a relativity new approach to mental healthcare.

If health is a contested concept, then mental health is even more so. Universally, the most quoted definition of mental health is provided by the WHO (2013)[5] that asserts that good mental health is:

> *… a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community*.

This is, possibly, the conventional view of mental health[6]. However, it embeds the concept of wellbeing which in itself is a contested concept. In Western countries there is strong allegiance to the medical conceptualisation of mental health that is enshrined in law. However, for those who are subject to legal coercion and forcibly treated, the definition remains problematic. Furthermore, whilst the WHO (2001)[7] emphasises the point that one in four people in the world may experience mental or neurological disorders, there is little recognition of the strong connection between mental health problems and social and political conditions that breed inequality and hence poor social relations.

Whilst the medical model may be recognising disorders, for many such as Szasz (1984), mental illness does not exist because, he argues, it is a social construct used to control deviancy. This is supported by Foucault (2011), who asserted that society groups, labels and controls people according to labels associated with the spirit of the age. An alternative way of describing good mental health is offered by Hungerford et al. (2012), arguing that poor mental health and mental illness is a spectrum of behavioural, cognitive, and emotional and circumstances that restrict emotional and social and wellbeing. The lives and productivity of

[5] http://www.who.int/mediacentre/factsheets/fs220/en/
[6] Yet this definition deserves further interrogation, for example what is normal? Who judges productivity and fruitfulness? How can contribution be defined or judged?
[7] http://www.who.int/whr/2001/media_centre/press_release/en/

individuals and mental illness can seriously impair, permanently or temporarily, the mental functioning of an individual.

Having 'good' mental health is a concern of most individuals and it is often not until the experiences of 'bad' mental health occurs that the focus is then on the challenges that can be associated with one's mental health. However, the boundaries between 'well' and 'sick' are not clear as they are diffused by cultural, psychological and social considerations. The conventional ways of treating mental health focus on the mental model of ill health and about 30 years ago, Engel, Professor of psychiatry and medicine, focused on a move towards a biopsychosocial model of medicine. In his article: *The Need for a New Medical Model: A Challenge for Biomedicine* (1977), Engel argues for the need to treat patients from a perspective that considers their social circumstances and personal experiences and states that, "the biomedical models ignores both the rigour required to achieve reliability in the interview process and the necessity to analyse the meaning of the patient's report in psychological, social and cultural as well as anatomical, physiological, or biochemical terms" (1977:132). In this way, Engel recognises a need to understand the experience of the patient as part of a treatment. Engel further argues that, in order to provide a basis for understanding the causes of disease and provide rational treatments and healthcare, a medical model must also consider the social context and the system which is dealing with the effects of illness. The practice of arts in mental ill health is a way of engaging and involving a holistic approach to the person experiencing mental health as the arts present benefits that support the individual in their daily life. These benefits will be considered in more detail in the sections below.

Literature has for decades placed emphasis on the power relations between mental healthcare staff and service users. This interaction between healthcare professionals and service users is at the very core of delivering healthcare services and play a significant role in the success of treatments. There is established literature examining the power imbalances between mental health professionals and service users (Warne and McAndrew, 2007, Townsend, 1998,

Chambliss, 1996). Classic literature includes Townsend (1998), who argues that any attempt to empower service users is undermined by processes such as risk management and the hierarchies developed to protect but also to control. Chambliss (1996) argues that routine and habituation alters perception and creates a certain way of doing things which gets in the way of developing a relationship beyond the clinical nature with the service user. An Australian study found that situations of power imbalance were evident in the relationships between nurses and service users as nurses felt the need to maintain control (Henderson, 2002). This is consistent with other studies which suggest that the power dimension in the interaction constitutes a barrier to meaningful and open communication between health care professionals and service users (Hewison, 2008) and the quality of communication between healthcare staff and patients is inadequate (Fallowfield et al., 2003, Heaven et al., 2006). However, the discourses about power imbalances in mental health have shifted to a discussion that is driven by the concept of recovery and services users' involvement in their own recovery.

In medical terms, recovery can be understood as a process of becoming well after injury or illness, or by returning to a 'normal' state of being after a difficult period of time. In mental health, however, the recovery process is described as a "personal process of changing one's attitude, values, feelings, goals, skills and/or roles" (Anthony, 1993: 527) and is about living life with hopes and dreams within the limits caused by illness. Onken et al. (2007) explains recovery as a new model of distinct beliefs, values, language and practice and a positive approach to mental wellbeing that may mean accepting some level of ill health. The recovery model is described as a process of a person's ability to create a new own role and to challenge or modify the oppressive domineering narrative associated with much psychiatry (Thornhill et al., 2004).

Recovery is a concept that has emerged from the experiences of individuals with mental health illness (Slade, 2009). In the book *Personal Recovery and Mental Health Illness: A Guide for Mental Health Professionals*, Slade (2009: 3) argues that, "the primary goal of mental health

needs to change from its focus on treating illness in order to produce clinical recovery, to a new focus on supporting personal recovery by promoting wellbeing" and advocates a move from traditional clinical concerns, such as managing risk in the direction of a more humanistic approach that is person-centered and supports individuals to establish their own goals. Hope, identity and meaning are themes that are identified as part of the key processes involved in the journey to recovery (Slade, 2009). These themes are also identified in the literature that supports arts engagement and recognises the health benefits for mental health service users (Sagan, 2012, Stickley, 2010, Secker et al., 2007b).

Another concept in recovery is introduced by Crawford et al. (2013) presenting the concept of 'mutual recovery'. With the emphasis on humanity and connectedness the concept seeks to embrace that sharing resources and creative practices can support resilience in mental health and wellbeing amongst professionals, informal carers and service users. The concept of 'mutual recovery' extends out of the notion of recovery in mental health, however, in recovery-based initiatives the focus tends to be on service users and do not consider that staff may also need to 'recover' or be 'recovered' in terms of their own mental health and well-being. In this way, the 'mutual recovery' considers both staff and services. Other literature investigates this area further (Crawford et al., 2015, Lewis, 2014).

Mental health service users are known to experience inequalities (Wright and Stickley, 2013, Secker et al., 2009, La Bonte, 2004) and some of the inequality is concerned with the lack of inclusion. Ironically, it is the same system that once systematically excluded groups that now promotes inclusion (La Bonte, 2004). In other words, the system that once marginalised mental health service users now invites them back in, through initiatives aimed at battling social exclusion; these initiatives could be in the form of publicly-funded projects such as community arts with a focus on inclusion and social capital.

To combat isolation and exclusion issues, arts activities have been shown to be helpful tools to enable individuals with mental health problems to socialise and become part of a group. The evidence for improving mental health problems through engagement in arts activities is prominent in the literature; this includes community arts practices, the Arts on Prescription initiative and arts programmes that are delivered within mental health settings, which I consider in the sections below. Arts engagement as a way of including people with mental health problems has proven effective, both in the context of recovery as well as for people with 'milder' mental health problems. Considering 'good' mental health in terms of wellbeing and quality of life through arts engagement is central to this study, as it explores some of the structures for project delivery; and how the interdisciplinary work is important for successful projects and programmes.

### 2.7.1 Community arts

Community arts are often associated with aims to increase the health and wellbeing of communities, which includes mental health wellbeing, physical health and creating social capital, and has seen a steady growth since the late 1980s (White, 2009). Community (or participatory) arts are used as a vehicle for various health promotion activities and there is much literature describing projects and programmes. However, most literature is considered 'grey' and it lacks the methodological frameworks that enable robust evaluation.

Community arts, or arts in the community, occupy a proportional part of the arts and health projects and initiatives and while some are linked to public health promotion, others are delivered by arts organisations and charities. Arts participation in communities encompasses different values and motivations and, in 1997, Matarasso asked the question: who defines the value, quality and meaning of community arts? This question has been answered through the emerging literature over the past 19 years and includes a literature review by Hemingway and

Crossen-White (2014) involving the community-based arts in health initiatives. The review summarises the evidence on how these initiatives engage local people. The review covers articles published between 2000 to the end of May 2014, and a total of 143 articles were identified. The review indicates that using arts in health settings (including visual arts, theatre, music and song) has had a positive impact on health and wellbeing, especially for those individuals with pre-existing conditions and/or receiving treatment. The review shows that initiatives that are developed sharing ownership with the community seem to be the most successfully integrated, and that quality varies and there is "a need to ensure any planned community arts in health initiative focuses on the interests of the local population and that the intervention is of high quality" (Hemingway and Crossen-White, 2014: 8). Although the review presents positive evidence for a community arts contribution to health and wellbeing, the current evidence based on arts in health initiatives within the community is limited, as much of the existing literature is grey and lacks methodologies that can sufficiently evaluate outcomes and impact.

Community arts influence on public health is also illustrated in White's book from 2009, *Arts Development in Community Health – A Social Tonic*, with case studies from Ireland, Australia, South Africa and the UK presenting research about the role of arts in a variety of community health settings. Examples include arts in hospitals, community lantern-making, arts workshops in HIV/AIDS programmes and a project to connect artists with health settings. The book covers "the pioneering, development and establishment of community arts and health programmes worldwide" (Pepin-Wakefield, 2010: 173) and argues that community arts has not only the potential to create community identity and cohesion, but also to promote social capital which the American sociologist, Robert Putnam, refers to as the glue that holds society together. Social capital is a well-established part of good health, and social relations are the most significant factors for wellbeing (Putnam, 2001). While participation in community arts projects can act as a catalyst for creating social relationships, they can also

build social capital and support social coherency, which can improve the mental health of individuals and communities.

Another approach that claims health benefits by focusing on the individual's wellbeing is that of Arts on Prescription which is expanded in the next section.

### 2.7.2 Arts on prescription

Arts on Prescription (AoP) offers engagement in the arts within the local community and has been delivered across the UK in various forms and shapes over the past 20 years. Examples of AoP programmes can be found in Stockport, Nottingham, Devon, Blackpool and Salford among other places (Bungay and Clift, 2010). Although the initiatives have been available for two decades, the published literature about AoP programmes is limited and much of the existing literature is available as reports where the description of methods are limited and it is therefore difficult to determine the rigour of the evaluation.

Arts on prescription (AoP) is part of the social prescribing programmes which have been delivered in different forms across the UK over the past 20 years, starting in Stockport in 1995. In a review of AoP practice in the UK, Bungay and Clift (2010) explore whether AoP schemes can contribute to a solution in addressing mental ill-health and examined the evidence that supports the value of such schemes. AoP schemes differ from the community art projects in that the 'prescription' part does not apply in the community arts context and the mechanism for being part of a such project are different. AoP schemes usually offer a programme of 10-12 weeks, where participants meet for 2-4 hours per week to engage in an arts or cultural activity and it is delivered in a specific framework.

Social prescription has been described as, "mechanisms for linking patients in primary care with a non-medical source of support within the community" (Friedli et al., 2007: 11) and Brandling and House (2008: 3) as follows:

> *… a formal means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local non-clinical services and provide a framework for developing alternative responses to meet needs.*

The review by Bungay and Clift considers the policy context for social prescribing which recognises that health is influenced by a wide range of "social, economic and cultural factors" and that "a current political emphasis appears to be on the wider community and the sociocultural factors that may impact on health and wellbeing" (2010: 278); the review explores twelve AoP projects in the UK. The review further recognises that implementing AoP is challenging, as the lack of scientific evidence makes it difficult to secure funding and to fight institutional barriers as the concept and framework is relatively new (Edmonds, 2003). The review by Bungay and Clift suggests that AoP may contribute to government objectives "through building social capital and community engagement and enhancing health and wellbeing" (2010: 280).

Other literature about AoP includes the articles of Stickley and Hui (2012a, 2012b), illustrating both the participants' and the referrers' perspectives on the experience of participating in an AoP programme. The publication *Social prescribing through arts on prescription in a UK city: Referrers' perspectives (part 2)* considers the views of GPs, social workers, project workers and occupational therapists who act as referral agents as well as the perspectives of the service users. The key findings highlight the importance of the referral

agents' commitment to the concept and the practice. For example, it enabled GPs to have more options of referral routes when dealing with patients with complex social problems. The occupational therapist recognised opportunities for making new networks in order to create more opportunities for the services users, and social workers commented on the benefits for the services users, including gaining confidence and learning new skills that enabled the service users to become more independent. Furthermore, the AoP programme has benefited a number of participants in terms of finding new opportunities for the future (Stickley and Hui, 2012a). In a follow-up qualitative study, conducted a year later, the progress tended to vary between the respondents and showed principally soft outcomes; an increased confidence and self-esteem enabled hard outcomes such as voluntary work and educational accomplishment (Stickley and Eades, 2013).

A review of the social prescribing schemes in the UK by Thomson et al. (2015) aimed to set the scene for the circumstances in which the concept of social prescribing had started. The review's objectives were to: "provide definition, models and notable examples of social prescribing schemes" and to provide evaluations of the schemes which included models of social subscribing such as 'arts on prescription', 'books on prescription', 'education on prescription' and 'exercise on prescription' (Thomson et al., 2015: 6). Outcomes from thirty-five schemes showed that in terms of evaluation, 59.3% had not been evaluated, 26.7% were evaluated qualitatively, 9.3% by clinical scales, 3.5% were evaluated using clinical scales and RCTs, and 1.2% by physiological measures. The high number of non-evaluated schemes suggests that there is a need for easy-to-use evaluation frameworks.

The review shows the benefits for the participants in terms of an increase in self-esteem and confidence, as well as a sense of control and empowerment, improved psychological or mental health wellbeing and a reduction in symptoms of anxiety and depression, resulting in a more positive mood. Museums and galleries were also mentioned as a potential community resource by Camic and Chatterjee (2013), which is significant in terms of the concept of

museums being places for wellbeing, as mentioned earlier in the chapter. The review further recommended that methods for evaluation, such as mixed-method studies (employing both qualitative and quantitative designs), present an alternative to RCTs, as RCTs are often expensive, time-consuming and are not always feasible for the setting (Thomson et al., 2015).

Beyond the UK, AoP was also delivered over a two-year period from 2012 to 2014 in the South of Sweden. In Sweden, the participants were all linked to a rehabilitation center at a hospital where they worked with the physical or psychological recovery of various illnesses. Using a quantitative evaluation approach, the project report from Sweden concluded that 123 participants had benefitted from a range of health outcomes, including improved mental health wellbeing and increased psychical abilities, and at the twelve-months follow up it showed that there was a 29% clinical change in health relating to improved quality of life and/or work abilities (Stigmar et al., 2016). This can be viewed as both a health benefit for the individual and, arguably, as an economic benefit for society. Following the trend from the UK and Sweden, funding has been allocated for a three-year pilot AoP project in Denmark. Four local authorities from across Denmark will deliver arts and cultural projects aimed at participants with a range of health issues commencing in October 2016. The method, approach and target groups are yet to be identified.

Having considered AoP programmes, I explore museums as a setting for supporting wellbeing. With the drive for wellbeing, some cultural institutions, including museums, are developing frameworks that consider the wellbeing of the visitors in general and with a specific focus on groups with mental health problems. Some argue that within a neoliberal society, museums need to show their relevance to society beyond being nice place for the privileged, and so are turning to developing projects which focus on health as a rationale for accessing funds and supporting the museums. Although this may or may not true, I consider museums to be places with untapped potential as stakeholders in contributing to public health.

### 2.7.3 Museums as places for wellbeing

In this section, I consider the concept of museums as settings for wellbeing and explore the literature that relates to the museum's potential role in the health and wellbeing of individuals and communities.

As mentioned earlier, part of the political agenda in the UK has in recent years been considering the wellbeing of the nation. Regional wellbeing boards have been established and attempts to measure the wellbeing of individuals have been put in place. Cultural institutions have also made their claim on the wellbeing agenda. The potential of using museums and galleries to promote health and wellbeing is described by Chatterjee and Nobel (2013) in the book *Museums, Health and Wellbeing*. They noted that in a study (funded by the UK Arts & Humanities Research Council in 2011), exploring museums, health and wellbeing (practice, method and evaluation), that a large proportion of the over 100 participating museums delivered activities directly targeted at people with mental health problems. Furthermore, the museums also worked with a wide range of health and social care partners including hospitals, social services and care homes in order to develop and deliver targeted programmes and projects (Chatterjee and Nobel, 2013). This can be seen as part of the development and commitment of cultural institutions to create links that work more closely with their local communities and engage in addressing some of the health issues in society.

Traditionally museums have not worked in collaboration with healthcare providers and, therefore, this new area of work requires a directed approach. In response to a call for guidance on how museums could contribute to the health and wellbeing of their community, the Research Centre for Museums and Galleries at Leicester University (RCMG) published *Mind, Body, Spirit: How museums impact on health and wellbeing* (Dodd and Jones, 2014). The publication highlights that in order to respond to the health and wellbeing of communities it is essential that museums look outside the institution. Working in partnership with other

organisations helps focus attention on the most appropriate ways to present collections, exhibits and interact with their audience. Furthermore, finding the right partners is essential (Dodd and Jones, 2014). This is supported by Wollard (2004) who also emphasises the need for museums to work with other professionals or organisations who have developed expertise in certain areas. The RCMG publication set out to illustrate how museums are … (Dodd and Jones, 2014:3):

> *… well placed to respond to changes in public health, using their collections to improve the health and wellbeing of individuals, to counter health inequalities within communities and contribute positively to the goals of public health bodies.*

The publication explores health and wellbeing as a societal issue and embraces public health from a social model perspective, placing focus on the whole person and the community within which the museum is situated. The publication provides examples of museums working in partnership with local health providers where the emphasis is on maintaining, nurturing and developing common aims within the partnerships. It considers the significance of existing practices and innovations and it draws attention to the untapped potential in terms of development opportunities for partnerships. In the conclusion, the publication places emphasis on the importance of capturing and evidencing the impact of health and wellbeing projects, as well as promoting the work internally and beyond (Dodd and Jones, 2014). However, the usefulness of the publication in relation to the operational practice of the museums would depend on the commitment and policy agenda of the individual museums, as not all museums see the value in, or have the frameworks to deliver, museum work for health and wellbeing.

Furthermore, it has been acknowledged that while museums seek to serve and involve people who may be marginalised, including service users with mental health problems, requires the involvement of other professional partners as essential (Silverman, 2010). Whilst this presents a way to develop relationships with new audiences it is essential that the staff are properly skilled to deal with the needs of the potentially vulnerable people and also to feel confident to deal with situations that may occur, which is relevant to this study as it explores the relationship between museum educators and services users.

As someone involved in arts and health practice and research, my experience has shown that museums have a lot to offer in terms of participatory engagement. These activities may take place at the museum or be delivered outside the museum, for example, in old people homes and hospitals or a community setting. Having considered museums as potential providers of settings for wellbeing, I focus on arts and mental health, which is an area of arts and health that specifically focuses on how participatory arts can benefit individuals with mental health problems.

### 2.7.4 Arts and mental health

Acknowledging the difficulties of defining health, wellbeing, mental health and arts in this literature review, this section considers the area of literature that refers to arts and mental health. The arts and mental health literature is mainly presented by a discourse that outlines the benefits for arts engagement for mental health service users. As the focus in the study centres on mental health, this section concentrates on the specific health and wellbeing benefits that are associated with mental health and arts engagement.

Many studies have illustrated that users of mental health services experience a range of benefits from engagement in arts activities. The benefits that have been identified are:

empowerment (Hacking et al., 2008); a sense of wellbeing, (Jensen et al., 2016, Jensen, 2013); recovery (Colbert et al., 2014, Sagan, 2012); therapeutic gains (Stacey and Stickley, 2010); developing identity (Sagan, 2012, Stickley, 2010, Daykin et al., 2010, Gwinner et al., 2009, Spandler et al., 2007, Parr, 2006); and social inclusion (Margrove et al., 2013, Wright and Stickley, 2013, Secker et al., 2009, Hacking et al., 2008).

Arts and mental health literature was also reviewed by Staricoff (2004) who showed that different art forms have different effects for people with mental health problems. The use of literature, poetry and creative writing was beneficial for both the service users and the care providers as it enabled the service user to gain control over their inner worlds, leading to an increased mental wellbeing while also helping health staff understand some of the underlying issues and factors that influence their behaviour. Drama, theatre and visual arts provided service users with effective ways of expression and an understanding of their world and promoted empathy between service users and staff. Service users benefitted from the use of music, dance and singing to enable the participants to recall past events, which promoted physical movement and self-expression. This indicates that the choice of art form and the approach might be an important consideration when anticipating and planning a project.

Secker et al. (2007a) carried out a large-scale mixed method research programme for the study *Mental Health, social inclusion and arts: developing the evidence base to* "identify appropriate indicators and measures of mental health and social inclusion outcomes and to develop and implement an evaluation framework based on those indicators and measures" (Secker et al., 2007: 6). Focusing on arts projects in the UK, with participants aged between 16 to 65 with mental health needs, the report included five components of work: *i)* surveys of arts and mental health projects in the UK, *ii)* retrospective analysis, indicators and measurements for evaluation frameworks, *iii)* outcomes measuring mental health and, *iv)* inclusion from the start of the project indicating a baseline and six months later a follow up and qualitative study. Benefits that were reported include an increased sense of mental

wellbeing and decreases in distress, which helped to combat social exclusion. Other benefits of participating in the arts projects were described in terms of giving purpose, meaning and hope, increased confidence, a sense of achievement, pride and satisfaction, as well as confidence and self-esteem and the ability to rebuild an identity beyond that of being a 'service user' (Secker et al., 2007). The report concludes that the results provided "sufficient evidence of mental health, social inclusion and, in particular, empowerment gains to justify support for arts and mental health work" (2007: 77) and that the "arts participation improved levels of empowerment and the evidence for improvements in mental health, as measured by the CORE (Clinical Outcomes in Routine Evaluation), was promising" (Secker et al., 2007: 77). The study was the first of its scale in the UK to consider arts and mental health.

Two qualitative articles were written based on the study, namely: *Catching life: the contribution of arts initiatives to recovery approaches in mental health* (Spandler, et al., 2007) and *Evaluating the impact of participatory art projects for people with mental health needs* (Hacking et al., 2008). Both articles made a significant contribution to the literature on arts and mental health by identifying that participation in art projects increases levels of empowerment and can influence social inclusion (Hacking et al., 2008). Furthermore, findings show that engagement in arts fosters hope, and creates a sense of meaning and purpose as well as developing new coping mechanisms and rebuilding identity. While these findings are difficult to standardise and measure, they are probably the most important outcomes for the participants. Spandler et al. (2007) suggest that having access to participation in arts projects may be an important element of recovery for mental health service users that find themselves "caught up in a cycle of hopelessness and despair" (2007: 78).

A systematic review, *The impact of art, design and physical environment in mental healthcare: a systematic review* by Daykin et al. (2008), incorporated over 600 papers published between 1985 and 2005 and includes a discussion of 19 reports of qualitative and

quantitative studies that satisfy the research criteria. The findings were discussed in relation to three themes, including: the impact of arts interventions in healthcare settings; the impact of design and environmental conditions in healthcare settings; and perceptions of art, design and environments in healthcare settings. The review identified an increasing volume of literature exploring the significance of the health environment, which indicates a growing interest in and focus on the influence that the environment of health settings has on service users' recovery and the wellbeing of healthcare staff. Although difficult to synthesise the data, due to the "diversity in settings, interventions and outcome measures used," the review presents some key findings, namely that "the arts can positively affect clinical and behavioural outcomes" as it may reduce depression and anxiety in specific groups (2008: 92). The positive outcome was that "environmental conditions have also been identified, including reduced stress, reduced risk, improved way-finding and enhanced perceptions of healthcare environments" (Daykin et al., 2008: 92). The effect of using the arts in mental health environments shows that service users can be helped to improve communication skills and provide new forms of expression, stimulate creative skills and build confidence. Considering a humanistic environment with a relational and a social concept that has creative approaches is referred to by Crawford et al. (2013) in what they call "mutual recovery" that may benefit not only service users but society as a whole.

The Daykin et al. (2008) review is limited to published literature and has not considered the vast amount of grey literature available in the field; nevertheless, the review is the first (and only) of its scale considering the impact of the environment in mental health settings.

*Qualitative Research in Arts and Mental Health*, edited by Stickley (2012a), encompasses a wide range of research in participatory arts in mental health showing a variety of qualitative methodologies. The book presents examples of art-based research projects seeking to promote mental health. An example is *The arts and mental health: creativity and inclusion,* where Parr (2012) starts by discussing the use of arts in mental health with reference to therapeutic

aspects and to Outsider Art. She draws attention to the notion of the mental health service users as outsider artists and considers how it is possible to use community arts projects for social inclusion of marginalised psychiatric patients. Parr then presents and discusses research from Glasgow and Dundee from 2003-2007, where participants engaged in various arts activities and reported positive outcomes that contributed to a sense of belonging and the development of their artistic and personal identities.

Recognising that the experience of engaging in arts is not unproblematic for mental health service users, as they might experience struggles to find creative expression during illness, the experience is related back to 'belonging' and Parr attempts to draw out different meanings of belonging. Parr explores belonging among those who are regular participants in arts groups/activities and peer-advice which foster positive emotions and self-esteem. She further points out that a crucial part of arts in the community mental health settings is "not open to clinical interpretation" (2012:11), which makes the approach different for the therapeutic setting in institutional sites. This non-clinical approach strengthens and fosters development of identity and a sense of belonging. The notion of identity is also explored in Daykin et al. (2010) who suggest that engaging in arts activities provide service users with access to a variety of new identities and is able to depart from the 'stigmatised' or relatively powerless one of 'patient' and this was reinforced by giving service users new voice to provide their opinion or speak about their experiences.

In *Social identity and belonging: the lost artists club,* Stickley analyses the findings from four participants that attended the mental health and arts group 'the lost artists club'. Like Parr, Stickley discusses social belonging and identity and considers a constructionist concept of self as "a continued process of development" (2012: 96), which can be part of a recovery process. The research illustrates that the participants of the project developed a strong group identity.

Another significant contribution to the arts and mental health is *Connection and reparation: narratives of art practice in the lives of mental health service users*, by Sagan (2012), who

explores the meaning of arts practice based in the community from the perspective of people enduring mental health problems. The meaning of arts as a tool for survival, recovery and its positive psychological functions are considered and the discussion is centered on how learning from narratives can be used to understand the role of art engagement in terms of wellbeing. The research was presented as a film about mental health service users practicing arts. Through the participants' narratives, Sagan (2012) makes sense of the meaning that is attached to arts practice for mental health service users. The study identified four narratives: *i)* narratives of ill health and making sense of it; *ii)* narratives of art therapy; *iii)* narratives of arts practice and the autobiographic; and *iv)* the 'I' in illness. She discusses the comments from participants and in a response to a participant's narrative about finding words limiting and their inability to verbally express emotions, Sagan explores the notion of the process. She draws parallels to the process that happens in talking therapies and "through an art practice which feeds into a personal positive narrative which in turn informs an art practice," it is possible to reformulate and helps to repairs them (Sagan, 2012: 9). Sagan understands arts practice to allow new spaces for people with mental health problems and new relationships through which it is possible to re-think and re-construct themselves.

The concept of identity is also found in the small scale study by Stacey and Stickley (2010), where the findings in the article *The meaning of art to people who use mental health services* shows that participating in arts can have multiple benefits for mental health service users; a distinction between extrinsic and intrinsic influences on creative expression is made. Extrinsic influences are seen as responses by the audience to the art works and the environment within which the art is created. Intrinsic influences are identified as the therapeutic value and identity in relation to art which shows health and wellbeing benefits for individuals with mental health problems (Sagan, 2012, Secker et al, 2007). The article offers an insight into the manifold importance that participation in arts can have for people that are using mental health services (Stacey and Stickley, 2010).

The use of the arts have been used for mental health wellbeing purposes historically and can be traced back to the earlier mentioned notion of catharsis in the Ancient Greeks (Belfiore, 2016), as well as using the arts in psychiatric settings dating back to the 19th century (Busine et al., 1998), where art was used to give services users an expression as well as an occupation. At SLaM, both in- and out-patients can attend arts activities and the drive for embedding the arts can be seen throughout the hospital. The Bethlem Museum and Gallery in Kent, which is part of SLaM, exhibits work from past and current services users alongside the hospital's history of psychiatry. Although the use of arts in mental health community settings also exists in Denmark, to date no research has considered how mental health services users have benefited from their engagement in arts. This study focuses on service users from a community mental health setting in Denmark and therefore this study is relevant as it provides research into an area currently unexposed.

Community arts projects and AoP projects are both interventions delivered in interdisciplinary collaborations, which are found at the core of most arts and health projects and programmes. In the section below I consider 'interdisciplinarity' in arts and health and what it might mean in the context of the field.

## 2.8 Interdisciplinary collaborations in arts and health

In this study, my focus is on the interdisciplinary nature of arts and health, recognising that historically arts and health (care) have been distinctive and separate arenas of practice. To date there has been no such study, apart from the occasional mention of issues in connection with collaborations between arts and health. This study is therefore well-placed to add to the knowledge in the field of arts and health. The literature relating to the concept of 'interdisciplinarity' is considered from a variety of disciplines and the review examines 'interdisciplinarity' as a concept, as well as how it might operate in arts and health.

Working in arts and health inevitably requires working in an interdisciplinary setting with practitioners from different disciplines. The Longman dictionary defines 'interdisciplinary' as "involving ideas, information or people from different subjects or areas of study" (Mayor, 2010: 848). 'interdisciplinarity' involves collaboration where information, tools, techniques, and theories and perspectives from different disciplines are integrated to advance an understanding or to solve a problem, which are beyond the scope of a single discipline.

The literature in the field illustrates the various collaborations between different stakeholders, professions and disciplines in the field. Artists work with healthcare staff; healthcare staff work across disciplines with local authorities and academics, where organisations and charities join forces in collaborative ventures, bringing a wide range of disciplines together to improve the health and wellbeing of individuals and communities. The interdisciplinary practices and research are facilitated by geographers, sociologists, occupational therapists, nurses, psychologists, doctors, artists, therapists, social workers and so forth, illustrating the many disciplines presented within arts and health. There are many examples of interdisciplinary projects between arts and health, including: mental health and arts (Parr, 2006); arts in hospital spaces (Macnaughton, 2007); and community participation and people with learning disabilities (Milner and Kelly, 2009), to name but a few.

While the debates about the meaning of health and wellbeing have persisted, there has been some recognition that there are valuable connections to be made between art, health and wellbeing. Indeed, the argument is that there is a contribution to the wellbeing agenda in many countries that is already being made: building social capital; contributing to health promotion; supporting community cohesion; improving the health of individuals with cancer and dementia; and mental health issues, are all among the findings from the arts and health literature (RSPH, 2013, Clift and Camic, 2016). Yet there are problems too. Interdisciplinary work between the arts sector and the health sector are faced with many challenges (White, 2009, Parkinson and White, 2013). These challenges are often considered to be political or

methodological and much literature is concerned with the research outcomes of projects, whereas there is limited literature that addresses the interdisciplinary practices between the stakeholders.

Angus (2002) pointed out that reports on arts and health projects frequently indicate difficulties for the stakeholders in defining their roles and responsibilities. The value of arts programmes in hospitals depends on the support of the senior management, and often members of staff do not understand the role of arts in the hospital (Aston, 2011). This concurs with Moss and O'Neill's (2009) findings, which indicate challenges in communication and establishing a common language between health and arts and Moss (2015) argues that the support and development of arts coordinators in hospitals should be the responsibility of both the health and arts sector. Jensen (2014) discusses the impact that participation might have on services users and emphasises the need for training of staff involved in delivering projects to guard against unintended effects and to ensure ethical considerations are in place in order to safeguard participants as well as practitioners, and White (2010) suggests guidelines for practitioners.

Ethical considerations are brought forward by Boydell and Parsons (2012), and Cox and Boydell (2016), bringing attention to the fact that engagement in arts can have an emotional, or even upsetting nature, and as a consequence that practitioners need to be able to deal with. Although this is not necessarily negative, there needs to be guidelines that support practitioners who are involved in situations with upset or distressed people, and there needs to be access to additional support if required. These issues need an interdisciplinary approach that will focus on sharing expertise and experiences between the professions and develop standards for practice. However, in order to develop practice, it is essential to better understand the relationship between the professions involved and the services users, which this study seeks to do.

## 2.9 Summary of the literature review

As a practitioner in the arts and health field, I am interested in the interdisciplinary approaches to arts and health that have been taken in many of the initiatives considered in the review. Furthermore, the review has also helped create a context for some of the challenges in arts and health, as well as the benefits to health and wellbeing for a range of individuals and communities. The review has provided a background for the study and answered some of the questions that I was seeking to clarify before commencing the study.

The review found that the various concepts and definitions of arts, health and wellbeing are in continuous debate and as a result are politically contentious. It identified that wellbeing and health are not universally defined; they are interconnected concepts and it is difficult to discuss one concept with the other and, while wellbeing is a universal term, there are nevertheless no clear mechanisms for measuring the concept. Health can be viewed through various lenses, however; versions of the social model are preferred in the context of arts and health which allows for a view of the whole person, including the external factors associated with the individual. The review identifies arts as a tool for making change and providing health benefits to communities, individuals and making life meaningful for some people.

In the quest for economic evidence for the arts in health the review found that the literature argues for the use of qualitative methods and against RCTs, as art practice in health does not necessarily fit the criteria for a clinical measuring tool.

The review also recognises the area of 'interdisciplinarity' as being challenging due to different epistemological and methodical approaches between disciplines presenting different paradigms. Furthermore, museums and galleries could have an impact on health and wellbeing by delivering projects in collaboration with other stakeholders in arts and health; however, there are challenges in such interdisciplinary collaborations, including the positioning of art projects in hospitals and community settings, and for health promotion in

museums/galleries understanding frameworks, roles and responsibilities and cross-sectoral communication.

The review has identified a wide range of arts and health projects, and research and studies across an international spectrum although the majority of included literature is from the UK, which has a more established tradition for delivering arts and health programmes. Community arts are identified as creating community wellbeing and social capital in addition to creating feelings of shared ownership. The review identified a growing interest for the field, manifested in the increasing number of published articles from an international perspective.

The review of AoP projects illustrates that although participating in the schemes improved health and wellbeing, projects were evaluated (if at all) without a common framework and better evaluation methods are needed. The literature about arts and mental health found that the primary focus is on the social and health benefits for the participants; these are identified as empowerment, greater ability to socialise, better communication skills, a reconstruction of identity and feeling included, and a sense of belonging, all of which contributes to recovery.

Finally, the review illustrates that although an interdisciplinary approach brings expertise to the field from arts and from health, there are also challenges associated with it which need to be addressed.

Having considered the literature that is relevant for the study, I present the rationale for conducting the study followed by my specific research question. However, first I describe my initial thoughts about the area of my interest and how that changed over time.

## 2.10 Rationale for study

I came to the study with a set of ideas of what I wanted to do. I wanted to know more about the relationship between the arts sector, the health sector, the professionals and the service

users within the arts and health context. I had named it the 'four-way relationship', having preconceived ideas of how it should look, and I created models for the mechanism of interaction between the stakeholders. Within this, I was particularly interested in how service users benefitted from participating in arts activities and what the ultimate working relationship between the stakeholders should look like. Essentially, I considered a solution-orientated approach. Such knowledge, I believed, would best be obtained by direct involvement of the stakeholders and by gaining their perspective and experiences; this would effectively create access to their 'worlds'. An understanding of the inner worlds of the stakeholders would enable the study to 'prove' that arts engagement has significant benefits for health service users, and the testimonies from the other stakeholders would provide a framework to develop a 'four-way model' of best practice. However, such an approach would test a hypothesis rather than generate one. It slowly became clear that such a study was too broad and would require collecting data from a large number of participants to satisfy what was required for a 'best practice model'. Narrowing down and refocusing was essential and this required time for reflection and to pursue more literature from the arts and health field.

In researching the literature, and based on my epistemological assumptions about arts and health, I began to see a gap emerge. While there is much evidence suggesting that mental health service users benefit from participating in arts activities (Spandler et al., 2007, Staricoff, 2004), there is little knowledge about the interdisciplinary working relationships between the professional practices; this area is inadequately explored. Having managed projects in both the health and the arts sector, I was already aware of some of the challenges faced by the interdisciplinary nature of the work. For example, in research funded by the Wellcome Trust it was discovered that the value of the arts programmes in hospitals depends on the support of the senior management and also that many members of staff do not understand the role of arts (and its subsequent benefits) in the hospital environment (Aston, 2011). Issues of effective

communication have been identified in addition to the need for healthcare professionals to understand the scope and practice of artists (Moss et al., 2012).

Considering the literature review, there is an assumption that arts engagement can address a range of health and social issues, including wellbeing and a sense of purpose, empowerment and recovery. Embedded in arts and health practice is an understanding that our health is influenced by a range of factors that includes individual, interpersonal, social, environmental, economic and political considerations.

Based on this assumption, the study explores and examines interdisciplinary collaborations in the context of arts and health practice. However, the work in this interconnected field between the art sector and the health sector is challenging as methodological approaches to projects that satisfy both sectors are problematic and different professional languages are often spoken. For example, the approach in the art sector is more explorative than the health sector that relies on evidence-based practice, and the professionals in the field come from different disciplines and paradigms. The study aims to explore and examine interdisciplinary collaborations in the context of arts and health and specifically explores the interdisciplinary relationship between health professionals, museum educators and mental health service users and apply an attempt at transparency to the practice, which is made up of stakeholders from a variety of disciplines.

In Denmark there are no traditions for using arts in the health sector and although there is interest in the area, there is still a long way to go before it will become mainstream practice. There may be many reasons for the lack of creative practice in the health sector; one reason points towards the silo-thinking between sectors and a lack of interdisciplinary thinking about public health service delivery (Jensen and Wille, 2015).

While there is no political framework for using arts in health settings, the arts and health field has grown and developed in the UK over the past thirty years. Some of the experience gained in the UK, particularly the interdisciplinary work of practitioners from different disciplines, is

interesting to consider in a Danish context where mental health issues are on the increase among the population, according to a report from the Danish Health Agency (Sundhedsstyrelsen, 2015). This variation in the length of experience necessitated a different approach for each study conducted in the respective counties. In order to gain an understanding of the interaction between some of the stakeholders in the field in Denmark it is necessary to set up a new project that would allow this exploration to take place. By contrast, in the UK, it is possible to explore the relationship between health professionals and museum educators through an existing project. Exploring two different sets of relationships within two different settings, with different levels of experience, enables rich data from the interaction between the health professionals, museum educators and service users.

## 2.11 Research question

In order for a comprehensive examination of the interdisciplinary nature of the relationship between the stakeholders in arts and health, it is significant to explore the interplay between healthcare professionals and museum educators. My research question is:

*How do collaborations in arts and health practice work?*

The objectives are:

- To explore the relationships between stakeholders in arts and health projects (health professionals, museum educators and service users)
- To examine the characteristics of the professions involved
- To study the challenges associated with the interdisciplinary work involved

The following questions inform the implementation of the research as well as the data analysis process:

1. What is being represented as logics from the involved professions? What are their understandings and identity?
2. How has this come to be? Is it in part societal, institutional and professional?
3. What practices are made possible and what are the challenges of this way of thinking/understanding?

These guiding questions will enable me to explore the institutional, interdisciplinary and professional logics of the data, in order to understand the broader context of relationships between the stakeholders in arts and health. The questions can connect the identified themes from the analysis with the theoretical underpinnings of the study.

Having provided a backdrop for the study covering the relevant area of arts and health practice and research through the literature review, and presented my rationale for the study and the research question, I introduce the next chapter. Chapter three, presents the theoretical framework for the study as well as defining the concepts used.

# CHAPTER THREE: Theories

## 3.1 Introduction

This chapter presents the underpinning theories, considers 'interdisciplinarity' as a concept and show how different disciplines come together in this study. The chapter also considers how a profession is defined and established; and identifies the professionals in this study. The underpinning theories are introduced as: the theory of professions (Abbott, 1988), Foucault's thinking on institutions (1975), and institutional logics (Thornton et al., 2012, Lounsbury and Boxenbaum, 2013). The institutions in the study are also defined.

## 3.2 Underpinning theories

In this study, I draw upon the theory of professions and institutional logics. The professions central to the study are health professionals and museum educators. Essentially, the study considers two rather different professions. While the health professions' functions are to promote health, to treat diseases and care for people, the museum educators disseminate information and knowledge about cultural heritage and educate and engage people in the area of arts and culture. It is difficult to consider the professions involved in the study without focusing on the institutions that they operate within. The institutions central to the study are the NHS, which employs health professionals, and the museums that employ the museum educators.

Using the theory of professions and applying institutional logics theory will help examine the relationship between the stakeholders and understand some of the tension and barriers in the interdisciplinary work. The theories will support an understanding of the issues that arise in arts and health collaborations and how they have manifested themselves, and are driven by the professions and institutions and ultimately embedded in practice. Such analysis will create

transparency to previously unknown areas of the interdisciplinary work in this area of practice, and highlight how professional and institutional logics potentially are embedded in arts and health projects.

I start by considering the theory of profession and the concept of professions that is relevant to the study and present Abbott's (1988) work on jurisdiction, which he argues to be central to the system of professions. I consider how Abbott's theory is useful in exploring some of the areas that the study set out to examine and also in presenting the professions central to the study. I consider Foucault's (1975) thinking about institutions and, separately, present the theory of institutional logics (Lounsbury and Boxenbaum, 2013, Thornton et al., 2012) that helps to explain the institutional context that is present within this study. Furthermore, I consider how the logics can be used as an analytical tool towards gaining an understanding of the interplay in arts and health. I begin each section by situating each of these lines of theory within their respective traditions.

Prior to introducing the relevant theories, I contextualise the concept of interdisciplinary as the nature of how the interdisciplinary field influences the theoretical considerations that are under consideration.

### 3.2.1 'Interdisciplinarity' as a backdrop

'Interdisciplinary' is a term that is often used when a subject is approached from different disciplines, but how can it be understood? The terms and concepts interdisciplinary, multidisciplinary and transdisciplinary are ambiguously defined and used throughout literature. The differences, according to Choi and Pak (2006: 351) are that:

> *Multidisciplinarity draws on knowledge from different disciplines but stays within their boundaries. Interdisciplinarity analyses, synthesises and harmonises links between disciplines into a coordinated and coherent whole. Trans-disciplinarity integrates the natural, social and health sciences in a humanities context and transcends their traditional boundaries.*

For others, there is less clarity; for example, Klein (1990) discusses the concept of 'interdisciplinarity' as being difficult as many related concepts exist with several interpretations including: 'multi-disciplinarity', 'cross-disciplinarity', 'interdisciplinarity' and 'trans-disciplinarity'.

Although 'interdisciplinarity' might be viewed as a twentieth century term, its historical antecedents can be traced back to Greek philosophy. Historians and dramatists took the essential ingredients from other domains of knowledge to understand their own material, including philosophy and medicine (Gunn, 1992). In other words, the Greeks used knowledge from different paradigms to make sense of significant subject matter and 'interdisciplinarity' was used to create some of the knowledge foundations which are used today.

The significance of 'interdisciplinarity' is described by Palmer (2001: viii), who sums it up rather well: "the real-world research problems that scientists address rarely arise within orderly disciplinary categories and neither do their solutions"; or as Youngblood (2007:1) puts it: "no discipline is an island entire in itself". In a study of intersecting thoughts in subjects, it is found that interdisciplinary collaborations are required because problems are

often too complex to be judged sufficiently or solved simply with the subject-knowledge of a sole discipline (Hübentdal, 1994).

A focus on individual disciplines and the work within various branches of knowledge that builds disciplinary expertise without seeking to acquire interdisciplinary knowledge was criticised by (Foucault, 1975). However, a few years before Foucault's critique of disciplines, 'interdisciplinarity' and 'transdisciplinarity' was coined by Jean Piaget in 1970, signifying a 'new space of knowledge' intersecting two or more disciplines. This can be difficult and "individuals and institutions can construct barriers to successful transdisciplinary working" (Timmons et al., 2015:12). In other words, 'interdisciplinarity' crosses traditional boundaries between schools of thought or academic discipline and 'interdisciplinarity' (Klein, 1996), which has developed from an idea into a complex set of claims, activities and structures. Foucault criticised the concept of academic disciplines and in his book, *Discipline and Punish,* he argues that academic disciplines originate from the same mechanisms of control that established the modern prison in France in the 18th century and that they continue to have aspects in common such as: "the disciplines characterize, classify, specialise; they distribute along a scale, around a norm, hierarchies, individuals in relation to one another and, if necessary, disqualify and invalidate" (Foucault, 1975: 223). In this way, Foucault (1975) suggests that there is a danger in the structured methods and systems for working within a discipline as it creates hierarchies, norms and boundaries that are difficult to move beyond.

According to Frodeman et al. (2010), the two primary forms of 'interdisciplinarity' are instrumental and critical. Instrumental 'interdisciplinarity' is defined as a problem-driven, pragmatic approach which addresses topics and integrates insights and theories to achieve a more comprehensive understanding; this can involve raising epistemological and/or political questions as well as recommending transformative policies. In this way, instrumental interdisciplinarity can be understood as problem-solving (Rowland, 2002) and a response to the external demands of society (Repko, 2012). On the other hand, critical interdisciplinarity

has a socially driven meaning which "interrogates the dominant structure of knowledge and education with the aim of transforming them, while raising epistemological and political questions of value and purpose" (Frodeman et al., 2010: 30).

The key distinctions between instrumental interdisciplinarity and critical interdisciplinarity are the objectives. While an instrumental approach seeks to solve real-world problems, a critical approach aims to question existing structures of knowledge and raises questions of purpose and value. In this way, the differences between instrumental and critical inter-disciplinarians are not absolute or unconnected; although they are different approaches it is possible to apply a 'both/and' approach which reflects the scope for both critique and interrogation (Repko, 2012). Research on universal problems such as healthcare and the environment frequently reflects a combination for critical and problem-solving approaches.

The term arts and health has no identifiable origin and has been constructed from two or more disciplines. There are parallel constructions, for example, Crawford et al. (2015) propose *Health Humanities*, which is the title of their book that has emerged from the International Health Humanities Network. Similar to Medical Humanities, Health Humanities is an interdisciplinary field incorporating the arts, humanities and social sciences as well as health and social care disciplines.

Medical humanities[8] are a relatively new interdisciplinary field and can be described as being open to both an instrumental and a critical approach. It can be seen as being instrumental to the solution of medical problems and the improvement of medical practice. From this perspective it offers a range of educational and professional practices which may help to create better doctors. On the other hand, medical humanities can be viewed as raising critical

[8] The distinction between medical humanities and arts practice in health, is according to Kirklin (2003) that it reflects a basic heterogeneity of purpose. Medical humanities are primarily addressed in pursuit of educational goals which are different from therapeutic aims or the goals of improving healthcare or community environments or a process for wellbeing. KIRKLIN, D. 2003. The Centre for Medical Humanities, Royal Free University College, London. *Academic Medicine,* 78**,** 1048-1053.

questions that pose a variety of understandings of the whole undertaking of medicine and medical care. From this perspective, the application of ways of thinking can raise significant questions about what it is to be a doctor or a member of healthcare staff and can challenge the social structures that medical practices are located within (Rowland, 2002).

In this way, it can be said that the interdisciplinarity that exists in arts and health practice falls into both categories i.e. problem-solving and questioning, and has a 'both/and' approach; pragmatic and leaving space for critique and interrogation of the disciplines in addition to economic, social and political structures. In the 'both/and' approach, arts and health seeks to answer questions, solve problems on research, borrowing and solving practical problems, aiming to achieve as much integration as possible from the contributing disciplines while questioning value and purpose.

'Interdisciplinarity' has not, until recently, been considered an epistemological norm in humanities and social sciences and there is little knowledge of how the diverse objects, subjects and methodologies of 'interdisciplinarity' are developed, formed and transformed within distinct environments (Callard et al., 2015). Therefore literature to support claims and explanations of different epistemologies in interdisciplinary work is limited and, although 'interdisciplinarity' is being brought forward as a solution to a series of contemporary problems, the logics of 'interdisciplinarity' are entangled and specific to different fields of 'interdisciplinarity' (Barry et al., 2008). Professional difference has been explained as 'tribalism' (Beattie, 1995) as a result of professions' separate evolution with profound boundaries between them (Baxter and Brumfitt, 2008). The results of different training and philosophical approaches underpinning professions may also be the reason for such differences (Fitzsimmons and White, 2006).

Arts and sciences belong to two different paradigms, where the arts are placed within the

interpretive paradigm (Guba and Lincoln, 1994) and sciences have been identified with a reductionist approach (Klee, 1997). Collaborative projects raise questions of how to understand the interactions of the professionals/disciplines involved, including conceptual and methodological questions about the collaborators and how relationships are built and developed (Bergman et al., 2014).

Different approaches and ontological foundations create barriers for 'interdisciplinarity' when no common or pragmatic logics are applied (Reay and Hinings, 2009). The work in the interconnected field between the art sector and the health sector is challenging. Being trained in a traditional discipline can be a barrier when working in interdisciplinary ways, as learning a different perspective or method might be challenging. Because of the nature of arts and health projects (straddling two disciplines) they are predominantly interdisciplinary. While the science associated with medicine and healthcare often strives to ensure the process of hypothesising, testing hypotheses, predicting and testing and producing systematic results to validate theory, the humanities associated with the arts do not ask the same kinds of questions or apply such rigid methods (Miller, 2011). In arts and health projects, the arts and sciences come together on various levels; however, the different approaches when combined have not previously been discussed in the arts and health literature.

Arguably arts and sciences belong to two different paradigms and while projects such as those emerging in the field of arts and health attempt to bridge the paradigms, silo thinking can create a split between science and humanities. This was observed decades ago by C.P. Snow, a British scientist and novelist who addressed the divide between the different paradigms and viewed the divide as potentially having serious consequences for the creative, intellectual and daily life.

In 1959, a significant Reith lecture[9] was given by Snow, entitled *The Two Cultures*. Snow claimed that uniting scientists and literary intellectuals would benefit society and that breakdown in communication between sciences and humanities was becoming an obstacle for solving some of the issues and problems confronting the world. In this way, his message was that an interdisciplinary approach between science and humanities was necessary to solve the issues in society as opposed to operating in different paradigms. Almost sixty years later the issue remains unresolved. Although Snow's *The Two Cultures* (1959) might offer a superficial and conceptually weak division between the world of the humanities and the sciences (Becher, 1993), it is often referred to in the debate of disciplinarity and interdisciplinary.

Bridging arts and science is essential for the arts and health field and with a focus on the nature of 'interdisciplinarity' in practice; this study seeks to understand some of the issues that arise in interdisciplinary projects. Underpinning this study is the notion that arts and health are equal partners in the field and in order to create successful collaboration, it is necessary to collaborate on project delivery to ensure content quality and safeguard the service user /patients.

Having considered interdisciplinary as a concept, and what it means in terms of arts and health projects, I present the definition of a profession, describing how professions become established and introduce the professions that are relevant to this study.

[9] "The Reith Lectures are a series of annual radio lectures given by leading figures of the day, commissioned by the BBC and broadcast on BBC Radio 4 and the BBC World service. The lectures were inaugurated in 1948 by the BBC to mark the historic contribution made to public service broadcasting by Sir John Reith, the corporation's first director-general". http://en.wikipedia.org/wiki/Reith_Lectures

### 3.2.2 Defining a profession

One of the identifying features of a profession is that it is able to self-regulate and can keep the public safe and charlatans at bay; to become a profession the State permits a group professional autonomy. By means of permission the group acquires influence and power associated with that authority (Foucault, 1980). State sanctioning is important to professions as it gives them status and a collective social role and responsibility. Professions, as described by Moran (1999: 100), "organise markets in labour" and "need to develop distinctive ideologies to protect the autonomy of their regulatory sphere". The medical professional has had significant advantage in this, which, according to Moran, stemmed, "from its historical connection with science and technology" (Moran, 1999:100). This is confirmed by Starr (1982: 4):

> *... the medical profession has had an especially persuasive claim to authority. Unlike law and the clergy, it enjoys close bonds with modern science and, at least for most of the last century, scientific knowledge has held a privileged status in the hierarchy of beliefs. Even among the sciences, medicine occupies a special position.*

An agreed definition of a profession is difficult to find as there appears to be no single agreed upon definition. General conceptions include the occupational control of work suggested by Freidson (1983), the sociology of middle-class occupation by Dingwall (1996), or theories of occupations of expert labour, as suggested by (Compton, 1990). Each is offered as a way to discuss the concept of profession. Other researchers avoid the question of definition and instead offer a list of applicable occupational groups (see Hanlon (1998), Abbott (1988)). Another definition is suggested by Evetts (2003: 397), discussing professions as:

> *…the knowledge-based category of occupations which usually follow a period of tertiary education and vocational training and experience.*

An alternative definition is offered by Savage (1994: 131) as "a profession is a network of strategic alliances across ownership boundaries among practitioners who share a core competence". For the purpose of this study, I define professions in line with Abbott's loose definition. He argues that a firm definition is unnecessary and states that "professions are exclusive occupational groups applying somewhat abstract knowledge to particular cases" (Abbott, 1988: 8), suggesting that abstract knowledge is the foundation of an effective definition of professions. The characteristics of knowledge abstraction are what keep professions apart from other occupational groups (Abbott, 1988) and the process of amalgamation and division helps professions maintain an optimal level of abstractions. In other words, a particular set of knowledge abstractions is the essence of a profession and what sets it apart from another profession.

### 3.2.3 Establishing a profession and a postmodern view

Professions can be considered an expression of the modern capitalist state (Johnson, 1972) because the prospects for professions to thrive and develop is made possible by contemporary societies where knowledge is a cohesive autonomous domain (Gellner, 1988) and where goods and services exist in a free market fashion (Weber, 1978). Some professions, including law and medicine, have rich and long histories, while in general, the growth of professions in Western society is a fairly current historical phenomenon. The origins of many modern day professions may be traced back to the nineteenth century or later (Jennings et al., 1987). The roots of many current professional bodies can be found in the form of social clubs, created to

provide an environment to share ideas on a particular subject without the intention of becoming a regulatory institution. However, as professions became established with distinct sets of interests, followers and bodies of knowledge, they began to pursue monopoly and privilege. They entered into particular relationships with the State to achieve monopolisations, or licensing (MacDonald, 1995). Such agreement has come to be termed the 'regulative bargain' with the State (Cooper et al., 1988). The political culture which has shaped such regulative bargaining can be considered significant for the development of a profession. A postmodern position seeks to understand professions as self-serving institutions that guard their positions, power and knowledge (Nolin, 2008). Here, models of professions are critiqued for being self-serving interest groups engaging in power-play and in competition with each other for territories of knowledge and authority. By this understanding, professions engage in struggles over jurisdiction with other occupational groups and seek to monopolise expertise (Abbott, 1988). The link between a profession and its work is referred to by Abbott (1988) in terms of jurisdiction, which is a central phenomenon for professional life. Jurisdiction is an exclusive claim, e.g. law, medicine and clergy.

Professions have been subjected to internal conflict (Bucher and Strauss, 1961) and critiqued for being an occupational category based on elitist power and economic privilege (Johnson, 1972). This view is further perpetuated by Johnson (1972), also arguing that a significant attribute common across professions is the ability to exert control over clients.

This argument was extended by Friedson (1989), who added to this observation that institutional power over labour markets was based on their claims of expertise. Freidson (2001) moved towards talking about occupations rather than professions; its development can be understood as destabilisation of the profession's power and legitimacy along with the coming of a more bureaucratic thinking about professions.

Professions have, through history, been viewed in various ways and a postmodern perspective involves a theoretical view of professions and professionals in more comprehensive schemes

of institutionalisation, viewing the relationship between professionals and institutions as more collaborative (Suddaby and Muzio, 2015) and moving towards a more bureaucratic way of thinking. An example is the health sector, which is snowed under by paperwork. Spending time on completing admission forms, care plans, risk assessments and complex discharge plans prevents the health professionals from practicing their 'actual' work (Lomas, 2012). In this way, the bureaucracy structures of an institution can weaken the professional work.

Understanding how professions have come to be, is relevant in order to appreciate their relationship with the State and central to this study, the professions' relationship with institutions and with each other professions. It is necessary to define the professions and the professionals in order to understand the professional practice of those involved in this study. In the next section, I consider health professionals and museum educators, as they occupy professions in this study.

### 3.2.4 Professionals in the study

The study is concerned with two groups of professionals: health professionals and museum educators. A health professional is an individual accredited by a professional body upon completing a course of study and usually licensed by a government agency, to practice a health related profession such as dentistry, medicine, nursing, occupational health or physical therapy (HCPC, 2012). The WHO (2010: 1) defines health professionals as professionals who:

> *… study, advise on or provide preventive, curative, rehabilitative and promotional health services based on an extensive body of theoretical and factual knowledge in diagnosis and treatment of disease and other health problems.*

While there are many definitions and descriptions of health professionals, depending on different world perspectives, defining a museum educator is significantly more difficult. Unlike health professionals, museum educators often come from a wide range of different disciplines including artists, actors, teachers, dancers, art historians and musicians (Tran and King, 2007). While the profession of museum education has a rich history, it has fewer official specifications and licensing for its practitioners. Standards of practice have been shaped from within museum education and then made available to the arena serving as guides to the profession (Bailey, 2006).

The medical profession has a long history of being professionalised with professional bodies, associations and so on, where in contrast the profession of museum education is relatively new. While professional associations have existed for decades, they have no formal authority to regulate the work carried out by museum educators (Tran and King, 2007). The critical elements that are lacking in the process of professionalising museum educators are defined by Tran and King (2007) as being a lack of a theoretically grounded body of knowledge and skills defining areas of work; no requirement for certification to ensure quality of work; and the instruments to train new practitioners varies within institutions (Tran and King, 2007). Although there are guidelines suggesting lines of best practice and ethical behaviour (for example see ENGAGE[10]), there are no official professional bodies that regulate the area. Accordingly, the professionalisation of museum educators is ongoing. Abbott (1991) suggests that the process of professionalism is not a unilineal evolutionary process, or a shared action by a cohesive group, but rather "a complex and dynamic process in which social and professional forces are interrelated" (1991: 380).

[10] Engage is a membership organisation representing gallery, art and education professionals in the UK and over 20 countries worldwide. Engage promotes access to, enjoyment and understanding of the visual arts through gallery education. www.engage.org

Central to professions are professional identities, which develop through education and work experience. Professional identity is constructed through discourse between individuals and identities are continually being constructed and altered (Bleakley, 2004). It is recognised as significant for professional salience and effectiveness to develop a professional identity within a field, linking professional identities strongly to job satisfaction and performance (Wiles, 2010, Day et al., 2005, Jeffery et al., 2005, Baxter and Brumfit, 2004). Professional cultures include values and behaviours. Part of the educational experience that occurs during the training of each arts professional or health professional reinforces "the common values, problem solving approach and language/jargon of each profession" (Hall, 2005: 188). Values are internalised in professions and are essentially unspoken and they become taken for granted, creating an obstacle that is invisible to other professions (Hall, 2005). Beliefs, understandings and attitudes about roles within the context of work are generally referred to as professional identity (Adams et al., 2006, Lingard et al., 2002).

Having considered some central points about professions, I explore the theory of professions by Abbott (1988) and discuss how Abbott's approach is useful in this study.

### 3.2.5 Abbott's theory of profession

The development of theories of professions has largely been dominated by sociologists and is a huge and complicated field with extensive historical roots (Nolin, 2008). The volume of literature on professions in sociology focuses mainly on professions as social groups and on the roles of professionals in society (Savage, 1994). Theoretical analysis where focus had been concentrated on ethic coding, associations and licensure has, according to American sociologist Abbott (1988), neglected the professional activities and the circumstances in which they are situated. Abbott's focus in *The System of Profession* (1988) is on the dynamics through which professions define their jurisdiction and the right to control a particular activity

or service. According to Abbott (1991), research on professions ought to focus on professional practices and the content of the professional work and the ways that professions claim jurisdiction on specific societal problems, rather than on the dependent organisational structure of professions. Abbott's approach has been subjected to critique by Turner (1989: 473) for not addressing certain topics and (DiMaggio, 1989: 535) notes how Abbott "brackets the question of how professions achieve collective rationality". Johnson (1989: 413) offers a critical comment about "obsession with competition as the overriding dynamics […]" However, Abbott's (1988) way of thinking about professions and the division of labour in relation to the State and within institutions, is interesting for this study and varies from Johnson's (1972) approach. Like Abbott (1998), Johnson (1972) sees professionalism as a particular type of occupational control that is about survival, however, unlike Abbott (1988), he reflects on professions through analysis of social division of labour and social power. The appeal of using Abbott's theories (1988) in this study is that he comes from a perspective that considers the organisation and the conflicts between professional groups for control and jurisdiction. Considering the focus on 'interdisciplinarity' in the study, Abbott (1988) provides ways to think about conflicts between professional groups and the role of institutions that Johnson (1972) is not concerned with.

His focus on professional practice in relation to society sheds light on why it is important to understand the professions' position before it is possible to understand interdisciplinary collaboration which enables us to see arts and health as an area of practice that is primarily between professions that may or may not be influenced by the institutions that they represent.

Despite the criticism, Abbott (1991) continues his focus away from the perception that professions hold a more or less fixed process of professionalisation; he regards the hidden concealed forces and drivers underlying professional practice as more important. Abbott (1991: 359) refers to the empirical facts and structural characteristics of professions as 'external appearances' and considers the process and interactions proceeding these outcomes

as the ‘intrinsic qualities of professions’ and being more significant to professions. By relating professions’ activities back to societal processes, the ‘black box’ of hidden motivation and drivers is opened and the professional practice becomes visible and can be clarified and explained (Vanderboom et al., 2014). Bouncing forward and backward between societal processes and professional practice, Abbott (1988) helps us understand aspects of professions to do with abstract knowledge and jurisdiction which is central to understand some of the dynamics and mechanisms of interdisciplinary work and how it relates back to societal processes. For example, the demand for evidence-based healthcare and the use of protocols becomes more comprehensible when it is explained and related back to specific societal and scientific perspectives. These perspectives have an emphasis on a healthcare practice, based on convincing evidence that practice has beneficial effects on patients that are concerned with principles of efficacy and efficiency (Vanderboom et al., 2014). If a different healthcare paradigm was dominant, different scientific principles and ways to perform healthcare practice would prevail. In this way, the societal context is an important consideration to explain the significance and meaning of certain professional activities and characteristics and the scope of jurisdictional boundaries and abstract knowledge.

Abbott (1988) argues that the various perspectives that are synthesised into a broad theory of professionalisation do not account for the different theories of professionalisation. The different theories of professionalisation include functional, structural, monopolist and cultural (Wuest, 1994) and Abbott (1988) asserts that the problem with these approaches is that they are based on fundamental assumptions that have been overthrown by empirical work. Theorists of professionalisation, according to Abbott (1988), wrongly assume that the actual work of professions is less significant than how they are organised to do it. Furthermore, he argues that it is wrongly assumed by theorists that the evolution of professions is unidirectional; in other words, he does not see the development of individual professions as independent or that professions are homogenous units that do not depend on other professions

and he recognises that the process of professionalisation does change over time. Abbott (1988) maintains that professions are objectively definable because of their influence and power in culture, "the social structure of professions is neither fixed nor uniformly beneficial; the nature of it is constantly subdividing under the various pressures of the market demands and inter-professional competition" (1988: 84). The environment that professionals are subjected to is in constant change with new professional groups emerging; technology is advanced and the political environment shifts. In this way, outside structures influence professions, perhaps not directly, but influence can be found in the structures within which professions exists.

Abbott (1988) makes a distinction between the formal and the informal jurisdictional claims. The formal is legal and public and the informal is the work place were jurisdictional boundaries often overlap when performing practical tasks. He argues that for change to occur within professions, there are two possible sources. One is from external factors initiating "opening or closing areas of jurisdiction and by existing or new professions seeking new ground" (1988: 90). In other words, new areas of jurisdiction are opened or old ones are closed. The second source of change is from internal factors that, unlike external factors, do not produce or close jurisdiction. Change that is initiated internally comes from the dynamic structures of professions as a result of the development of new knowledge. In arts and health projects the professions involved are likely to develop new knowledge through the interdisciplinary collaborations. Similarly to Abbott, Friedson stresses the importance of abstract knowledge for professions , "advanced training is required for the complete performance of the task in question" (Brint, 1993: 263). Also, Friedson's concept of professional power is the essence of 'control over work', based on knowledge monopolies (Brint, 1993: 266), which closely resembles Abbott's concept of jurisdiction.

The capacity for a profession to sustain its jurisdiction sits partly in the prestige and power of its academic knowledge (which is different from practical professional knowledge).

Academic professionals show the rigour, the clarity and the logical scientific character of professional work (Abbott, 1988). In essence, abstract knowledge serves to legitimise professional work as well as, in the case of medicine to discover new treatments, inventions and methods of effectivity and it has the ability to reform practical knowledge. Abstract knowledge accomplishes three tasks: legitimation, research and instruction, and in each it forms the vulnerability of professional jurisdiction to outside interference. Here, knowledge abstraction enables the survival of the professions. Knowledge systems that are governed by abstraction can redefine problems and tasks and grasp new problems, as for example, in the case of medicine where medicine has taken possession over alcoholism, obesity and numerous other social ills (Abbott, 1988). An effective abstract system would define the professional jurisdictional borders with clarity and depict an obvious line between what is part of and what is not included in the claimed tasks. However, in most work settings the professional division of labour is established through negotiation and habits that embody situation-specific rules of jurisdiction (Abbott, 1988). In the claim for jurisdiction, a profession asks society to recognise its rational structures through exclusive rights. In this way, Abbott defines jurisdiction as a combination of the culture of the profession in order to classify a problem, to make sense of it and to take action in order to find answers, in other words, to diagnose, to infer and to treat, in social structures such as legal and public. Abbott (1988) is focused on relationships between different occupations and sees professions as a dynamic system of professional groups striving for jurisdictional claims over expert knowledge.

The notions of knowledge and how it is produced and controlled within institutions is relevant to this study. As the nature of arts and health is interdisciplinary and while knowledge is co-created, is it also separately embedded in the professional practice of the professions involved and questions of how to share this knowledge and who it belongs to, is of interest to this study. Knowledge and institutions are also of interest to French philosopher, Foucault, whose work straddles disciplines and includes philosophy, sociology, history and literary theory.

### 3.2.6 Foucault and institutions

While Abbott (1988) is asking us to view professions from various perspectives, Foucault (1975) is suggesting that we observe institutions through a wide-ranging lens. One of the substantial developments in postmodern society has been the expansion of the public sector and private institutions. Instructions are often controlled or regulated by complex legal sets of procedures, which can be difficult to understand even for the people who work within them. Institutions are subjected to social, political and economic changes in society and respond to changes which are reflected within their own system.

The concept of knowledge and how it is used within society and within institutions is interesting for Foucault (1975) and he views knowledge as a production that is bound up in historical regimes of power and socially produces its own 'truth'. Foucault questions the notion of 'truth' and how we can really know the 'truth' of a society. The concept of 'truth' in institutions is problematic to the point that some features of communication and discourses may be considered as reflecting a complete concept of 'truth' when they rather reflect only a rough attempt to describe what took place. More precisely, the 'truth' is a reflection of the subjectivity of those who take part in such a social construction. This so-called 'truth' will, in turn, develop into certain logics that are used by professionals and institutions respectively and collectively.

A Foucauldian perspective asks us to understand an institution from multiple viewpoints, which include its formal legal status, and the examples of behaviour that are associated with it, as well as the institution itself with the ideas and concepts that create its institutional character (Bevir, 1999). Foucault's perspective on institutions presents a study of process or activities. He argues that in disciplinary regimes such as hospitals, universities or any other institutions, it is the individual that is seen to be subjected, to the point where a struggle against these practices and procedures is pointless, as the institutional requisites become entrenched in the individual themselves (Mills, 2004). This perspective posits that the norms that are accepted

are often beyond our perception and they create a self-discipline that does not require the force of others to ensure compliance. In this way, logics are enforced and reinforced by individuals by means of the nature of merely being part of an institution.

Foucault considers institutions to exist as a consequence of being constantly restructured as cycles of processes and activities which are dependent on each other, as well as institutions being in a state of flux (Bevir, 1999). In this way, Foucault sees institutions as being in continuous movement which enables them to survive. This perspective fits with the way that Abbott (1988) understands professions being in flux and seeking to change with the wider environment that they are confronted with as a way of survival. If we accept this as representative of professions and institutions, then the interdisciplinary field of arts and health must be viewed as fluid with stakeholders that are in flux both within and between professional and institutional settings, which arguably creates excitement and yet simultaneously it also makes the field vulnerable. The fluctuation allows for innovative work while the nature of ongoing restructure means both are exposed to and at risk.

Foucault is aware of the role that institutions play in shaping individuals. However, he does not believe that the relationship between individuals and institutions is only ever oppressive and constrained (Foucault, 1975). On the contrary, he suggests that power comes from many places and is a combination of various different power relations and that power is everywhere. It does not consolidate or embrace; rather it emerges as all kind of social relations (Miller, 1993) and it surfaces everywhere from the relations in economy and productive processes, all the way into the core of what society is constructed of, such as relations in the family, school, groups and so forth. In this way, it can be argued that professions are not without the influences of, and within the institutional structures, that they work; however, power alone is not adequate to explain every aspect of social relations. An example is the (current) battle between junior doctors and the Government in the UK. After negotiations about pay broke down, the junior doctors went on strike objecting to the prospect of a new contract. The

industrial action, supported by the British Medical Association (BMA), provides a national focus on the junior doctors' working conditions as well as allowing them to display their power within and beyond the institution. According to Foucault (1975), the relationship between all institutions and staff or individuals is one of power, and understanding the structures enables the use of such power.

The appeal to draw on Foucault in this study is that he does not belong to one theoretical position but he takes inspiration from a multitude of disciplines and without a unitary position it is possible to use Foucault to consider some of the structures and discourses in the arts and health field. Foucault may not offer solutions to the problems (Mills, 2004), but he helps us to deconstruct the interdisciplinary setting of the field of arts and health through an approach that aims to provide a more detailed picture and unpick some of the structures that bind the field.

Having considered how Abbott's theoretical lens can shed light on the tasks of professions and the link between jurisdiction and tasks and a Foucauldian approach to thinking about institutions, I move on to consider institutional logic. I understand institutional logics to be influenced by a Foucauldian way of thinking, taking on Foucauldian ideas and such theoretical approaches are useful in unpicking some of the institutional and professional structures that bind the arts and health field. In addition, it supports an analysis of the data that will provide transparency to expose some of the systems and structures that exist behind and within the interdisciplinary practice of arts and health.

### 3.2.7 Institutional logics

The sociological theory of institutional logic suggests that actors within an institution are able to understand and make sense of their circumstances by providing "assumptions and values, usually implicit, about how to interpret organisational reality, what constitutes appropriate behaviour and how to succeed" (Thornton, 2004: 70). Institutional logics guide the

manifestation and legitimation of organisational forms and practices (Suddaby et al., 2008) and institutional logics and practices have a well-established connection (Lounsbury, (Lounsbury, 2007, Thornton, 2002). It is also recognised that logics are subjected to historical conditions and that the organisational fields are often characterised by multiple and frequently conflicting logics (Reay and Hinings, 2009, Washington, 2004, Hoffman, 1999). To contextualise the overarching concept of institutional logics which has been developed from institutional theory, it is necessary to take a few steps back.

Institutional logics is a core sociological theory that focuses on how wider beliefs systems shape the cognition and behaviour of actors, embracing a wide core of foundations including social constructivism and a focus on culture and meaning making (Friedland and Alford, 1991). The concept of logics became principal to institutional theory when introduced by Friedland and Alford (1991) as an attempt to emphasis the significance of social context. In defining institutional logics, they stated that every social societal sector is characterised by a central logic associated with "a set of material practices and symbolic constructions", shaping and confining the behavioral range of social actors (Friedland and Alford, 1991: 248). Institutional logics were later defined in more detail by Thornton and Ocasio (1999: 804) as follows:

> *…the socially constructed, historical patterns of material practices, assumptions, values, beliefs and rules by which individuals produce and reproduce their material subsistence, organise time and space and provide meaning to their social reality.*

In this way, institutional logics helps to explain how and why particular things have shaped the social world of institutions.

It is a core assumption that the interest, identities, assumptions and values of organisations and individuals can be found embedded with prevalent institutional logics. Thus, institutional logics is a theoretical lens which can explain how institutions both enable and constrain actions through their logics that guides and organises principles and provides actors with vocabularies of motive (Friedland and Alford, 1991). In essence, logics describe the contradictory beliefs and practices in western organisations (Alford and Friedland, 1985).

According to Waldorff et al. (2013) after an emphasis on the institutional structures in the external environment that shaped homogeneity and stability in organisations, neo-institutional researchers shifted their focus and became interested in heterogeneity and change. Scholars shift in attention included areas such as: conflicting or multiple coexisting logics (Friedland and Alford, 1991, Thornton and Ocasio, 2011), institutional and agency entrepreneurship (Greenwood and Suddaby, 2006, Boxenbaum and Battilana, 2005) issues of struggles and power (Lawrence and Suddaby, 2006, Clegg et al., 2006) as well as the joint interaction between institution and practices (Lounsbury and Crumley, 2007).

In this way, neo-institutional studies have moved towards a micro-level focus that analysis the interplay between several levels (Lounsbury and Crumley, 2007, Marquis et al., 2007 Haveman and Rao, 1997) as well as on the work of creating, maintaining and interrupting societal institutions (Waldorff, 2010). Injecting various social meanings into institutional theory brings pluralism and variety and can shed light on the dynamic processes within the institutions which is a helpful tool in understanding some of the institutional process that are relevant to the study.

Logics are significant as theoretical concepts because they can help explain links that create a sense of common purpose and agreement within an institution (Reay and Hinings, 2009).

However, institutional logics can also help exploring the conflicting and multiple logics that are likely to exist in interdisciplinary collaborations and particularly with reference to professional groups where institutional logics and the professional project may come into conflict. Approaching the study from a logics perspective helps understand the professional and institutional perspective and enable an understanding of potential challenges and barriers to the work in arts and health practice which this study explores.

### 3.2.8 Individual's responses to institutional logics

As members of society, individuals are influenced and exposed to the various institutions of society identified by Friedland and Alford (1991) as: family, religion, market, state and professions. These institutions provide the cultural symbols and practices that direct commonly known areas of life (Panche and Santos, 2013) and individuals get embedded in the various institutional logics through their interaction with social networks (Palmer et al., 1993). Individuals get influenced by institutional logics in different and various ways depending their involvement in the institution (Panche and Santos, 2013). Examples of individuals complying with given logics within institutional complexity have been illustrated in various contexts including museums (Alexander, 1996), a rape centre (Zilber, 2013), architecture (Jones et al., 2011), or community banks (Almandoz, 2012).

Formal education presents a powerful platform for producing professional norms and legitimation (DiMaggio and Powell, 1983). It offers a 'ready-to-wear' template that will guide conduct and behaviour (Panche and Santos, 2013). However, institutional logics are also shaped through the experience of work and the strength of professional norms including conferences and professional members' clubs that promote and define the normative rules of professionals' behaviour (DiMaggio and Powell, 1983).

Studies have shown that the individual's responses to competing institutional logics manifests in a wide range of ways even if they are situated within the same institutional context (Creed et al., 2010, Binder, 2007, Meyer and Hammerschmid, 2006). This is because the individual's response to complexity of logics is driven by their level of devotion to the different competing logics involved which in turn influences the inability to take distance,to resist or to attempt to alter it (Panche and Santos, 2013).The level of devotion is likely to shape the level of commitment to the logics (Greenwood and Hinings, 1996) and form the way they respond to institutional complexity (Panche and Santos, 2013). This helps us better understand the professions in this study, and that they are first and foremost individuals and will respond to problems and complexities in their own way influenced by commitment and involvement in the given situation.

### 3.2.9 Institutions in this study

Several authors suggest that healthcare presents an institution where multiple logics exist (van den Broek et al., 2014, Reay and Hinings, 2009) making it an institutionally complex field. For example, Reay and Hinings (2009) shed light on how within the Canadian healthcare system both professional and business-like logic coexists. There is an expectation that healthcare staff act in accordance with professional logics that emphasises quality of care while managers are more concerned with a more business-like logic with focus on effectiveness (Reuf and Scott, 1998).

The development over recent years for museums to become more inclusive and accessible places has led to changes that have also developed a set of complex and competing logic within the museums too (McCall and Gray, 2013, Sandell, 2003). However, already in the 1920's logics were in conflict as described by Alexander (1996) in a study of American

museums where external funders expressed demands of accessible exhibitions which were in conflict with the curators who favoured erudite exhibitions for specialists leading to tension.

Institutional logics offer an analytical tool to examine the interplay between the professions and the institutions involved in arts and health collaborations. Examining the logics that are at play in the present study will support an understanding of the logics that are presented by professionals in interdisciplinary arts and health projects. In this way, it becomes possible to understand some of the logics that professionals carry with them and apply in their communication and practice when working in interdisciplinary ways which will enable an exploration of the broader context. Specific sorts of logics apply to healthcare professionals and the NHS while other sets of logics are embedded in museums and employed by museum educators.

## 3.3 Summary of chapter

In this chapter, I provided a comprehensive account of the theoretical underpinnings of the study. I introduced the concept of 'interdisciplinarity' and how it has not previously been critically considered in the context of the arts and health field. Professions and their post-modern context were also considered alongside the professions associated with this study. The institutions involved in this study were introduced as a healthcare institution and museums with different operational logics. I also introduced theory of professions, a Foucauldian perspective on institutions and institutional logics which provides the theoretical underpinnings for the study. Drawing on Abbott's (1988) theoretical considerations about professions helps us to understand the function of professions and their jurisdiction while a Foucauldian perspective on institutions provides a lens for transparency, and the sociological theories of institutional logics allow for the examination and exploration of the logics at play

in this study and this is the main focus. These theoretical underpinnings provide a platform to unpick the layers of complexity in the interdisciplinary work of arts and health practices.

Having introduced the underpinning theories in the study, I consider the methods of gathering data and the instrument of analysis followed by the findings in both Denmark and the UK in the next chapter.

# CHAPTER FOUR: Methodology

## 4.1 Introduction

In order to gain an insight and understanding of this specific intersection of arts and health, I considered that a qualitative approach would be best suited for the study as it would allow interaction with the participants in a way that could draw out their experiences. In this chapter, I present my position and the methodology considering the choices I have made along the way and I acknowledge that a limitation of this study is the scale of the JOAP project and the scale of the visits to museums in Denmark. The study does not make claims that are beyond the scope of the findings from the projects involved. Furthermore, this study remains limited by my interpretation of my area of focus.

## 4.2 My position

I come to the study with particular beliefs about what knowledge is, what is knowable and how I would go about gaining knowledge. This is also referred to as a position, defined as the "basic belief system or worldview that guides the investigator" (Guba and Lincoln, 1994: 105). While working implicitly from a position the task is to have a critical understanding of making choices and communicating my worldview from this position. I position myself within the interpretivist paradigm and attempt to make sense of the data in terms of the meanings that the participants bring with them. Their personal experiences describe the routines, problematics and the meanings in their lives that, in turn, help to explore a human or social problem. The findings of the study emerge through the dialogue with the participants and the knowledge from the interviews with the participants becomes the foundation on which this study is built: seeking to examine the concept of professions and institutional logics in the interdisciplinary work of arts and health practices.

In the same way that the participants shape their own position generated from one of the multiple truths and logics conceivable in arts and health practices, I, as the researcher,also have my own lived experiences, which is a position from which I cannot wholly depart. All 'truths' are constructed by humans and situated within the historical moment and social context, although multiple meanings may exist within the same data (Ritchie et al., 2013). I have arrived at this study with certain beliefs and notions of what matters, which can be said for the participants as well. The different approaches will invariably represent the positions of the various participants as they relate back to their lived experiences and represent their 'abstract knowledge' (Abbott, 1988). The service user participants will have another approach to the understanding and their experiences, and thereby hold yet another position.
The notion of 'truth' is discussed by Foucault (1980: 131), who suggests 'truth' to be understood as a system of ordered procedures for the purpose of systems:

> *…each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true.*

This study approaches the 'truth' from an interpretivist perspective, whereby the 'truth' can be constructed from a variety of positions and will be based on different assumptions, values and

beliefs just as the notion of the 'truth' that is embedded in different societies, institutions, professions, individuals is based on a set of discourses that have been accepted as 'truth'.

As such, the philosophical underpinnings of qualitative research are associated with the characteristics of interpretivism. A qualitative approach offers subjective ways of understanding and valuing the knowledge and experience from the individuals involved in the study (health professionals, museum educators, service users) as well as my own experience and subjectivity. A definition of interpretivist beliefs is offered by Orlikowski and Baroudi (1991: 15), who state that:

> *…interpretive studies assume that people create and associate their own subjective and inter-subjective meanings as they interact with the world around them. Interpretive researchers thus attempt to understand phenomena through accessing the meanings participants assign to them.*

Qualitative methodologies are concerned with discovery; they are inductively oriented and the process offers validity and interest in a profound understanding of the research contexts (Ulin et al., 2005). Interpretivists argue that humans construct their own social realities in relation to one another. Therefore, one's encounters with reality are subjective and experiential. According to constructivist thinking, like that of Foucault, the world is independent of human minds; however, the knowledge of the world is always human and socially constructed or co-constructed (Crotty, 1998). Interpretive researchers place emphasis on an understanding of the world through frank reporting and conversation from participants' perceptions and experiences (Merriam, 1988). Interpretivists use data-gathering methods that are considerate of the context (Neuman, 2003) and which encourage participants to speak freely to permit comprehensive

and descriptive details of social phenomena. In this way, the interpretivist lens offers an approach that considers the various social constructions that are part of the arts and health professionals and service users' experience of participating in an art project and the process.

I chose a qualitative approach because little is known about the intersection between arts and health disciplines and the interdisciplinary working within arts and health, and so gaining understanding through subjective experiences from those involved is a good starting point. The intersection is represented by the interaction between the stakeholders, namely the museum educators, the healthcare professionals and the service users. I apply the theory of professions (Abbott, 1988), Foucault's thinking on institutions (1975) and institutional logics (Thornton et al., 2012, Lounsbury and Boxenbaum, 2013) when considering the intersection which I discuss in chapter four.

### 4.2.1 The nature of a qualitative approach

There is no single way of carrying out qualitative research in social science (Ritchie et al., 2013). Qualitative approaches can be difficult to clearly define, as there is neither a theory nor a paradigm that specifically belongs to qualitative research. Qualitative research also lacks a distinct set of methods and practice (Denzin and Lincoln, 2011). However, in spite of varied and, at times, the differing nature of basic assumptions about its essential qualities, a number of authors have endeavoured to define qualitative research (see Denzin and Lincoln (2011), Flick (2009), Holloway and Wheeler (2010), Silverman (2004)). Often qualitative research is described as a naturalistic interpretive approach involving the exploration of phenomena (Flick, 2009) and how to obtain an understanding of social behaviour by studying individual subjective accounts of social lives (Avis, 2005). Qualitative research can, according to Denzin and Lincoln (2011: 3), be described as a "set of interpretive, material practices making the world visible". These practices have the ability to transform and expose features of the world

through “a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to self […]” (Denzin and Lincoln, 2011: 3). Researchers using qualitative methods explore things in “their natural setting, attempting to make sense of interpreted phenomena” by way of the meaning people give to them (Denzin and Lincoln, 2011: 3).

Qualitative research is often associated with a certain form of data, usually involving words and/or imaging as opposed to numbers (Ritchie et al., 2013). The direct approach by the qualitative researcher manifests itself in the volume and richness of the data, as well as what the researcher brings to the analysis and interpretation of data. In this way, qualitative research is often distinguished because it generates a hypothesis from the data analysis instead of the hypothesis being stated at the onset (Silverman, 2013), unlike quantitative methods that start with a hypothesis. This is what raises questions about the supposed ‘objectivity’ that so-called scientific knowledge requires, because qualitative research rests upon the participants’ and researchers’ own subjectivity (de Gialdino, 2009).

Issues of how the social world can be studied include philosophical questions and, in broad, general terms, the two overarching ontological positions in social science are realism and idealism (Ritchie et al., 2013). In this way, the nature of the world and what there is to know about it is defined by the lens which is used. Realism offers the position that an external reality exists independently of an individual’s belief or understanding of it (Blaikie, 2007). This position holds that a distinction can be made between the ways the world is and how interpretation and meaning of that world is maintained by others. On the other hand, idealism offers a position that reality is essentially mind-dependent and only understandable through socially constructed meanings and the human mind (Hughes and Sharrock, 1997). In other words, we cannot know the external reality independently from our understandings and beliefs.

Adopting a qualitative approach to view the world of arts and health practice and the findings, the study accepts a position that the social world is different from the natural world in the way that it is open to subjective interpretation and that social study cannot be governed absolutely by laws, because individuals have agency and therefore make choices about their ways of being (Giddens, 1984, Hughes and Sharrock, 1997). Based on the assumption that there are no fixed regulations that govern arts and health practices, this study holds an interpretivist position and rejects the idea that the social world is determined by a set of social laws. Moving the focus away from quantitative approaches, post-structuralism's attention to qualitative approaches, offers new ways of way of viewing the social world.

### 4.2.2 The rise of post-structuralism

In response to the critique of some of the philosophical assumptions underpinning social research in general, postmodern theory was influential. The emerging critique challenged the notion that scientific research methods were the singular source of knowledge. In this way, postmodern effects changed the way of understanding and interpreting social science research. Postmodernism refers to a collection of theories including post-structuralism associated with thinkers including Lacan, Derrida, Foucault and Kristeva, among others (Poster, 1988). The key principles in post-structuralism are that texts exist and are something to be interpreted; that researchers' bias exists and society and language are governing systems that shape perceptions, including those of the researcher, and so should be examined (Savin-Baden and Major, 2013). In this way, it applies structure to a subject that actively and simultaneously shapes and utilises discourse (Foucault, 1980), tracing knowledge to the practice/discourse that frames knowledge articulated from within the discourses.

In postmodern theories of subjectivity, the notion of the self is in a place of disagreement and conflict with itself that is forever in process and formed within power relations. Subjectivity,

as defined by Weedon (1987: 32), is "the conscious and unconscious thought and emotions of the individual, her sense of herself and her way of understanding her relations to the world". However, this subjectivity is changeable; an individual's existence in the world shifts depending on social relations and historical experiences and, therefore, the sense of self may momentarily shift in response to specific relational demands. Thus, the self is always in flux and constantly shifting in response to specific conditions and situations. Therefore, notions of subjectivity capture the active process of a subject position in the process of becoming, rather than merely being, in the world (Jackson and Mazzei, 2011). This view of subjectivity will allow for the study to examine the health professionals, the museum educators and the service users' discourses from a perspective that allows and acknowledges discontinuity of the shifting forms.

While there is little agreement on the precise definition of postmodernism, perceptions from this approach are described as having suspicion and scepticism toward scientific endeavours to provide objective accounts of reality (Ritchie et al., 2013). Questioning an objective reality and beliefs about the world resulted in a postmodern claim that there are no set or predominant meanings, "because all meanings are a product of time and place" (Ritchie et al., 2013: 15). Not being able to depict the social world or provide authoritative accounts of findings created, according to Denzin and Lincoln (2011), a crisis among social researchers, as they were not able to capture fixed meanings. Progression from the so-called blurred genres between 1970 and 1986; and moving away from positivist and behavioural approaches to social sciences, towards more pluralistic interpretative open-ended perspectives, this so-called representational crisis developed during the mid-1980s. This representational crisis addressed the degree to which it was possible to capture lived experience and centered on the issues of reliability, validity and generalisation, and it raised questions about how qualitative research can be assessed (Denzin and Lincoln, 2011).

Having considered my position and the qualitative paradigm as my chosen methodology, I introduce the design of the pilot study that I conducted in Denmark to explore the meaning of arts engagement for mental health service users.

## 4.3 Introduction to methods

I begin by presenting a model illustrating the sequence of the entire data collection. The participants were recruited in Denmark and in the UK in order to provide a study that reflects different approaches to arts and health practice and possible lessons to be learnt. The data collection took place in various locations and participants were from different backgrounds, as illustrated in the model and described below:

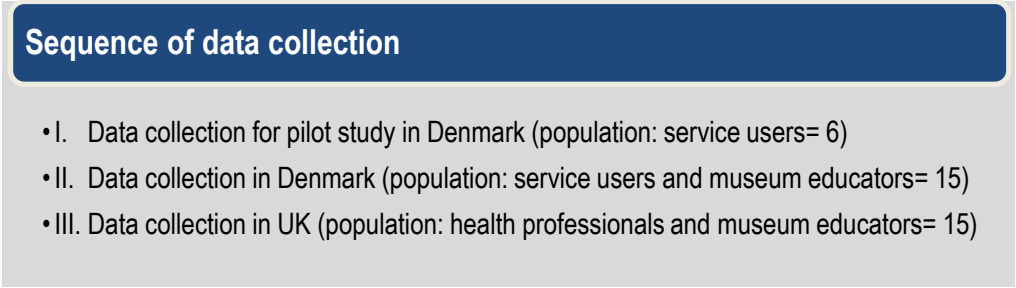



Illustration 1

## 4.4 Introduction to pilot study

The choice of using a qualitative research design was based on the rationale that the pilot study was conducted in order to understand and explore the meaning of arts engagement for mental health service users which included a visit to a museum. Making sense of the world based on socially constructed knowledge-claims lead to a qualitative research approach and in the qualitative paradigm there are various methods for conducting interviews and collecting data. After some reflections I became satisfied that semi-structured interviews with participants was the right tool for exploring the participants' experiences and using a

framework analysis with a thematic approach (Ritchie et al., 2013) would satisfy the study and answer the research question. This was partly because it emphasises patterns within the data, enabling a description of a phenomenon associated with my research question, but also because a thematic analysis allows the expansion of meaning beyond the individuals' experiences (Guest et al., 2013).

### 4.4.1 Ethics for the pilot study

The pilot study was approved by the Research Ethics Committee, Faculty of Medicine and Health Science at the University of Nottingham (as this PhD study is registered at the University of Nottingham). The study was conducted according to the rules and regulations of the HKI and national guidelines and appropriate ethical and regulatory permissions were respected. HKI's guidelines of working with vulnerable adults were followed and the participants had access to support workers throughout the study. When I confirmed the visit at the booking office at the National Gallery, I made the staff aware that the group included people who use mental health services and that this study was with the consent of the participants; however, no other background information was given to the staff at the National Gallery.

### 4.4.2 Participants

Given that, my PhD-project was a collaboration Hans Knudsen Instituttet[11], my focus on participating service users was de facto the people who used the facilities at HKI. The recruitment of participants took place at the art workshop, attended by people with mental

[11] Hans Knudsen Instituttet (HKI) is a social economic organisation working with people who have been long-term unemployed, provides 'sheltered' employment opportunities for people with mental health problems and other disabilities, as well as vocational courses for young people. http://www.hki.dk/forside/

health problems at HKI where I displayed posters with information about the project and verbally informed the service users about the research. Six people volunteered to take part in the pilot study and the participants ranged in age from 30 to 55 years old: two were male and four were female. Ethnicity and marital status were not identified. The inclusion criteria were: people who use mental health services, who attend arts activities at HKI and who also attended an arts workshop at the museum. There were no exclusion criteria, as the pilot study did not require a specific number, age or gender for participation. The participants had all attended the art workshop at HKI for a period of between three and eight years.

### 4.4.3 Programme for the pilot study

The visit to the National Gallery was arranged by me (as the researcher) and financed by HKI. My role in the visit was to organise the travel to and from HKI, support the participants if required, and observe the sessions and later to conduct the interviews with the service users.

The theme of the workshop at the National Gallery was 'identity and portraits'. The itinerary consisted of two parts: firstly, a one-hour session in the gallery, introducing different art works exploring the theme; and secondly, a one-hour session in the workshop. The introductory gallery session entailed a talk by the museum educator, who spoke about selected art works related to the topic of identity. The workshop session took place in the workshop area of the museum, where the participants were invited to explore the theme by making their own portrait (by painting or sculpting); this was facilitated by the same museum educator. The aim of the workshop was to explore and understand different ways of representation.

### 4.4.4 Data collection

I conducted six one-to-one semi-structured interviews to elicit in-depth personal experiences of the service users, and the interviews were recorded and varied in length. All interviews

were conducted within a week of the visit to Statens Museum for Kunst (the National Gallery). The interview questions were designed to explore the experiences of mental health service users engaging in arts and cultural activities, with a focus on their individual well-being. The interviews took place at HKI and were audio-recorded and conducted in Danish. I then transcribed the interviews and translated them into English. Written consent was obtained at the beginning of each interview. Once transcribed, I gave all the participants printed copies of the respective transcriptions and the opportunity to make comments to ensure they were happy with the data. All transcripts were approved by the participants. All participants were informed that their identity would be kept anonymous and that they could withdraw at any stage should they wish to do so.

### 4.4.5 Instrument for analysis of data

I used a framework analysis with a thematic approach (Ritchie et al., 2013). Framework analysis is a method for analysing qualitative research data and was developed by the National Centre for Qualitative Research. After transcribing the interviews and translating them from Danish to English, the transcripts were read again and emerging themes were identified. The process of data analysis using the framework model consists of using subthemes or topics, then transferring the indexed data from the transcripts to the appropriate subtheme, resulting in a set of data in an analytic structure grounded in the participants' own accounts. The framework method facilitates systematic analysis and it relies on the creative and conceptual ability of the analyst/researcher to make sense of the meaning, salience and connections by sifting, charting and sorting material (Ritchie and Spencer, 1994). I analysed and contextualised the findings within the broader socio-political literature and in the context of healthcare and the arts. The proposed themes were presented to my supervisors together with

the raw data. After some amendments to language and grouping, a final version was agreed, which resulted in the data being sorted into broad categories under themes.

### 4.4.6 Reflexivity

Conducting the pilot study provided important learning for me. Establishing good relationships with the participants prior to the interviews was key. I allocated time to spend in the art workshop and, as well as informing the participants about the project, I ensured that I was present and interactive seeking to create a relationship and some level of trust between myself and the participants. Furthermore, it was important to involve all the staff at the HKI art workshop and keep them updated with the progress of the study, in order to promote inclusivity and enable staff to answer questions about the study as part of creating a safe environment for the participants.

During the interviews, it became evident that eliciting answers proved challenging and, although the participants had access to the questions prior to the interviews, it was probably the first time they had had to articulate their thoughts and feelings about their personal experiences of participating in arts activities. It is likely that some participants were medicated, which might explain why some interviews were challenging, as the participants were either very unresponsive or went off track and gave information outside the scope of the study. The phrasing of the questions may also have created a challenge for the service users, making me (the researcher) more alert to the importance of the wording of the questions. Another reason may be a lack of language to explain the connection between engaging in art and their own sense of wellbeing; it is possible the participants had never reflected upon that before or, indeed, been interviewed about it. It became important to bear in mind that some healthcare contexts prove challenging to work in, with potential barriers for communication (Taylor, 2005).

Transcribing the interviews and translating from Danish to English provided an insight to the data, as every word was reconsidered. It also provided time to rediscover the transcripts and reflect upon the participants' personal experiences and meaning. The interviews unexpectedly revealed strong feelings from some participants regarding cuts to creative resources in the Danish mental health hospitals. The findings show that service users have experienced a significant reduction in access to creative activities while hospitalised, and they felt that this had a negative impact on their health needs and their recovery process. The findings also identified questions including: what are some of the assumed structures and systems perceived by mental health service users, and how do cultural institutions identify the training needs of their staff? Furthermore, the findings confirmed my assumption about arts activities being beneficial for the participating mental health service users and raised questions about a common language between service users and museum staff. Conducting the pilot study influenced my thinking about the various roles and relationships between the professions and the service users in arts and health practices. I became more focused on what constitutes a 'good' experience for service users, what makes a 'bad' experience, and to what extent and how can the professions and the institutions involved influence the experience? I seek to explore some of these issues through the questions posed to the participants in the following larger study.

## 4.5 Introduction to main study in Denmark

Following the pilot study, I conducted further qualitative interviews in Denmark as part of the main study which was informed by the findings from the pilot study. In this section, I illustrate the method that I used for this part of the study. The section considers the method of data collection in Denmark followed by ethical issues and approval, recruitment of participants, data collection, instruments for analysis and the role of the analyst.

### 4.5.1 Methods of collecting data in Denmark

This stage of the data collection involved four museums and museum educators in Denmark from Nationalmuseet (the National Museum), Statens Museum for Kunst (the National Gallery), Arken and Davids samling (David's Collection), as well as service users from HKI in Copenhagen (the main business focus of HKI is described in chapter three). Here the focus on the service users from HKI was a natural choice given my position as a collaborator with the organisation.

I have chosen a semi-structured interview approach that will be used to elicit information and allow the participants time and scope to talk about their particular experiences. The approach also remains open to new ideas that might be brought up during the interview. This method of data collection explores the different subjective ways that respondents understand what they do and the context in which they do it (Yates, 2004). Such an approach seeks to understand and value the knowledge and experience from the perspective of the individuals involved, which in the context of this study is the health professionals, museum educators and service users. The strengths of semi-structured interviews include developing trusting and empathetic relationships with participants (Gomm, 2008) and a flexible and fluid structure. The majority of qualitative research interviews are semi- or lightly structured (Leicester and Lovell, 1997). Issues concerning the authenticity of the responses have been raised by Gomm (2004), who refers to demand characteristics as moments when a respondent's answer is influenced by what it is assumed the situation requires. The interviewer effect is discussed by Denscombe (2007), who explores how people respond differently depending on perception. Further critique of semi-structured interviews identified limitations that include not always allowing an opportunity for the responder to offer his/her own unique perspective (Savin-Baden and Major, 2012). Although this is likely, it depends upon the skills of the interviewer. Acknowledging that these are characteristics of interviews, the approach has sought to be reflexive in order to address the preconceptions or distortions that I have unwittingly

introduced in my interviews.

This method of research also requires good listening skills, which are essential for the researcher to develop (Rubin and Rubin, 1995). The pilot study helped me develop skills as an interviewer and it also improved my observation skills while interviewing. I became more alert to changes in the participants and, if they appeared uncomfortable, I adjusted my interviewing style accordingly.

### 4.5.2 Ethical considerations and approval

The study was approved by the Research Ethics Committee, Faculty of Medicine and Health Science at the University of Nottingham. It was conducted according to the rules and regulations of Hans Knudsen Instituttet in Copenhagen, and national guidelines and appropriate ethical and regulatory permissions were respected. HKI's guidelines of working with vulnerable adults were followed and the participants had access to support workers throughout the study. The booking offices at the four museums were made aware that the group included people who use mental health services and this was undertaken with the consent of the participants; no other specific background or information was given. When I made the various bookings I subsequently invited the respective museum educators to contact me if further information was required.

### 4.5.3 Participants in Denmark

Throughout the pilot study I gained experience in recruiting service users at HKI, and having already built relationships of trust with some of the service users, this proved to be beneficial for this stage of the study, as some of the service users were keen to participate again in this larger-scale study. The recruitment this part of the study spanned two departments at HKI : *i)* the sheltered art workshop, and *ii)* the special vocational education for young people between

18-24 years old (STU – særlig tilrettelagt ungdomsuddannelse)[12]. The recruitment from the sheltered art workshop was conducted by me and the arts facilitator. After introducing the study to the prospective participants, I provided them with an information sheet about the study and gave ample opportunity for them to ask questions. Initially, nine service users from the sheltered workshop volunteered to participate in the study.

The second part of the recruitment was from the special organised education unit for young people, where the recruitment process was conducted slightly differently. I held an information meeting with the teachers from this unit and provided detailed information of the study, as they were to disseminate this information to the students. Once the potential participants were identified (through their teachers), an information meeting was held for the service users, allowing for further questions about the study and providing additional information. It was an opportunity for me to meet the potential participants and vice versa. Written information was also provided for the participants, that included their role in the study and how the information would be collected, stored and analysed. An additional five participants volunteered. Prior to the first trip, the participants had read, completed and signed the consent forms. The total number of participants for the study was seven from the sheltered workshop and four from the special vocational course, totalling eleven service users from HKI with various mental health problems. The inclusion criteria for this part of the study was: ability to give informed consent; attendance at the art workshop at HKI (sheltered employment); being a student at HKI (special vocational course) and being between the age of 18 to 65 years old.

This part of the study also included the museum educators that facilitated the visits at the museums, and the recruitment of those took place following the visits to the four museums. I contacted the four respective museum educators, informing them about the research and

[12] A vocational course designed for disabled young people and other young people who for physical or psychological reasons are not able to complete a mainstream education course.

asking for their participation in an interview. All four museum educators volunteered as participants and were included in the study. I conducted the interviews at various locations in Copenhagen convenient to them; the length of the interviews varied. They were all female and had worked in their roles at the respective museums for between two and twelve years. They all had multiple functions at the museums, including administration tasks, practical workshop facilitation and educator/guide roles, and were from different educational backgrounds including history, teaching and creative studies. Below is an illustration showing the numbers of participants from the Danish part of the study:




Illustration 2

### 4.5.4 Participant withdrawal

Two people from the sheltered workshop withdrew. One participant did not attend at the meeting point for the first visit and another left the project on the first day due to personal issues. The remaining seven participated in the visits to the four museums, although not all participants were able to make each of the four museum visits.

From the vocational course, one participant withdrew from the study after one trip due to personal reasons and the four remaining participants continued for the rest of the study.

### 4.5.5 Data collection in Denmark

I selected four museums in and around Copenhagen with an educational department offering guided tours and within reasonable travelling distance from HKI. Due to practical reasons including the use of public transport, time limitation and consideration for physical and mental health needs, the choice of museums was limited. Nevertheless, the museums offered a variety of collections that I gauged would interest the service users.

The significance of the guided tours was that it guaranteed interaction between the museum educators and the service users. The arts facilitator at HKI played a significant role in reminding the participants of the visits and meeting times and keeping the momentum going. The visits were scheduled on four consecutive Friday afternoons. Although not the ideal time for an activity, this was the only available time for all the participants due to their existing schedules. Apart from the eleven participants, two members of (support) staff and myself participated in the visits. Some of the participants arrived at the museums by themselves, while others travelled with me as part of a group leaving from and returning to HKI.

A theme was offered at each museum including: *The role of the mask; The body in art; Identity and community,* and *Portraits in Islamic and European art.* The themes were chosen based on my knowledge of the participants and what I thought might interest them within the limited themes offered by the museums. The museum visits included a guided tour exploring the given theme for approximately one hour, followed by a practical workshop (where it was possible), also lasting approximately one hour.

The participants from the sheltered art workshop were interviewed at HKI in a private room and I conducted individual interviews with the participants from the special education department in situ. All interviews were conducted in Danish (see appendix VI for interview schedule). The interviews created a possibility for sensitive issues to arise for discussion. However, there were no intention to pressurise the participants to talk about issues or reveal

information about themselves that they preferred to keep private, and the support workers/teachers were aware that the interviews had taken place and remained alert to changes in behaviour. Additional staff at HKI (social workers, the arts facilitator and psychologists) were available on site at the time of the interviews and were able to offer support if needed. However, there were no issues during or following the interviews that required further support. I conducted eleven semi-structured interviews with the participants. The interviews varied in length, with an average duration of 28 minutes; they were digitally recorded and were conducted within a period of two weeks following the last museum visit.

Initially, I was satisfied that I would gain insight into the relationship between the service users and the museum staff by interviewing the service users, and that I would gain the required information from museum staff at the second stage on my data collection in the UK. However, after conducting the interviews with the service users, I understood the value in also adding the voice of the museum educators from Denmark. This was partly because no such study had ever been made in Denmark, and partly that I assumed that I would find a gap between the understanding from the services users' perspective and that of the museum educators which I wanted to explore. The semi-structured interviews with the four museum educators took place after the application for an extension of the area of study was approved by the Research Ethics Committee, Faculty of Medicine and Health Science at the University of Nottingham.

### 4.5.6 Instrument for analysis

The method of thematic analysis that I used for the pilot study was developed at the National Centre for Social Research (NatCen) by Ritchie el al. (2004). It seemed appropriate in the context, as I was looking for ways to understand the individuals' experiences. A thematic approach allows for categories to emerge from the data (Saldaña, 2009), provides the opportunity to develop the study from individual experiences (Guest et al., 2013), and permits

for social and conceptual interpretation of the data (Braun and Clarke, 2006). Some critique of thematic analysis is that nuanced data might be missed (Guest et al., 2013) and flexibility can make it difficult to focus on what part of the data to concentrate upon (Braun and Clark, 2006).

After conducting the pilot study, I became interested in investigating other ways of analysing the data, as I considered that the NatCen approach lacked a detailed description of method and wanted to explore a discourse analysis approach. Not that a discourse analysis approach would offer more structure; however, a Foucauldian discourse analysis, in particular, offers a methodological approach which Foucault referred to as 'gadgets', encouraging researchers to use these as a 'thinking tool', altering to suit the purpose of individual projects (Foucault, 1980). Using a Foucauldian discourse analysis approach seemed appropriate to explore the issues central to this study and I considered the strengths of discourse analysis, including emphasis on the equal status between participants and research and giving voice to the participants (Burr, 1995). I then considered some weaknesses, including the difficulty of application for practical purposes and that a discourse analysis could culminating in negative realism (Raskin, 2001) as well as its difficulty to grasp as it lacks prescription to use as a method (Lettinga, 2002). I finally decided against using a Foucauldian discourse analysis as I wanted to produce a piece of work with an outcome that could potentially have some level of practical application, which is difficult through a discourse analysis.

I became inspired by Braun and Clark's (2006) approach to thematic analysis, which provides a detailed account of the analysis method. I considered further the strengths of a thematic approach, which is explorative and context driven and I ultimately decided to use this approach. The strengths of the structure of the Braun and Clark (2006: 8) method complemented the epistemological framework of the study as it seeks to:

> *… be a method which both works to reflect reality and to unpick and unravel the surface of 'reality'. However, it is important that the theoretical*

> *position of a thematic analysis is made clear as this is all too often left unspoken (and is then typically a realist account). Any theoretical framework carries with it a number of assumptions about the nature of data, what they present, in terms of 'the world', 'reality' and so forth. A good thematic analysis will make this transparent.*

The Braun and Clark (2006) framework for analysis complements my chosen epistemological theoretical framework, as using a thematic analysis allows for a theoretical freedom and can therefore be applied across a range of theoretical approaches. It examines the way events, realities, experiences and meanings of participants are the effect of the discourses operating in society. The study will regard experience and meaning as social production and reproduction, rather than something that resides within individuals (Burr, 1995). Thematic analysis seeks to theorise the structural conditions and socio-cultural frame rather than the individuals' motivation.

The uniqueness of a thematic approach is the acknowledgment that analysis happens intuitively, that through the process of data immersion and reflecting on "connection and interconnections between codes, concepts and themes that 'Aha' moments happen" (Savin-Baden and Major, 2013: 440). Braun and Clark (2006:4) argue that "thematic analysis should be a method in its own right" and they present a six-phase guide for doing a thematic analysis. Braun and Clark (2006) claim that although thematic analysis is widely used, there is no clear agreement about what a thematic analysis is, or how to do it, and the a six-phase guide for conducting a thematic analysis can be a helpful tool. I illustrate below the steps I took as an analyst, creating transparency about the process and demonstrating rigour in the analysis process.

The six-phases as provided by Braun and Clark (2006: 32) are as follows: 1. Familiarisation

with the data; 2. Generating initial codes; 3. Searching for themes; 4. Reviewing themes; 5. Defining and naming themes; 6. Producing the report. The process of becoming familiar with the data, identified as phase one occurred fairly naturally, as I collected all the data myself and transcribed the majority of it. The data collected in Denmark was also subjected to translation into English, which I completed. After the final check of the data against the audio recording I was satisfied that the transcriptions and recordings were aligned and when I was familiar with the data I moved onto the second phase of the process. The coding of the data has been described as "a systematic way in which to condense extensive data sets into smaller analysable units through the creation of categories and concepts derived from the data" (Lockyer, 2004: 137).

I selected data and labeled it with descriptive codes, in order to keep track and remind myself of the context the data was taken from. I also created lists of ideas for themes. This raw data was transferred into the third phase of the process entailing the search for themes. Much social sciences research is based on discovering themes in the data. Without thematic units, researchers do not have anything to describe, compare or explain, and being explicit about how themes are established allows access to the methodological choices (Ryan and Bernard, 2003). However, defining what constitutes a theme is complex. Establishing three principles in thematic analysis, Opler (1945) observed: *i)* themes are only visible through appearance of manifestation in data; *ii)* some expressions themes are "obvious and culturally agreed on, while others are subtler, symbolic and even idiosyncratic" (Ryan and Bernard, 2003); *iii)* cultural systems include sets of interrelated themes. The significance of any theme relates to how often it appears, how pervasive it is through different cultural practices and ideas, the reaction of people when the theme is disrupted and to what extent the force and diversity of the theme's expression is controlled by particular contexts (Opler, 1945). In this third phase, I dedicated much time to searching for common statements, opinions and comments from the participants, resulting in themes emerging. I created mind maps and changed the descriptive

codes into overarching themes, in order to make a collection of contending themes and subthemes.

Phase four requires reviewing the themes against the coded extracts, as well as the entire data set, creating a thematic map. This part allows for an opportunity to validate the codes. Reliability is important as it indicates the same things are measured. A robust intercoder agreement suggests that the concept is not based on the researcher's imagination and adds to the probability that a theme is valid (Sandelowski, 1995). In phase four, I reviewed and refined the themes in order to validate the codes. This part of the process showed that some of the contending themes did not have enough data to support them and others merged with each other. At this point in the process I began to further consider the theoretical considerations in relation to the themes that had emerged. Although the theoretical significance of consideration had had weight during the process of analysis, it was at this point that I took active steps to consider how the theory would work with the findings. While it was possible to continue the process of fine-tuning and developing more nuanced coding frames, I decided to stop, recognising that the frames were already robust as a narrative of my themes, and subthemes had emerged.

In phase five I focused on the ongoing analysis to polish the details of each theme and the complete story told from the analysis by generating well-defined definitions and names for all the themes. Defining and refining is, according to Braun and Clark (2006), a way of identifying the essence of each theme and not paraphrasing the content of the data by identifying why it is significant. In this part of the process, I selected the themes that I wanted to include in the study, continuing to rework and redefine the chosen themes. I also selected some of the quotes that I wanted to use to illustrate the findings.

The final phase, phase six, presented an opportunity for a final analysis by considering the section of extracts and relating back to the study questions and literature in order to produce a

write-up. In the final part, I developed the discussion from the findings. Throughout the writing journey, researchers should remain mindful of rigour and quality to produce valid reports of high standards with credibility (Holloway and Wheeler, 2002). Writing up findings has both political and ethical implications, as it has the potential to affect lives (Schostak, 2002). Throughout the entire analysis process, I worked in consultation with my supervisors, in order to ensure rigour and continuously question my ability to remain impartial in my role as a researcher and an analyst.

### 4.5.7 Role of the analyst

The role of the analyst is to work with what is "said or written, exploring patterns in and across the statements and identifying social consequences of different discursive representations of reality" (Jørgensen and Phillips, 2006: 21). There are many common sense and taken-for-granted statements expressed in the study, which is precisely why it becomes difficult, as it is the common sense understandings that are being investigated. Therefore, I endeavored to keep a distance between myself and the material by attempting an anthropological approach in trying to make sense of a foreign territory. In other words, I attempted an emic approach (being an insider because of my background in the field) by letting the data speak to me and setting aside my assumptions. Although my methodological approach was inductive, the role of the analyst did create some tension between the emic and etic (outsider) approach. I allowed for the themes to emerge which are strengths of the etic approach; however, in the analysis I also drew on previous ideas, perspectives and developments of comparisons across contexts, which is a strength of an etic approach (Morris et al., 1999).

Having considered the methods of data gathering and approach to analysis, I present the

findings from the UK.

## 4.6 Methods for data gathering in the UK

This part of the data collection took place at South London and Maudsley NHS Trust (SLaM) in the UK, where health professionals and museum educators from the JOAP project were participants. The JOAP project at SLaM was of interest to me, as it was developed from within the hospital, raising the assumption that the hospital had an understanding that arts activities could benefit service users. Although SLaM has a long tradition of working with the arts on the mental health wards, the JOAP project presents a unique approach, which enables the service users to leave the wards and participate in visits to museums. In the arts and health field it is more common for cultural institutions to initiate projects than hospitals and in-patients rarely leave the hospital to visit a cultural institution. Therefore, the JOAP project presented a structure that is not only about the service users' engagement with the arts, but also specifically about the collaboration between the health professionals and the museum educators.

South London and Maudsley NHS Foundation Trust provides the widest range of NHS mental health services in the UK. The three-year JOAP was initiated and funded by SLaM NHS Foundation Trust in 2013 working with the acute ward for older adults (aged 65+) with a diagnosis of dementia or other ongoing mental health problems. The hospital wards involved in the project support patients through recovery and rehabilitation.

The overall aim of the Journey of Appreciation Programme is to provide service users with opportunities to experience museum workshops and to create new interests and experiences to expand their quality of life. Furthermore, the project aims to improve the therapeutic relationship on the wards and in the Community Mental Health Teams (CMHTs) and bring

good practice from the Art into Life Project[13] at the Tate Modern, and experiences from other museums and galleries, into the service to energise the environment and change the culture.

I chose not to make the patients/service users part of my study in the UK to keep the focus on the relationship between the museum educators and the health professionals, in order to answer the part of my research question that has to do with the health professionals and museum educators and I covered the service users' perspectives in the first stage of my data collections from Denmark (as well as in the pilot project).

### 4.6.1 Ethics

Prior to the second stage of the data collection in the UK, I obtained ethical approval from the University of Nottingham's Medical School Ethics Committee, CAG (Clinical Academic Group) and R&D (Research and Development) approval from South London & Maudsley NHS Trust. I provided all the participants with an information sheet about me, the aim of the study, the name and contact details of my supervisor, and the ethical approval of the study. The participants were encouraged to seek further clarification from my supervisors and from me. The participants were informed that they may choose to withdraw from the study at any time, without stating any reason, and that a potential withdrawal from the study would not have any negative implications for their professional role and legal rights (ESRC, 2015, Silverman, 2004).

[13] Art into Life is a free introductory workshop for community groups at Tate Modern which is led by experienced staff. The programme is not only particularly suitable for community groups new to gallery visits, but also to groups from a wide range of backgrounds. The more regular visitors include groups in further education, elders' organisations, mental health service user groups and community centres. Each session is tailor-made to include all interests and abilities. It might involve looking, talking, simple practical activities and the use of handling objects. http://www.tate.org.uk/visit/tate-modern/group-visits/art-into-life-workshops.

Permission to record all the interviews involved in the study was sought prior to the interviews. Privacy and anonymity of all participants and the collected data was ensured. Fictitious names were used for the participants all the way from the analysis process to writing up the findings (ESRC, 2015). The data collected was secured in password protected computers and locked cabinets provided by the school to Ph.D. students; only my supervisors and I retained access to the data. All research data was secured according to the School of Nursing, Midwifery and Physiotherapy data archiving policy after the completion of the study.

All participants had the opportunity to read and comment on the transcripts from the interviews and all participants approved of these.

### 4.6.2 Participants in the UK

The recruitment of participants for this part of the study took place in two stages. To support the recruitment of health staff, the coordinator at SLaM introduced me, via email, to the relevant health staff and I continued the communication in order to schedule interviews with them. The health staff who were considered relevant were whose who had participated in the JOAP project.

The second step of this stage of recruiting participants involved interviewing the museum educators from the participating museums. I contacted the staff involved from Tate Britain, Tate Modern, the Horniman Museum, Dulwich Picture Gallery and the Cinema Museum via email, providing information about the study and an invitation to participate. They were already aware of my study, as they had previously been informed by the project coordinator at SLaM. Below is an illustration of all the UK participants' professional backgrounds.




Illustration 3

### 4.6.3 Data collection in the UK

In the UK part of the study my interest was in the interdisciplinary JOAP project. The JOAP project is a multi-partnership project delivered by SLaM with Dulwich Picture Gallery, the Horniman Museum, Tate Modern, the Cinema Museum and Tate Britain. The programme aims to engage in-patients/service users and healthcare staff in museum and gallery visits, with follow-up creative workshops. This interdisciplinary partnership created a frame for a study into the relationship between the health professionals and the museum educators. The inclusion criteria for the study was: museum staff who had worked in the JOAP; health staff who had worked on the JOAP; aged between 18 to 65; and participants who were able to give informed consent.

Again, I applied a qualitative approach with semi-structured interviews and the interviews were conducted in English (see appendix VI for interview schedule). The one-to-one interviews with the health professionals and the museum educators were digitally recorded and varied in length. The interview questions were designed to elicit personal experiences of

health professionals and art professionals working on an interdisciplinary project. All interviews were conducted between February and March 2015.

The first part of the data collection at SLaM involved interviews with health professionals that had participated in the JOAP. The participants were interviewed in a private room in various locations within the hospital and all interviews were recorded (one interview was conducted by Skype). The interviews varied in length, lasting an average of 44 minutes. The second part of the data collection involved interviews with museum educators from the participating museums. The interviews were semi-structured; two were conducted in a one-to-one setting and four on Skype.

## 4.7 Summary of chapter

In this chapter, I stated my position within the interpretivist paradigm and how the dialogue with participants is an important consideration within the data collection. I acknowledged that, I as the researcher, have lived-experience which I take with me in my researcher role, and that the notion of 'truth' is constructed by humans, and therefore each society has its own regime of 'truth'; therefore 'truth' can be seen from various perspectives. The chapter considered the nature of a qualitative approach emphasising that we cannot know an external reality separate from our understandings and beliefs. Qualitative methodologies are concerned with discovery and encounters with realities that are subjective and this study adapts an approach, that offers a lens considering various social constructs that may be part of arts and health collaborations and as in post-structural theories of subjectivity, the notion of self is forever in disagreement with itself and in flux. It is through such understandings that the study is conducted.

The chapter presents the methods applied for the pilot study conducted in Denmark, including; ethic approval, recruitment of participants, the design, the data analysis, findings and reflexivity. In this chapter, I illustrated the methods applied in data gathering as well as the

different stages in Denmark and in the UK. The analysis of the data was explained step by step in the framework provided by Braun and Clark (2006) and the role of the analyst has been discussed.

Having gathered empirical data in Denmark, my focus moved to the UK, where arts and health over the past two decades has emerged and is now embedded in many healthcare settings. I wanted to understand more about the UK's interdisciplinary approach to arts and health. For this purpose, I collected data at SLaM that work in collaboration with museums to create arts experiences and activities for service users from mental health wards.

In the following chapter, I present the findings from the pilot study, the main study form Denmark and the study from the UK.

# CHAPTER FIVE: Findings

## 5.1 Introduction

In this chapter, I start by a brief presentation of the findings from the pilot study followed by the findings from the main study in Denmark and the chapter concludes with the findings from the UK.

## 5.2 Presentation of the pilot project

The presentation of the findings for the pilot project are briefly presented in this section partly because of the small scale of the study indicating a larger study is needed and partly because more details of the study can be found in the article *The perspectives of people who use mental health services engaging with arts and cultural activities* (Jensen et al., 2016). The following are examples from the three themes that emerged from the data; *views on arts and culture for wellbeing, visit to the museum* and *the creative process.*

In the theme *views on arts and culture for wellbeing* one service user commented on how drawing helped him get through the day by making connections and a summary:

> *It connects the day ...by summing up what's happened that day and if there is certain things that has made a deep impression on me then I painted it in some funny way. Lasse SUDK*

The theme v*isit to the museum* revealed a variety of comments and some were more negative than others were. One service user commented on how she felt spoken to like a child:

> *I think it was very unfortunate with her* [the facilitator at the museum] *... there was nothing happening ... so right from the beginning because she is used to small children ... and she treated us like little children. Laila SUDK*

In the theme *the creative process* one service user commented on how engaging in the arts enabled a space away from negative thought and the ability to be in the present:

> *When I'm creative everything goes away. The only thing in my head is what I am doing right now. Lene SUDK*

The findings concur with findings of other studies, that engaging in arts activities is beneficial for people with mental health problems (Stickley, 2011, Spandler et al., 2008, Secker et al., 2007). The participants reported it as being therapeutic, enabling a sense of calmness and escape. The findings also suggest that if museums were offering creative activity to people who use mental health services they should equip staff with training designed to support appropriate ways of working.

As an observer, I could see why some participants thought that they were spoken to as children. I observed that the choice of language when communicating with the service users suggested that was she used to working with children which her body language also suggested, by bending down and leaning into the conversation. Some of the service users later commented on similar observations. I also noted that the tour around the gallery could have been shorter, as the participants started to lose focus approximately half way through and that the participants could have benefited from having chairs to sit on during the tour. Several participants also have physical health problems that prevent them from standing up for long periods of time. When I asked the museum educator whether museum staff received training to

work with vulnerable groups, she was of the understanding that this was unnecessary, as artists (she was an artist as well as a museum educator) had ‘a good understanding of people and therefore had an implicit ability to deal with diverse groups of people’.

One recommendation borne out of the pilot study was to conduct a larger-scale study to better understand and explore the relationships between the service users and the museum staff. This recommendation led to the next step of the study, conducting a study with a larger group of participants and additional museums being involved. The findings from this part of the study are presented below.

## 5.3 Introduction of findings from Denmark

Below is a table of the data set which illustrates the participants’ codings, the country and whether the participant is a service user or museum educator. Pseudonyms have been introduced to protect confidentiality.

| Participant code | Country | Service user or staff |
|---|---|---|
| Rikke SUDK | DK | Service user |
| Jan SUDK | DK | Service user |
| Karsten SUDK | DK | Service user |
| Thomas SUDK | DK | Service user |
| Lotte SUDK | DK | Service user |
| Lasse SUDK | DK | Service user |
| Lillian SUDK | DK | Service user |
| Katrine SUDK | DK | Service user |
| Jens SUDK | DK | Service user |
| Henriette SUDK | DK | Service user |
| Mads SUDK | DK | Service user |
| Jannie MUDK | DK | Staff: Museum educator |
| Matilde MUDK | DK | Staff: Museum educator |
| Tilde MUDK | DK | Staff: Museum educator |
| Charlotte MUDK | DK | Staff: Museum educator |

Illustration 4

In the data analysis, two overarching themes emerged from the data, reflecting the participants' experiences of engaging in the arts activities. The two themes emerging from the findings were: *disconnecting dialogues between service users and museum educators; and self-experts in arts and health* and involved service users and museums educators as participants. I present the findings theme by theme and by sub-themes as appropriate. In presenting the findings, I use illustrative quotes from the participants to demonstrate similarities and differences.

***Table 1: Themes and sub-themes***

| *Theme* | *Definition* | *Sub-themes* |
|---|---|---|
| Disconnecting dialogues between service users and museum educators/DK | Interaction between service users and museum professionals at visits to museums | - 'We are not third graders'<br>- Awkward interaction<br>- Lack of training |
| Being self-experts in arts and health/DK | Service users' connections to arts and cultural engagement | - The role of arts/culture<br>- 'I think of something else when I draw' |

## 5.4 Presentation of findings from Denmark

In this section, I present the findings from the interviews in Denmark. The questions asked during the interviews for this stage can be found in appendix VI. The data illustrates comments and statements from service users from HKI who participated in the visits to the museums, as well as museum educators from the four participating museums, namely Nationalmuseet (the National Museum), Statens Museum for Kunst (the National Gallery), Arken and Davids samling (David's Collection).

The first overarching theme is *disconnecting dialogues between service users and museum educators*, describing aspects of the communication between the service users and the museum educators from the perspective of the service users and the museum educators. The second overarching theme, which is *being self-experts in arts and health, illustrates* how the service users relate to arts and cultural engagement.

## 5.5 Theme one: Disconnecting dialogues between service users and museum educators

This theme, *disconnecting dialogues between service users and museum educators,* emerged in the data from participants offering comments on the interaction with the museum educators and vice versa. Some services users had strong feelings about the interaction with museum staff in Denmark, although three of them did not have any negative comments about the visits to the museums. The less positive experiences are brought into focus, as they were significant in demonstrating some of the challenges in developing the field of arts and health, as well as presenting a contrast to the UK equivalents, who were more prepared and trained. The findings are presented in the following subthemes: '*we are not third graders', awkward interaction* and *skills are needed.*

### 5.5.1 'We are not third graders'

When asked about the interaction with the museum educators, five of the service users reported finding the approach of the museum educators to be inadequate and they commented on the lack of understanding of museum staff in how to deal with adults with mental health problems:

> *Some of them* [educators] *were at a level where you thought they were dealing with fifth grade ... but I can understand if they mostly deal with schools.* Lotte SUDK

Although unhappy with being approached like a child, Lotte recognised that there might have been an underlying reason for that.

> *We should not be involved with the layman who does not know [...] and people who talk to us as children. It puts pressure on us.* Lillian SUDK

Criticism of the approach from Lillian who is suggest that the lack of skills adds an unnecessary weight on the service users.

> *Well, they talked to us as if we were children, in particular at the National Gallery.* Jens SUDK

The comments illustrate that being spoken to as a child was an experience that was shared among several service users and had negative connotations.

The rhetorical approach from the museum educators in Denmark suggest that they were used to working with schools and had little experience of dealing with groups that were not from traditional educational institutions. The museum educators commented on the lack of training opportunities within the museum setting and that their primary experience came from working with school children:

> *I believe that the artists who are here – we use ourselves a lot. And it* [the way of interacting] *is the natural approach we have. But of course it would always be good with training. I often get younger and very young children.* Tilde MUDK

Tilde suggests that being an artist gives insights that allows a natural interaction with visitors as well as she welcomes training opportunities.

> *I work with children with special needs. So I think that there is currently little knowledge about how you can optimise a museum visit for them [...] I have not had that many adults who have different needs.* Charlotte MUDK

Charlotte, who works with children, suggests that there is a need for knowledge about working with children with special needs in museums and she is not familiar with working with vulnerable adults.

> *We have never been on any courses. We do want to but there is no money because none of us are full time employees.* Tilde MUDK

Tilde comments that the lack of training opportunities is a financial issue and due to the employment terms.

> *For example, there is a course, it is the school service offering courses, such as dialogue-based teaching. And I have heard good things about it and have suggested it at work, but so far nothing has happened.* Jannie MUDK

Jannie's comment on training opportunities suggest that she has been proactive in her professional development by proposing a specific course, but it had not been acted upon by the museum.

The school teacher approach from the museum educators was also noted by another service user, Katrine, who commented on being addressed and treated as children in the museum:

> *Yes, they should know that…we are not third graders.* Katrine SUDK

Being approached in a similar way to a school child was perceived as negative by the service users and created unconstructive feelings among some service users, which reinforced a negative self-image and cultural assumptions.

### 5.5.2 Awkward interaction

Throughout the interviews there was an apparent dissatisfaction from some services users, as they related to the way the museum educators approached the group. A service user commented on experiencing a reversal of the learning roles and that the visits had become more about the museum educators learning how to deal with people with mental health problems. From the service user's perspective, instead of having an educational experience, she questioned who was teaching whom:

> *It is not us who should teach the museum staff how to deal with people with mental health problems, they should teach us about the paintings instead.* Lillian SUDK

Lillian suggested that the roles were reversed and that the services users provided learning opportunities for the museum staff.

Another service user commented on the lack of understanding about mental health issues, not only by the museum educators but by society in general:

> *They did not realise that we hear voices, most of us who were there … and what it means to be hearing voices. That is generally how it is in society that there are few who know what it is like to hear voices. So… I do not think that people know what it is about, in general.* Jens SUDK

Jens' comments suggest that he is conscious of the general lack of awareness of what is like for a person to be hearing voices.

Some of the service users expressed other frustrations about how they experienced the interaction with the museum educators. They felt that they were treated in a discriminatory manner with an assumption about their intelligence. The service users commented on the approach used by the museum educators being significantly unlike the approach that they might have used with other groups:

> *If, for example, we had just been a regular study group, then it would have been different, but now we are people with mental health diagnoses and it would immediately be assumed that we were stupid, unintelligent and needing things to be spelled out for us.* Lillian SUDK

Lillian implies that she and the other service users were treated differently due to their diagnoses and that there were cultural assumptions about the intellectual abilities of people with mental health difficulties.

> *Sometimes there are other ways of explaining which is not dumbing down […] Sometimes I got annoyed. But how are you supposed to communicate.... having mental health problems does not mean that you are unintelligent ... but they* [museum educators] *do, of course, not have the general knowledge as art historians… and they would probably also speak differently if it was people from the Academy of Arts than if it was us. I think it was okay but they* [museum educators] *could have contributed with a little more knowledge.* Lotte SUDK

Lotte also felt that she was discriminated against because of her mental health problems and implied that a different group of visitors would have been treated with a different approach.

Lotte was particularly alert to the way in which communication was conducted and felt that the approach to the group was limited to a level which was not stimulating or inspiring. Having come to the museum expecting to learn and gain knowledge, the level of dialogue was in some instances disappointing and upsetting:

> *Sometimes I got a little angry at the educators because I think they talk down to me, right? So when you see an angry mask and the question is, what does the mask look like? Well ... yes, we are not that medicated.* Lotte SUDK

Lotte suggests that the dumbing-down approach made her feel angry and patronised.

The interaction between the museum educators and service users made one service user feel overlooked, which resulted in negative feelings, while another questioned the equality of the setting:

> *Yes. Yes, they* [the museum educators] *were a little too snobby for me….Too snobbish….Well, they did not really notice me…. I think it was forgetfulness. Yes, I felt a bit forgotten. I did not feel good about it. I find it difficult to make myself noticed, right?* Henriette SUDK.

Henriette recognises that she has difficulties in making contact and getting noticed, but did nevertheless feel overlooked.

> *It might impact that we come from a place like this, where people are already struggling, and that might make them feel that they are more worthy than us. I do not know.* Jens SUDK

Jens associates being a mental health service user with life struggles and wonders if belonging to this group means that others presume that they have more value.

Some service users also remarked on the way the sessions at the museums were structured and the way in which knowledge was passed on. Service users commented on how the professional approach lacked a personal touch, which would have enabled a better learning experience:

> *They* [the museum educators] *came with a lot of professional factual information as they stood and read from a piece of paper, but did not have their own words and did not think of something that people remember instead of all that professionalism they have found.* Lotte SUDK

Lotte suggests disappointment in the way that the session was delivered and suggest that she would have preferred a more personalised approach that would helped her remember.

> *She* [the museum educator] *did so through a template. She could have varied it a little, but it's also hard when the theme is portraits.* Lasse SUDK.

According to Lasse, the session was delivered through a template approach and he thought that variety would have been useful.

> *It was also the way it was facilitated, she spoke about each piece of work for about 15 minutes, which killed the pictures. I think that you should be able to view art and get something out of it without an explanation […] She* [museum educator] *over-explained the work that is the three things we are allowed to see. And then we were shoved into the workshop. I thought that was nonsense.* Lillian SUDK

Lillian's comment implies a dissatisfaction with structure and delivery of the session and indicates that the methods of delivery may not have been appropriate for the group.

Service users identified that the various museum educators applied different methods and approaches to facilitating the sessions, and the service users identified preferences for this interaction and commented on how other interactions were less good:

> *I liked the one* [museum educator] *from the David's Collection best. She explained more. The other asked too many questions. I thought that was annoying. She didn't explain much, mostly just asked questions. Just like that. Rikke SUDK*

Rikke suggests a personal preference for not having to answer questions.

> *I think the last two times they* [museum educators] *were good. I think the first ... she ... annoyed me a little. Not in a negative way, but because she was constantly demanding ... that we should give our input.* Karsten SUDK

Also Karsten implies that being asked too many questions felt challenging.

> *It was just the same wording as it was in high school, that is what I felt but I cannot remember. I just thought that it was the same story that they* [museum educators] *delivered 20-30 years ago.* Lasse SUDK

Lasse suggests that he had heard it all before and implies that approaches to museum education have not changed that much in the past 20-30 years.

The learning at the museums presented a varied experience for the services users and some commented on how the museum educators could have geared the sessions more towards their needs, considering their mental health as well as their intellectual needs. Such an awkward interaction resulted in having unintended negative effects for some service users.

### 5.5.3 Lack of training

When asked about training opportunities, the museum educators stated that they would like more training in order to deliver sessions to specific groups. At the same time they also felt that they had the required skills to conduct their job. The museum educators commented on how they were just 'thrown into' the work, with little time to develop skills and were given few training opportunities. However, simultaneously one museum educator also commented on believing that practical experience had equipped her with the ability to deal with any group of visitors, Charlotte explains the training received at the museum:

> *Very little. Yes, I have received a little* [training]; *I would say I was thrown right into it. When I joined...I was allowed to be a 'colt' as they say. So I followed an experienced guide once and then it was my turn.* Charlotte SUDK

> *Um ... It was a very short period of time that I was allowed to observe. Twice I think or maybe three times. Um ... But otherwise it was pretty much just throwing myself into it. And it was nerve-wracking at first. But, uh, I do not know ... I think ... that the groups are very different then, so it makes a difference being allowed to just teach the groups. Um ... So yes, I was thrown into it, but it's fine now. Now I feel that I have the capacity to receive any group, in principle.* Jannie MUDK

Jannie recalls that it was nerve-wracking just being thrown into it but suggests that her practical experience equipped her to work with groups from diverse backgrounds.

One museum educator noted that working with blind people, in the context of the Year of Disability in 2003, had helped develop skills for facilitating disabled people:

> *I have lots of experience with it because in the year of disability in 2003 I got a lot of work at the museum… I facilitated blind people making plaster.* Tilde MUDK

Tilde implies that working with blind people in the past contributed to her ability to work with people with mental health problems.

It was recognised by one museum educator that facilitating groups in a museum required various skills, including those beyond their own subject-knowledge; knowledge and understanding how to interact with different groups of people was also mentioned as a requirement by the museum educator. She is aware that facilitating groups in museums requires communication skills that reach a wide audience and to be able to utilise various skills in given circumstances:

> *It requires many skills. It does not just … art history and knowledge; it requires that you are an especially good communicator. But also that you have a broad experience with many different people because our group of people ... we teach the children from first grade to high school and then we also have adults. So it requires a wide range of communication skills, I would say. You have to be ... you must have a good overview and you must learn to speak in a special way too.* Charlotte MUDK

> *The most important is that the group and I have a good time together. Because it provides a very good contact and gives a warm atmosphere that you are actually ... specially invited to be at the museum. So it is very important that adults can open up.* Tilde MUDK

Tilde recognises the importance of having a good time with the groups and recognises that good personal contact can enable a safe environment and that creating a positive environment is part of the skills required.

Taking comfort in having worked as a teacher enables the museum educator to work in a certain formalised way, which she sees as beneficial to the performance of her job at the museum.

> *I'm glad that I have the personal experience that I have. I have also been working as a teacher, so I'm really happy with my personal experience because when you are facing these groups or an ordinary class and you do not know how to deal with it, I take comfort in knowing I know what to do according to the book.* Matilde MUDK

The museum educators recognise their lack of training and knowledge about individuals with mental health problems and dealing with marginalised groups. However, at the same time they commented on feeling equipped to deal with any group, which creates a paradox in terms of the professional logics that they work from.

Having presented the findings from the first theme, I present the findings from the second theme which includes service users' experiences of engaging in arts activities.

## 5.6 Theme two: Being self-experts in arts engagement

The theme, *being self-experts in arts engagement*, emerged from the data as the service users described their connection to arts and cultural engagement. The service users expressed having access to arts and cultural activity as something positive and described it as being central to their lives, with therapeutic gains. They demonstrated a robust comprehension of how this helped and supported them through their daily lives. In this way, they became self-experts and were able to find tools that supported their wellbeing. Below I present the findings under the subthemes: *the role of arts/culture*, and *'I think of something else when I draw'*.

### 5.6.1 The role of arts/culture

When asked about visiting a museum, it was commented on as being inspirational, useful and positive as part of a recovery for mental health service users. The service users found museums to be places where they found stimulation and a place for learning, relaxation and wellbeing:

> *Museums are very important ... important for people from the hospital who have been through crises, for inspiration… if they spent their time on creativity, then museum and galleries are a good idea … It makes my life better… I gained inspiration from the visits.* Lotte SUDK

Lotte sees museums as places for both visual learning, stimulation of new ideas for her own artwork and as a source to gain new knowledge.

> *You can learn something from it. At museums, one can learn and understand… looking at the drawings, the pictures, the body language, the painting and statues.* Jan SUDK

> *It's very inspiring. It always makes me want to go home and do something. It gives me ideas and experiences. I like that.* Lillian SUDK

Also Jan and Lillian comment about the museum as being places for acquiring new learning and understanding.

> *I generally get stressed quickly. So this is relaxing just to walk around and look at things ... For example, in museums that we have been to…you could walk around have a look and stay in your own world and think a little about the displays. And try to get some inspiration.* Karsten SUDK.

Karsten explains how he uses museums for relaxation and how wandering around the museum creates an inner space of calmness.

> *Visiting a gallery .... well, seeing things in a new perspective and things like that ... It opens my eyes for different perspectives in life or something. Something you would not have got elsewhere. It improves my wellbeing being there, yes. It really does.* Jens SUDK.

Jens suggests that for him visiting a museum can create a new life perspective and it improves his sense of wellbeing.

When discussing the role of arts engagement, Lasse described how making a drawing every day was essential in order to connect his thoughts. Making a drawing and being able to place it in a drawer created a release and helped improve through derailment, which had a negative impact on him. It was described as being a positive and essential part of everyday life and the 'diary drawings' were seen as a self-helping tool:

> *Now I am very receptive to information, which I am partly excluded from but also inflicted upon […] so it is a bit difficult and laborious. Associations are imposed on me… That's why I draw so much, to get the associations away…. they are placed in the drawers and then we say that it is the end of that…That's why I make diary drawings […]* Lasse SUDK

When asked about the significance of 'doing art' several service users described engagement in arts activities as a form of play and something that they associated with a child-like way of being:

> *I think the closest you can compare it to is when you were a kid and you were playing. Yes, because within myself I call it playing. For it is a game and I think that it is one of the healthiest things we can do in life is to play.* Lillian SUDK
>
> *You enter another world ... It's a fairy tale world. New things happen ...and then you get somewhere else."* Rikke SUDK.

Rikke comments about being transported into a different world where new things are possible.

> *Yes, on the one hand, I thought I went back to childhood, right? On the other hand, it was self-development nevertheless, right. Yes. Yes. Like if you take a swing or something on a playground. Yes ... Yes, it is positive to play.* Henriette SUDK

Positive association are made between play and arts engagement and Henriette also makes a link to the aspect of self-development that is involved.

This association with play, childhood and fairytales created a feeling of reconnection with innocence, which the services users referred to as being positive. It is most likely a state of being that is difficult to access for individuals with mental health problems, which make arts engagement even more significant in terms of therapeutic values.

### 5.6.2 'I think of something else when I draw'

One service user expressed how her engagement with culture and arts activities had helped her to overcome suicidal thoughts and improved her issues of low self-esteem. Furthermore, it had also helped to create a feeling of worthiness:

> *Yeah, I would have committed suicide if I had not had it. I would have ... it gives me ... I feel that I am worth something that is what it gives me…* Lotte SUDK

Another service user, Karsten commented on the effect that participating in arts and cultural activities had had on his level of stress. It was described as an engagement that was useful for creating new positive thinking patterns:

> *I use it more for relaxation. Oh, as I said, it's… it's what I called a stress reliever […] For example, if you are just going through a period where there is not so much energy, then my thinking can very quick turn negative. Then I use it as a little diversion.* Karsten SUDK

Lasse also commented on how he used drawing to create a common thread through the day, which could otherwise be difficult to find:

> *It's a new thread. A new thread for free. It is sometimes difficult in everyday life to find the common thread.* Lasse SUDK.

Being able to think about something else when engaging in art and cultural activities was commented upon by a couple of the services users. Jan suggested that the engagement in arts creates a relational and focused space where he is able to enter a peaceful and worry-free space enabling an escape from negative thoughts and patterns:

> [Being] *relaxed, quite...and peaceful … and also focused… I think of something else when I draw.* Jan SUDK

> *I feel good. There are no worries, I'm completely lost in what I am making, it is great. That is how I feel when I play and they can call it art or crafts, I really do not care.* Lillian SUDK

The findings show that from the perspective of these respondents engaging in arts and cultural activities created a so-called 'therapeutic space' for the service users. The service users recognised the significant role that arts and cultural activities have in their lives.

The findings in Denmark present an insight to the experiences of services users visiting museums, their interaction with museum educators and the implications of institutional logics approach. The findings have highlighted some significant tensions in the interdisciplinary work between service users and museum educators that created unintended negative effects. The service users saw museums as places of relaxation and inspiration, and that can create a sense of wellbeing. Being involved in arts and cultural activities creates different positive experiences for the service users and they are experts in what such engagement can do for them.

The lack of experience of the museum educators in working with mental health service users was evident in the findings, as well as the museum educators' lack of training opportunities.

The findings from Denmark suggests that it was a problematic for both service users and museum educators to work together. While the service users' emphasis was on the interaction with the museum educators, the museum educators' focus was more in relation to the institution. Therefore, I moved to the UK to explore a more established field of practice in order to see how collaborations might work there.

In the next section, I present findings from the UK. These findings will provide a key to explore the relationship within the professions involved in the Journey of Appreciation Programme[14] (JOAP), which are health professionals and museum educators.

14 Journeys of Appreciation programme (JOAP) is a multi partnership project delivered by South London & Maudsley NHS Trust with Dulwich Picture Gallery, Horniman Museum, Tate Modern, Cinema Museum and Tate Britain; engaging in-patients/service users and healthcare staff in museum and gallery visits with follow-up creative workshops.

## 5.7 Findings from the UK

In this section, I present the findings from the UK. Below is a table of the data set which illustrates the participants' coding, the country and whether the participant is a museum educator or a health professional. Pseudonyms have been introduced to protect confidentiality.

***Data set of participants***

| Participant code | Country | Service user or staff |
|---|---|---|
| Lisa MUUK | UK | Staff: Museum educator |
| Renee MUUK | UK | Staff: Museum educator |
| Melissa MUUK | UK | Staff: Museum educator |
| Keira MUUK | UK | Staff: Museum educator |
| Roberta MUUK | UK | Staff: Museum educator |
| Rebecca MUUK | UK | Staff: Museum educator |
| Naomi HPUK | UK | Staff: Health manager |
| Holly HPUK | UK | Staff: Hospital arts manager |
| Heather HPUK | UK | Staff: Ward manager (nurse) |
| George HPUK | UK | Staff: Ward manager (nurse) |
| Fabia HPUK | UK | Staff: Care assistant |
| Charles HPUK | UK | Staff: Occupational therapist |
| Daniel HPUK | UK | Staff: Occupational therapist |
| Martin HPUK | UK | Staff: Nurse |
| Leah HPUK | UK | Staff: Occupational therapist |
| Scarlett HPUK | UK | Staff: Lead occupational therapist |

Illustration 5

In the data analysis, three overarching themes emerged from the data, reflecting the collaboration of the JOAP project. The three themes from the UK findings were: *a risky business for professionals in arts and health; competing logics in arts and health practice; and hierarchy of experts in arts and health collaborations*, which included health professionals and museum educators as participants.

I present the findings theme by theme and by sub-themes as appropriate. In presenting the findings, I use illustrative quotes from the participants to demonstrate similarities and differences.

***Table 2: Themes and sub-themes in the UK***

| Theme | Definition | Sub-themes |
|---|---|---|
| A risky business for professionals in arts and health/ UK | Professions dealing with uncertainties in an interdisciplinary arts and health setting | - Risk and safety<br>- A vulnerable business<br>- Taking healthy risks |
| Competing logics in arts and health practice/UK | Different perspectives found in professions and institutions involved in arts and health | - Assumptions and competing logics<br>- Connecting logics<br>- Towards interdisciplinary logics |
| Hierarchy of experts in arts and health collaborations/ UK | Health professionals and museum educators involved in an interdisciplinary arts and health setting | - Hierarchical barriers<br>- Sharing expertise<br>- The 'better' expert |

To understand how collaborations in arts and health could work in a context with a longer history and a more developed policy perspective, I looked to the UK, where a large number of partnerships in arts and health already exist. I was particularly interested in the JOAP project, which is a collaboration between SLaM and several museums in South London. The JOAP project, I believed, would provide an insight as to how the professions and institutions (the hospital and the museums) worked in an interdisciplinary collaboration.

As discussed earlier in the chapter, this study regards a profession through the lens of Abbot (1988), and a professional as someone who has an exclusive occupation and applies abstract knowledge to specific cases. The occupants within professions are professionals who conduct some sort of professionalism to uphold the standards, rules and regulations of their given professions. These occupants are seen as agents of institutional work (Lawrence and Suddaby, 2006).

In this study the majority of museum professionals (referred to as museum educators) had an educational function within the museum setting, whereas the health professionals had various professional functions ranging from senior management to nursing through to occupational therapy and so on. The settings discussed by the participants are mainly the museums settings (Tate Modern, Tate Britain, the Horniman Museum, the Cinema Museum and Dulwich Picture Gallery) where the arts activities took place; however, references to the hospital setting do also occur. The questions asked during the interviews for this stage of the study can be found in appendix VI.

## 5.8 Theme one: A risky business to work in arts and health

Below I present the findings that provide insights into the theme, *a risky business to work in arts and health*. This theme emerged from the comments from the participants when

describing various aspects of being involved in the JOAP project, including the nature of interdisciplinary working with service users, professional responsibilities, roles and developing their practice. The sub-themes in this section are: *Safety and risks; a vulnerable business;* and *taking healthy risks*.

### 5.8.1 Safety and risk

All participants were aware of their roles, which were distinctive and bound, and the aims of the JOAP project, as they had been briefed respectively at SLaM and at the museums. Notions of risk-taking were observed by a number of participants in this study and as the participants came from different professions they offered various ways of describing their thoughts and experiences of and about risk.

The health professionals are used to working within institutional health settings such as hospitals and other kinds of care facilities and, therefore, the museum institutional environment is likely to be an unfamiliar setting for them to work in. Invariably, when working in an unknown setting, levels of anxiety are increased. The nature of interdisciplinary collaboration with a non-health discipline was also unfamiliar for the health professionals, as they do not generally work with museum educators and vice versa. In this way, a group of professionals worked in an unknown environment with 'colleagues' from unfamiliar professions and disciplines and in different institutional settings.

While it is 'normal' and healthy to experience some degree of anxiety, it can also hinder the ability to develop and adapt to an environment and might become an obstacle to fully engage in a project (Borkovec et al., 1991). The JOAP project created numerous reasons for anxiety among the professionals. Museum educators might have some experience with service users with mental health problems, but they are not considered part of the core audience at museums. Furthermore, the nature of working in an interdisciplinary way may create

challenges and uncertainties for the professionals. They arrived from different disciplines with certain logics and assumptions with which they embarked on the journey into the unknown, while also exploring new grounds as in the JOAP project.

In the JOAP project, one of the senior healthcare professionals described aspects of the anxiety as being about taking service users out of wards and outside the hospital. This anxiety was based on a fear of the unknown and not being able to plan for unspecified circumstances, but the anxiety also had to do with the nature of the interdisciplinary working:

> *There was a bit of caution initially from some of the ward managers about those kinds of things. What happens if? What happens if? You can plan for everything and nothing, can't you really? I think we're reluctant to give control to the arts therapists or to just artists …So inviting a completely alien world in or engaging with it is quite unnerving. Quite unsettling. Quite risky.* Heather HPUK

The JOAP project involved health professionals in a context where they were challenged to give up some degree of control to other professionals, i.e. the museum educators. The health professionals had to work closely with the museum educators without any previous experience of working together and, in addition, the museum educators were in charge of leading the sessions at the museums. A health professional described it as creating feelings of discomfort and asked the question 'what happens if?' This question was clearly a concern for other health professionals as well. The health professional commented on the safety of the patients and risk assessments being an integral part of their responsibilities and therefore treated it as a priority above all else. The element of taking risk was mostly addressed and considered by the health professionals, who thought risk and safety issues in their work was at a different level

to that of the museum educators. The health professionals who were nurses commented on risk from the perspective of safety:

> *For me as a clinician, as a nurse and the manager responsible for the welfare of twenty patients, it was about safety… It was about risk assessment. It was taking the right patients. You mustn't forget we had twenty inpatients that were acutely unwell. The service we provide, people are admitted to our wards in crisis, challenging behavior, severe low mood, suicidal ideation, challenging behavior, mania, psychosis, all mental health problems in their acute phase… As a clinician, I guess that one of the priorities for everyone is safety… I guess you can argue that I was a little bit risk averse in the beginning. But that changed through my learning and development.* George HPUK

George draws attention to the health needs of the service users and that it is his primary job to ensure that they are safe.

> *Obviously we've got people who are at risk; possibly they come in here and people are suicidal. We have to make sure that they're well enough to go on the outing.* Daniel HPUK

Also Daniel was concerned about whether or not the service users were at risk.

> *Because mental health and its training is all about risk assessment, managed risk assessment. The safest way to manage risk is to totally control the environment and the individual.* Heather HPUK

Heather suggests that the safest way towards risk management is to take full control of both the service users and their environment.

The health professionals were aware that their training had contributed to the focus on risk assessments, as medical and care professions are subjected to legal codes of conduct and are at risk of being prosecuted for their actions or lack of them. However, as a result of being part of the JOAP project, a nurse commented on how his attitude towards risk and safety changed during the project as confidence grew. Learning and developing requires moving out of a comfort zone, which was observed by both the health professionals and the museum educators in this study. Comfort zones are safe and leaving requires giving up some level of control. It is likely that being used to taking control makes it difficult not to. As stated by one health professional when commenting on the service users' ability to participate in the JOAP project:

> *Actually, I don't think it is our decision to make, I think it is the patient's decision, but we're very good at making decisions on behalf of the patients. We are control freaks.*
> Heather HPUK

Heather sees health professionals as being concerned with control and willing to make decisions for patients without them being consulted on the matter. Issues of control are likely to be embedded within the institutional logics of the NHS.

### 5.8.2 A vulnerable business

Some of the museum educators questioned whether they had the professional skills and were equipped to perform the required job in terms of working with the service users involved in the

JOAP project. Although most of the participating museum educators had received some training in working with groups of service users with (mental) health needs, there were risks inherent in the project. Some museum educators recognised that they did not know all the needs of the services users: this group was unfamiliar to some of the museum educators as they come from a hospital ward in comparison to the other visitors of the museum:

> *I think when they come to the museum and some people have been on the ward for a long time it must be very overwhelming and it must make some people very anxious and they are often feeling fragile and have low energy…I don't know their individual needs at all...Yeah, I don't know the histories, obviously.* Roberta MUUK

Roberta is aware that the service users all have life stories that include health related issues that she does not know.

> *I've worked with other mental health adult groups but not necessarily older adults, and every participant in those groups really is very different and has quite different needs and it is so beneficial having a support staff with us for the group because they know those adults better than I would.* Rebecca MUUK

Rebecca acknowledges difficulties in working with particular groups and different participants and embraces the presence of the healthcare professionals.

> *Coming in contact with someone really quite vulnerable, he/she maybe say something upsetting or behave in a way that is upsetting – is something we are not used to.* Roberta MUUK

Rebecca suggests that museum educators are not used to working with people that are vulnerable.

The findings show that the museum educators embraced the vulnerability of the service users despite being faced with their own professional vulnerability of not fully feeling equipped to understand the needs of the service users.

The findings illustrate that risk is being discussed differently by the two groups of professions. While health professionals focus on risk assessment, museum professionals were discussing risk in terms of not knowing the needs of the individuals. Whilst there is always an element of anxiety associated with exploring art and creativity and entering the unknown, the museum educators also commented on the challenge of working with people using mental health services. A museum educator described rising to the challenge and the risk of professional exposures:

> *I have taught so many different sessions now. I think in general they were a very challenging group to work with. I would walk into a room and think: "this might be tricky" and sometimes it was. But I love it.* Renee MUUK

These reflections by Renee show that working with vulnerable services users has enabled learning that was seen as valuable and part of a shared learning context:

> *The fact that people were coming at a time of vulnerability when using in-patients mental health services, as well as after they have left the hospital. That was a really great aspect of shared learning for all of us.* Lisa MUUK

Lisa commented that the health professionals came with their own concerns about art and were therefore not that supportive, which created further challenges for the museum staff:

> *Because we felt that they came* [health staff] *in with their own anxieties about art. Actually that had not been addressed…weren't yet comfortable* [service users] *because actually the staff were coming in with as much anxiety as the service users… Actually that's quite a lot for us to handle when those members of staff have no arts experience because their level of support of the participants then is quite limited.* Melissa MUUK

Working within a context of vulnerable service users and with health professionals that are anxious about being in a museum setting created additional pressure on of the museum educators.

### 5.8.3 Taking healthy risks

When commenting on aspects of risk-taking, a health professional commented on how it was significant to be prepared and learn to take risks, which also included encouraging other health professionals to take risks:

> *I think it is about learning to trust, but equally probably from our perspective* [health] *how we prepared the JOAP* [project] *in regards to taking healthy risks.* Leah HPUK

When commenting on interdisciplinary work in the health sector and its need to develop, health professionals noted that it is necessary for the NHS to take risks in order to offer service users more holistic treatment by working in an interdisciplinary way:

> *I think more risk-taking, more willingness to take risks. I don't mean to make people feel unsafe but just to take risks about allowing different disciplines to work together; different people to interact with the service users.* Naomi HPUK

Naomi acknowledges that she has become more willing to take risks in the interdisciplinary setting.

> *It's taking risks to take people out. That's part of the recovery model. A calculated risk. We can be quite risk averse, we can and nothing will happen […] You need to take risks going forward.* George HPUK

George suggests that taking informed risks are necessary for the health service to move forward.

The comments illustrate the health professionals' recognition of the significance of risk-taking, 'interdisciplinarity' and development as being interwoven and essential for moving towards a different way of delivery of healthcare.

When commenting on the nature of collaboration with other disciplines, a museum educator noted the apprehension of health professionals during a risk assessment exercise at one of the museums:

> *I remember* [health] *staff being really quite concerned when they did a risk assessment, just in terms of bringing the group to the Tate Modern; in particular, they saw risks everywhere. They were just like 'Oh, I don't know if we can do this'. We got there and it felt like a real achievement, I think, and the staff then became more comfortable bringing the groups… they were less worried.* Rebecca MUUK

Rebecca suggests that through the interdisciplinary approach and experience, the healthcare professionals have become less anxious about risks at the museum.

Participants from both professions suggested that taking risks and moving out of comfort zones had helped them grow and develop in their respective professions. Furthermore, they commented on participating in the JOAP project as being personally beneficial:

> *I've really benefitted from it personally and professionally. I've seen a lot of places I haven't been to before myself and I've broadened my personal knowledge… I've developed personally and professionally.* Daniel HPUK

Daniel suggests that being involved in the JOAP project has enabled him to grow professionally and as a person.

> *A totally new dialogue. I think different understandings as well. A different understanding of the people they're working with. They see them as people who've lived lives, who've got experiences they could learn from.* Naomi HPUK

Naomi suggests that new dialogues and a better understanding of the service users were created as a result of participating in the JOAP project.

> *The staff and the service users were learning together. The sense of it was a mutually positive experience. There was quite a lot of intimacy between a service user and a staff on those visits… in a way that's uncommon… and above all service users and staff took value from that […] I was really struck by what a powerful experience it had been. I was also very struck on how they talked about staff, although I was struck with what staff described and what service users described was very similar.* Scarlett HPUK

Scarlett talks about the bond that was created between service users and health professionals and being surprised by the intimacy that followed.

> *I have benefitted a lot. For example, I've never been to Tate Modern before.* Fabia HPUK

Fabia acknowledges that she had never visited one of the museums before participating in the JOAP project.

> *It was also a privilege to work with careers and friends alongside each other. There was really great aspects of*

> *shared learning for all of us […] I have gained from the satisfaction that the knowledge didn't just sit with me, it's being cascaded*. Lisa MUUK

Lisa suggests that the learning from the project can be shared with the rest of the institution.

> *I was learning about their hospital environment and where they came from. And what was really nice was that nurses and support staff coming with the group and it was a new experience for them and they actually were on the same level as the patient*. Rebecca MUUK

Rebecca suggests that she learnt about the service users and the hospital and implies that participating in the JOAP project brought service users and health staff on an even level.

The health professionals and the museum professionals also commented on how the JOAP project had created a closer relationship between the staff and the services users. Comments were made about how relationships became more equal and that bonding took place between service user and health professionals:

> *It strengthened the bond between staff and patients and patients and patients. It's good for teamwork from the point of view of staff working with each other… For most of the patients it didn't end at the visits. They talked about it for a few days afterwards.* Daniel HPUK

Daniel acknowledges that the JOAP project was beneficial for the teamwork for the health professionals as well as for the service users.

> *Away from the ward. So we take off our name badge […], you are a member of the public. We're equal. I'm not carrying keys around with me, it's ... we're equals so people talk to you more openly as well*. George HPUK

George suggests that leaving the hospital created new frameworks that were more equal and opened up for new dialogues.

The comments show that the experience of working in an interdisciplinary way provided personal and professionals gains for the health professionals and had benefitted service users.

The findings show that by embracing the health risks, the health professionals, museum professionals and service users gained on various levels from participating in the JOAP projects. Participating in the JOAP project had enabled a closer and more equal relationship between service users and health professionals and museum educators in addition to learning about health issues.

Having presented the first theme, in the following section I present theme two, which illustrates some of the challenges in interdisciplinary working in arts and health, as described by the participants.

## 5. 9 Theme two: Competing logics in arts and health practice

One significant outcome of this study is the findings from this theme illustrated that the institutions and professions involved in the study are driven by logics that are created at the core of their respective institutions and they have various professional approaches. The study found that both the logics of the professions and the institutions were at times competing. The

sub-themes in this theme are: *assumptions and conflicting logics, connecting logics,* and *towards interdisciplinary logics.*

### 5.9.1 Assumptions and conflicting logics

Connecting arts with health or health with art initiatives was described by the participants as being positive, although connecting the disciplines created challenges at time, especially as the different disciplines are also embedded in different sectors. This challenge was acknowledged by a museum educator, who had experience of working with other sectors and interdisciplinary approaches:

> *In a way, you're always going to have the challenge of bridging two different disciplines.* Melissa MUUK.

Commenting on some of the barriers of working in collaboration, the participants made it clear that both professions had assumptions about the other. These assumptions related to certain differences between the methods and approaches of working in the hospital and those working at the museums. Some participants acknowledged that assumptions were present and identified those as a hurdle in the collaboration:

> *We went in with assumptions and the hospital went in with assumptions…being inflexible and making assumptions about each other I think got in the way a bit.* Melissa MUUK

Mellissa acknowledges that there were assumptions on both sides.

> *And maybe sort of an assumption that Tate has a lot of money and that we can deliver these programmes.* Lisa MUUK

Lisa suggests that some assumptions were about financial aspects of the JOAP project.

It was further noted that working as part of different systems and having different approaches was a condition of the working with other disciplines. Assumptions about the differences of disciplines and sectors were evident in most of the interviews.

A health professional commented on how the arts sector approached work compared to the health sector:

> *The arts are quite flexible and they're quite up for things, but you need the health* [sector] *and it's probably less flexible and has more constrictions.* Charles HPUK

Charles suggests that the different sectors had varying approaches and that the health sector is less flexible than the cultural sector.

Working with service users and how to approach potentially difficult situations did, in some instances, cause friction between the professions. A museum educator, who had previous experience of working with users of mental health services, expressed an opinion about the approach by health professionals:

> *SLaM were very keen things should be in a certain way because they knew the client base. But actually we know that client base from a different point of view.* Melissa MUUK

In this instance, the museum in question also worked with groups of people with mental health issues as part of their core programme and felt that they had gained specific knowledge which was not shared by the health professionals. Such colliding professional logics created tension and the museum dealt with the issue by offering training sessions to the hospital staff which was not taken up:

> *Maudsley* [SLaM] *would say that they didn't really need the training sessions… from our point of view; we felt they did.* Melissa MUUK

From the perspective of the health professionals involved in the situation, it was often minor issues that created tension within the collaboration. Nevertheless, the situation generated strong feelings for one health professional and presents how competing logics of approaches can create barriers for collaborations:

> *Silly things… like there was a concern about, I think, we wanted our service users to have refreshments when they got there, but they didn't want that to happen ... I remember hearing about the last visit and being quite, personally, quite irritated and quite annoyed with them.* Scarlett HPUK

Scarlett acknowledges that the disagreement with the museum affected her on a personal level.

A health professional commented that the museum educators could not have the same understanding of the service users as they lacked their background history. In this way, the

health professionals claimed to have a better understanding of the needs of the service users and therefore were able to act accordingly:

> *I think if the arts professionals knew their* [the service users'] *recent history or past history, which they didn't, but if they did, perhaps they would have viewed things differently… when we say something they need to listen.* George HPUK.

George claimed authority on 'abstract knowledge' about the service users and claimed the final word, and thereby the authority to make decisions about the service users.

### 5.9.2 Connecting logics

The professional logics carried by the participants also supported working together. They had a similar approach in terms of expectations towards the interdisciplinary collaboration. The comments about what signifies good collaboration between health and the arts were comparable. Learning from each other was mentioned repeatedly by the participants. Sharing professional knowledge was mentioned as being particularly beneficial for the participants. Numerous participants stated that learning new skills and gaining knowledge about (mental) health or arts was significant for the collaboration; however, this learning had also been important for giving confidence to develop new creative initiatives for the service users:

> *The training that we do is really good because the museums learn quite a lot from people… we're also learning much more about the needs of the people* [service users], *so it's a good way for us to kind of keep in touch with our community a little bit.* Roberta MUUK.

Rebecca suggests that the mental health awareness training had been beneficial and opened ways in which the museum could be more inclusive.

> *Mutual understanding and collaboration, just being honest with each other about what is working and what is not. I think that it is really important and the evaluation is also really crucial.* Charles HPUK

Charles indicates that being able to an honest dialogue about collaborations is important.

> *Most of the art that I've done here… all the art I've done here as an OT* [Occupational therapist] *has been two dimensional… what JOAP has taught me is to think more about art in three dimensions.* Daniel HPDK

Daniels suggests that he, as an OT, has been inspired to work with art in different ways by participating in the JOAP project.

Working within an institution was acknowledged as a barrier for the interdisciplinary work by some participants and that within systems you become blind to your own ways of practice. Although some barriers were evident in the collaboration and institutional logics created certain challenges, there was an overall agreement that the professions could contribute to each other's professional approaches. There was an overall recognition that the skills from both professions were essential for project delivery to be successful.

> *Especially if you are in a system, you sometimes don't see your own institutional ways anymore and then you just need a fresh look from an artist to just help you to break down those barriers in a very facilitative way. I think that's where the arts are so helpful in helping us to help our service users better.* Leah HPUK

Leah suggests a blindness towards one's own institutional logics and how that can be challenged by interdisciplinary collaborations.

> *The joint delivery is excellent because we know we are dealing with some people who have serious mental health challenges. I do not think that we would have been able to deliver with the confidence, humor and finesse that we did, if we constantly worried that we may have to take care of someone who suddenly became quite ill.* Keira MUUK

Keira acknowledges the need for a variety of professional skills that is needed in arts and health practice.

Honesty among the professionals was mentioned as one of most important contributing factors for success when working in an interdisciplinary way. Being honest in the JOAP also meant questioning the core activity of the project for one health professional, who voiced uncertainty about being involved in arts activities:

> *I think all of us, health professionals and arts professionals, were committed to making this work. What really struck me was the honesty…. I can remember really admiring a nurse who was very sceptical about the project because he was able to say what he was sceptical about… that we couldn't look after people properly and somebody might fall. He was sceptical that the contemporary art world was meaningless… wasting people's time.* Lisa MUUK

Lisa embraced the sceptical opinion of the health professional and recognised that working together required an openness to think as a team and appreciate what could be achieved together, although it was also challenging.

When asked how arts and health projects should be delivered, almost all participants commented on the need for a collaborative approach emphasising co-development:

> *Both parties need to be involved. There need to be a willingness from both sides to want to do something. For me it needs to be equally developed on both sides for that to work.* Leah HPUK

Leah suggests that joint delivery is important and that projects also needs to be co-created.

> *You need people who are committed to the same vision. […] If you've got that then there will be a future and also continuity.* George HPUK

In the collaborative approach, having the same vision and developing a project together was important, as commented on by George.

### 5.9.3 Towards interdisciplinary logics

For the museums it was also important to have made new connections. Making new connections and partnerships enables the museums to develop expertise in new target groups which, in turn, benefits the audience's development of the museum. A museum educator described the link with the hospital as encouraging and providing an insight into an area which the museum would like to build upon. The collaboration also provided a more general understanding of what is happening in the health sector which the museum educators could use in other contexts and support developing new institutional logics for the museums:

> *It has developed our links with the health sector really quite well… I think, really inspiring and interesting and professional health workers who have helped us learn more. We have learned more about what they want, but they have also given us good contacts and awareness of what is happening in health, mental health at the moment.* Roberta MUUK

A museum educator noted that there was much knowledge in the interdisciplinary team but also commented on the need for training opportunities in order to equip both professions with the skills to develop the work in arts and health:

> *I think what was lovely was that we had a team with so much knowledge. We had my team with the arts knowledge and our coordinator also has a social care background…then we have a team of people at SLaM who come with their health knowledge […] There could be more training on both sides. I think a big part of the future is empowering arts professionals to know about the client groups that they're working with and vice versa, preparing the health professionals to feel comfort in going to artistic settings.* Melissa MUUK

Melissa observed a need for the health professionals to be more comfortable in the art setting and suggested that it was not only the museum educators that needed to understand more about health issues, but also the health professionals that needed to be better prepared for visiting the museum environment. Through the interviews it became clear that some of the health professionals that participated in the JOAP had not visited a museum before.

Some of the benefits on a wider scale of connecting disciplines from the health sector with the art sector were described by participants as being ecological. Participants commented on how both professions needed each other and, in particular, how health professionals could benefit from the arts in their work with service users:

> *Healthcare needs art and I think arts have such a great contribution towards healthcare. It's just a natural connection. It´s almost like healthcare has got all the clinical skills, they have got all the expertise on mental health needs that service users have, but we need inspiration. We need something to inspire to support people, to support their recovery with. I think that is where art plays a big role.* Leah HPUK

Leah acknowledges the role that the arts can play in healthcare and especially in recovery.

> *I think that just means that the quality of arts and healthcare work that's happening at the moment has just gone up and up… it feels to me more like that what is happening now is that theirs is a good understanding of the two sectors and the strengths of each other and how we could work together.* Roberta MUUK

Roberta suggests that the arts adds to the quality of healthcare and that there is a good understanding of the strengths and benefits of cross-sectorial work between the art sector and the health sector.

> *I think the arts are quite willing. I think it's us letting go a bit more. I understand they* [the art sector] *derive a lot of positives from engaging in schemes with health and I think they have to do a certain quota of stuff. Everything to gain for our patients really.* Heather HPUK

Heather acknowledges that the collaboration was mutually beneficial for both sectors involved and essentially an advantage for the service users.

Throughout the interviews, hints of 'them' and 'us' were being expressed as being present in the JOAP project, which is the health professionals on one side and the museum educator on the other side. This is manifested in the different logics that each profession arrives with and contributes to the notion of competing logics. Professions and institutions are often bound by their self-understanding and a strong notion of identity, making another profession or institution 'the other'. It was commented on in terms of silo thinking:

> *I think interdisciplinary working is really exciting and that can really help cut across some of those silos because we are all alive and we all have health…but one has to make active efforts to combat the silos. Whether it is the culture sector or the health sector.* Lisa MUUK

Lisa recognised that silo thinking gets in the way of interdisciplinary work and the responsibility to combat such thinking lays in both sectors.

While logics were perceived from different perspectives within the professions and institutions, the participants also commented on the challenges of the hierarchical structures present in the JOAP project. The findings are presented in the section below.

## 5.10 Theme three: Hierarchy of experts in arts and health collaboration

The theme *hierarchy of experts* emerged from the data in relation to the participants referring to their professional knowledge, the lack of the other's knowledge, and commenting on creating interdisciplinary expertise as well as feeling disempowered. In this theme, the sub-themes are: *hierarchical barriers, sharing expertise* and *the 'better' expert.*

### 5.10.1 Hierarchical barriers

Hierarchical constitutions impacted upon the delivery of the JOAP project and the study found the concept of hierarchy was voiced in various ways by the participants. The healthcare professionals commented on the NHS as an institution with hierarchical logics and the participants in the JOAP project observed different aspects of power relations between the professionals working together at SLaM. The NHS is referred to as a hierarchical institution where everything has to be approved by senior professionals, leaving more junior staff with a feeling of little or no authority and it was mentioned as a barrier to the collaboration:

> *[…]it's incredibly hierarchical…One of my concerns is how dis-empowered a number of the more junior staff are. They* [junior staff] *can't make decisions unless everybody above*

> *them is agreeing … The hierarchicalism of the organisation [NHS] gets in the way.* Naomi HPUK

Naomi suggests that the structure of the NHS is an obstacle for collaborative work.

> *I think that we need to learn to be a bit more flexible. Do we have to have ward round every Tuesday if that's the best day for a visit? How do we negotiate those across the hierarchy? The consultant decides the ward rounds and the occupational therapist might decide the JOAP is more important. Whose time is more important? Actually, neither of them. It's the patient that's more important.* Heather HPUK

Heather suggests that the NHS ought to put the service users' needs before ridged internal institutional structures.

Top down approaches makes it difficult to plan at ground level and deliver a service that is centered on the service users' best interests, according to the comments for the ward manager.

A museum educator remarked that it was difficult to work with an organisation that has such a pronounced hierarchical structure, as it interfered with progress and project delivery. It was commented on as creating an imbalance of power in the JOAP project:

> *There is a huge size differential between the NHS and smaller partners organisations like ours. The size of the NHS throws up all sorts of problems like for example, the difference in hierarchy of decision making; nobody I was talking to was a decision maker. I would like to see more authority to be handed down to hospital staff so that when we have a meeting*

> *… that people coming to those meetings do have authority to enter into discussions and make decisions […] In terms of creating more effective partnerships, earlier engagement with the partners that they might be working with would be so helpful. The point is they* [the health sector] *have all the money; they've got the participants – so they have all the power. That's a huge imbalance in the relationship as well.* Keira MUUK

Keira suggests that institutional structures were a challenge in the JOAP project and it was a question of power.

Comments on relationships between the health professionals and the museum educators were made by a couple of the participants. A museum educator noted that there was a distinction between the approach of the senior museum educators and the senior health professionals in the contributions to the project. There was a direct reference to the medical model being accepted as the dominant model in healthcare:

> *It never occurred to the consultant to visit the gallery to take part in the workshop. Instead it was required that I delivered a presentation on the ward. Referring back to the model* [medical], *I see it is clear that arts professionals are not always seen as equals to doctors.* Lisa MUUK

Lisa suggests that the consultants are on the top of the hierarchy in the collaboration.

Another museum educator, who engaged in some follow-up work on the hospital wards, also commented on the lack of consultants' engagement in the JOAP project:

> *I wanted to work with everyone involved in the ward. So I worked with the receptionist and the care workers. I think I worked with everyone but the doctors, so I thought that was a great shame.* Renee MUUK

Renee implies that the doctors were not visible and out of reach in terms of getting directly involved in the JOAP project.

A museum educator commented on how some healthcare providers use arts organisations to deliver projects and compensate for services that do not have financial priority within the institution. The museum educator suggested that it creates an uneven balance in the partnership:

> *In our experience to date it seems that healthcare providers essentially need arts organisations to subsidise the healthcare providers work in the arts…*Keira MUUK

Kiera saw this development as negative, as it does not create a balanced relation between project partners. Similar observations were noted by another museum educator:

> *I do think that if it had been more of a round-table discussion from the beginning rather than enlisting museums to help with the project that the hospital had written. If they'd sat down with the museum from the beginning and said what do you think might work in your museum? Rather than saying 'this is the format you have to follow.* Melissa MUUK

This was further agreed by another museum educator, who noted:

> *There was a little bit of having to shoehorn our project delivery into the existing project.* Keira MUUK

Keira suggests that engagement with the museum should have happened earlier in the planning of the JOAP project.

The museum educators saw the project as belonging to the hospital and noted dissatisfaction about being 'recruited' to deliver a service for the hospital (SLaM) rather than it being a collaborative partner from the onset of the project. However, the model of delivery manifested itself in recruiting additional museums as the JOAP project developed, and therefore it was not possible to identify all partners at the start of the project.

### 5.10.2 Sharing expertise

Although a hierarchy of experts was found to be present in the JOAP project, the health professionals and the museum educators also expressed the 'division of labour' to be predominantly positive; having different roles demanded an understanding of each other's positions, openness to share expertise and respect for others' professional approaches. They commented on the need for sharing skills and expertise and identified that the other professions had contributions to make:

> *I think sometimes as health professionals we don't necessarily have the skills to engage in that area* [arts] *as well. I know that's one of the things that you think is unique about the*

> *JOAP. Bringing in ... recognising that and bringing the expertise in from those who have that.* Scarlett HPUK.

Scarlett acknowledges the need for an interdisciplinary approach and recognises that skills from both health professionals and the arts are needed.

The health professionals and the museum educators recognised that working together required an openness to think as a team and appreciate what could be achieved together. It was also recognised that interdisciplinary approaches required time to develop:

> *I think it's very much about cross-disciplinary, interdisciplinary collaborations and better understandings of each other, harnessing what we can do together.* Holly HPUK

Holly suggests that an understanding of each other's roles supports the interdisciplinary work.

> *There was enough common ground between myself and the healthcare professionals in terms of how I approached the service users, how I ran the project.* Renee MUUK

Renee acknowledges that it is important to establish common ground between the disciplines.

> *You need to dedicate time and resources to make that happen. It does not happen naturally. The gallery, the cultural sector has to deliberately set aside staff, physical space and money to make this happen.* Keira MUUK

Keira suggests that additional time should be allocated to create an interdisciplinary foundation between the staff involved.

Understanding the core of the JOAP project was seen as essential and the fact that the essence of the project needed an interdisciplinary approach was recognised by both professions. A health professional acknowledged that problems were unavoidable when working in collaboration with experts from different disciplines:

> *This whole thing only works if you could have a collaborative relationship whereby the inevitable problems are dealt with sensibly on both sides, because there're always problems because it's not a straight forward task. You have to be able to have those discussions.* Scarlett HPU

Part of sharing skills also involved getting the inspiration to develop new ways of supporting the service users. A health professional noted that, although they were equipped with the expertise and medical skills, they were still missing tools in order to deliver stimulating services:

> [We have] *got all the clinical skills and all the expertise in mental health needs… but we need inspiration. We need something to inspire, to support people… to support their recovery with…. I think that's where art plays a big role.* Leah HPUK.

Being able to create new ways for interaction and engagement with the services users, and inspired by the museum educators, was seen as beneficial and added a new set of tools to the health professionals' tool box.

### 5.10.3 The 'better' expert

It was clear that not all the collaborations with the museums ran smoothly. When commenting on the partnerships in general, one particular museum was mentioned by several of the health professionals. It turned out that the issues between SLaM and the museum had led to the museum's withdrawal from the project. The issues arose over a disagreement about how to work with the service users. However, the exact circumstances remain unclear, as there was never a follow-up conversation between SLaM and the museum:

> *There was one particular part of the project which has been more complicated. In fact, that gallery* [museum] *has decided to withdraw. We tried and they offered some staff training. There were things that they felt they had a handle over, I guess different opinions, I guess around how we went about things. That was a bit of a clash really. I know there was a sense of difficulty for my SLaM staff in the way things developed really I suppose. There was some learning for both sides. I think it's interesting that the partner* [the museum] *decided to withdraw really.* Scarlett HPUK

Scarlett acknowledges the conflict and difficulties that the situation had brought but did also see the learning opportunities involved.

A museum educator also commented about the conflict and explained that she felt that SLaM did not recognise the expertise that the museum had from their own experience of working with a similar service user group:

> *[…] if I can be honest there was a bit of conflict really between what the… what South London & Maudsley …*[SLaM] *wanted from us and what we could deliver and what our expertise was […] I just felt that maybe something broke down in the dialogue between us.* Melissa MUUK

In the interview, Melissa stated that the museum wanted to focus on their own projects, which was the reason they withdrew from the partnership. Melissa also commented that they had worked with a similar service users group for a long time as part of their core programme and had gained much experience and knowledge:

> *There were just too many things that we could not reconcile, actually, with the way that they wanted to work and the way we were used to working. Having ten years' experience of* [PROJECT NAME] *they felt* [my team] *quite strongly there were things that they would prefer to do and Maudsley* [SLaM] *weren't happy with them.* Melissa MUUK

In the view of Melissa there were differences in the logics of approaching the work with the service users. Both the museum staff and the health professionals claimed to have the better method in working with the service users, which created competing logics.

There was some scepticism from the health professional when commenting on the museum that had withdrawn willingness to engage with the particular group of service users:

> *There wasn't the opportunity to come together to resolve differences […] I would wonder how much they were really able to embrace our service users. We're talking about a not very sexy group of people who really have substantial mental health problems [...]*
> Scarlett HPUK

The museum's motivation, its ability to fully commit to working with mental health service users, and to work through 'difficult times', were questioned by the health professional. There were also other comments about museums' general interest in engaging with new audiences being tokenistic and pursued in order to generate funding.

Another situation was described by a museum educator where the way of engagement with the service user differed between the two professions. The museum educator commented on how an approach of engagement was understood differently by the museum educator than by the health professionals, and questioned the way the situation was handled. There was a fundamental difference in understanding the situation, where the museum educator saw no wrong in a service user approaching a task prior to receiving instructions, but the health professional perceived the situation differently:

> *From an artistic point of view, that's a really exciting thing that someone would just pick up a paint brush and start. But we had one incident where the person who'd brought them, someone from the hospital, felt that it was really*

> *inappropriate that they hadn't listened to the instructions yet and painted over their work in white. For us, that was a really uncomfortable moment… from our point of view what they were doing was fine. It was not right or wrong and that's the whole point of what we do, there is no right or wrong.* Melissa MUUK.

Melissa suggests that the difference in approaches is a challenge for the interdisciplinary work.

Having started the task before the instructions were given was seen as exciting and something that could be part of a creative process by the museum educator. However, the health professional intervened with the understanding that the action was wrong, as permission to start the task had not been given.

A health professional commented on the significance of being a professional and how knowledge and skills are part of professionalism which needs to be held onto:

> *If you think about it, it's important to us as professionals to be professionals. If you give a little bit of knowledge or skill, people feel threatened. I think it's difficult, I think that's often one of the barriers to collaborating. It's important to us to be good and to be the best and to know it. For probably a lot of reasons.* Heather HPUK

A fear of giving too much knowledge away was Heather's explanation of barriers in collaboration. The need to hold onto knowledge was perceived as a tool to remain professional and draw boundaries around the health profession.

The findings in this theme illustrate the difference in approach by the professionals and that it was possible to find common ground among the experts (their view on how to work collaboratively), but that the hierarchical structure and disciplinary approach somehow gets in the way.

## 5.11 Conclusion of findings

The findings present an insight to the interdisciplinary work in arts and health practice. It represents the participants' different understanding and sheds light on some of the issues that are at stake in the relationships between health professionals, museum educators and service user in arts and health projects.

The pilot study provides findings about various roles and relationship between stakeholders in arts and health and suggests that there were issues to explore in the interaction between the service users and museum educators. Furthermore, the findings show that services users experienced benefits from engaging in arts activities.

The findings from the main study in Denmark illustrate that the interaction between the service users and the museum educators was a challenge and provoked negative feelings for some service users. Some service users experienced the communication with the museum educators as inadequate and with a lack of understanding of their mental health problems, which resulted in undesirable experiences and had unintended negative effects. The museum educators noted that they mainly had gained their experience from working with school groups and in general had received very little or no training at all. They all welcomed more training opportunities. Furthermore, the service users described their connection to arts and cultural engagement as being an essential lifestyle, which they identified as having a positive effect on their recovery and wellbeing. It created a therapeutic space away from negative thoughts.

The UK findings illustrate that risk taking is perceived and experienced differently among the professions involved in the JOAP project. While health professionals commented on risk taking and the safety of the service user, museum professionals identified issues about not knowing the needs of the service users. Both professions agreed that risk taking was essential for developing practice in arts and health for mental health service users. Furthermore, being involved in the project had developed the participants professionally as well as personally and it had strengthened the bond between the health professionals and the service users.

The findings also illustrate that institutional logics from the institutions (hospital and the museums), and the professions (health professionals and museum professionals) often clashed. Although the participants had a similar view regarding what it takes to work in an interdisciplinary way, the findings show that there are some hurdles to overcome in order to find ways towards interdisciplinary logics. The findings also showed that each profession offers professional skills that were seen as being essential by the participants for successful project delivery in arts and health practices.

Hierarchical issues are evident in the findings and they are seen as barriers, both within the NHS and as part of the JOAP project between the professions. Although the health professionals and the museum educators are able to share some of their expertise, the findings identified a power struggle between the professions as to who has more expertise in dealing with the service users, resulting in a museum withdrawing from the JOAP project.

## 5.12 Summary of chapter

In this chapter, I presented the findings from Denmark (the pilot project and the main study) and from the UK. By exploring practices in Denmark and in the UK, the findings raise questions about arts and health practice, and research and policy in relation to the current socio-political settings in both countries and provide some contrasting approaches.

Although my empirical evidence is collected in Denmark and in the UK, it is not my intention to compare the two countries. This is partly because my data does not allow for such comparison, and partly because it relates to different settings and participants in the respective countries and the socio-political influences are different. By collecting empirical evidence in two countries, it is my aim make distinctions of what is useful in understanding the different settings and in considering how developments in the field are interlinked with the political agenda. It will also provide lessons learnt for future practice.

In the following chapter, I explore the findings from Denmark and from the UK in terms of the underpinning sociological theoretical considerations using theory of professions, theory of institutions and institutional logic, as well as other relevant literature to discuss the relationship between the health professionals, the museum educators and the service users.

> *Medical education had equipped me well for the challenge of addressing many of the biomechanical problems associated with conditions such as heart disease, cancer and arthritis. Conversely, my training had left me largely unable to alleviate pain and anxiety, to ease the trauma of death and bereavement, or to resolve the intractable social, political and economic problems that seemed often to determine individual and community patterns of illness and to shape welfare services* (Jackson, 2014).

# CHAPTER SIX: Discussion

## 6.1 Introduction

In the previous chapter I presented the underpinning theory, the method of the study and the participants' views and experiences of visits to museums and engagement in arts activities in Denmark. The findings from the UK described the views and understandings of health professionals and museum educators involved in the interdisciplinary collaboration of the JOAP project. In this chapter, I discuss these findings in the light of the existing research, literature and current arts and health practice. Before moving to the discussion, I provide a brief summary and reminder of the research aims and the underpinning theories.

The aim of the study is to explore the relationships between some of the stakeholders existing in arts and health collaborations. In the study, they include health professionals, museum educators and service users. The study is underpinned by the theory of profession by Abbott (1980), Foucault's theories about institutions (1975) and the sociological theories of institutional logics (Thornton et al., 2012), as previously discussed in chapter four. Abbott's (1988) theory of the system of profession focuses on the relationships between occupational

groups, theoretical knowledge and the possibilities for practitioners to exclusively apply such knowledge within their occupational practice. The theory helps us to understand the professions in the context of the interdisciplinary JOAP project and explore the possible tensions between the professions. Terms that are used by Abbott (1988) include 'abstraction' and 'jurisdiction'.

The knowledge abstractions central to the two professional groups included in the study (health professionals and museum educators) have different foundations. Health professionals' overarching abstractions have to do with scientific understanding of diseases, treatment and care pathways. This presents a wide spectrum of knowledge types that includes: patient knowledge; practitioners' knowledge; medical knowledge; resource and process knowledge; and institutional and relationship knowledge (Abidi, 2008). Museum educators have sets of different knowledge to build on and to refer to which include: theoretical and object knowledge, with foundations in the humanities; audience and community knowledge; and communication and dissemination knowledge, enabling a translation of the objects that moves between community and museum (Silverman, 2015). The differences in knowledge abstraction and the implication for arts and health practice are explored in the chapter.

Abbott's other focus is on jurisdiction, which he claims to be the link between task and legal structures in a profession. He considers jurisdictional claims to be central to the existence of a profession and jurisdictional boundaries to be subject to competition from other professions; in this way, professions are concerned with jurisdictional claims to keep competition at bay (Abbott, 1988). In addition to Abbott's theory on professions, Foucault's thinking on institutions is employed to explore how institutions may influence the professions in this study. Foucault (1975) studies institutions from a broad perspective, including that of historical, cultural and political considerations. Foucault questions the concept of 'truth' within institutions, how the notion of 'truth' is created by institutions seemingly creating their own version of 'truth' based on the subjectivity of those engaged in the institution. Through a

Foucauldian lens, it is possible to explore what may lie behind some institutional logics which are found in the study.

The concept of institutional logics is employed as a sociological lens to explore the relationship between the institutions and the health professionals, museum educators and services users. The term institutional logic was introduced by Alford and Friedland (1985) to describe the contradictory practices and beliefs inherent in the institutions of modern western societies. They describe capitalism, state bureaucracy and political democracy as three contending institutional orders which have different practices and beliefs that shape how individuals engage in political struggles. Institutional logics are embodied in practices, and are sustained and reproduced by cultural assumptions and political struggles, with which Foucault (1975) concurs. Institutional logics theories are not dissimilar to Foucault's discourses about social structures and institutions (Foucault, 1975); however, while Foucault's focus is on power relations within and behind social structures and institutions, institutional logics does not refer back to one specific factor but recognises a wide spectrum of possible factors that can encapsulate the various relationships between capitalism, state and democracy.

Institutional logics provide a connection between individuals and their cognition and socially constructed institutional practices and structures which are helpful to explore the interdisciplinary work in arts and health. I use these logics as a lens to understand and discuss the findings. The literature from arts and health and other relevant research is used for synthesising and is employed to contextualise and highlight aspects of the findings that contrast with, or add to, findings in the existing literature. There is currently limited literature exploring the nature and the concept of the interdisciplinary work between the arts and health field of practice and, while the majority of literature in the field addresses the evaluation of the participatory arts projects, it pays little attention to the work of the interdisciplinary work practice that such projects often require.

As the area of the study comprises complex, multiple layers of logics, it creates a challenge to determine the roots of the logics presented. However, by paying attention to the multiple logics that guide the professionals and the institution, the discussion examines the possible origins and reasons for certain ways of interaction between the health professionals, the museum educators and the service users. In the theory of professions, Foucault's thoughts on institutions and institutional logics are discussed in the findings with reference to existing research and literature using theory to analyse and synthesise.

The findings are discussed in five sections. In the first section, I discuss the complexity of logics. The second section discusses different approaches to risk central to the study and the third section the paradoxes of new roles in arts and health. The four section covers territories and hierarchies and the chapter concludes with a discussion on recovery and arts engagement.

## 6.2 The complexity of the logics within the arts and health field

The findings from the UK and from Denmark illustrate that there is a cocktail of logics through which to navigate, as the professions and the institutions in this study are embedded with multiple logics. As the health professionals and the museum educators are situated within institutions, i.e. museums and the hospital, it is pertinent to discuss the health professionals' and the museum educators' relationships with their respective institutions. Professions often have complex relationships with the institution within which they work (Zilber, 2013, Panche and Santos, 2010). Professions and institutions are concerned with logics and, according to Friedland (2012), it is difficult to describe institutional logics efficiently. He claims that institutional logics are not interactional regularities, or competitive or coercive organisational interactions, and logics cannot be reduced to single transactions or the structuration of organisational fields, but they cannot be separated from them either. Accepting Friedland's statement means that consenting that institutional logics are also partly

constructed by the logics derived from professions, they can therefore not easily be discussed as a separate set of logics.

Although the logics between institutions and professions frequently overlap, some logics are distinctively constructed by institutions or outside influences rather than by the professions. Institutions are moving towards further governmental control and professions are under pressure to change from traditional normative professional control and adapt more bureaucratic controls (Muzio et al., 2013). Transnational governance structures are increasingly bureaucratic, which results in institutional changes that have made the influence of professions increasingly reduced (Suddaby et al., 2008). An example of professional logics contrasting those of the institution is illustrated in the findings by a health professional identifying the increasing need to adapt to new initiatives and having to achieve new targets set by health commissioners and not being allowed time for proper implementation. Also, museums are subjected to demands from central and local government that subject museum staff to a work structure where a variety of policies and expectations create multiple demands (McCall and Gray, 2013).

While the institutional logics of the NHS are complex and often contradictory serving numerous political agendas, the institutional logics of museums in the UK have changed over the past decade, as museums have become institutions that strive to be more inclusive for a broader part of the public. These changes have also developed a set of complex and competing logic within the museums (Munro, 2014, McCall and Gray, 2013). On the one hand, museums are concerned with curation, preservation, and developing knowledge, while they also need to develop to attract new audiences, be inclusive and work in partnership with other agents (McCall and Gray, 2013, Watson, 2007) and consider and interact with the needs of their communities (Sandell, 2003).

The logics associated with practices are the established rules of behaviour of 'field-level actors' and refer to a belief system and connected practices that prevail in a field (Reay and

Hinings, 2009). Belief systems are associated with the organising logics that shape the behaviour of stakeholders within the field. The belief systems define the meaning and content of institutions as they refer back to a set of belief systems and associated practices (Reay and Hinings, 2009), making logics of practice and profession inseparable from institutional logics. In this way, the beliefs of the institution can unconsciously and unwillingly become part of the logics of the profession. The museum educators in Denmark had unwillingly become part of the logics of the museum, which did not provide the training opportunities that they wanted. They have also, to some extent, become blind to their own practice, as they felt equipped to deal with any group of visitors; such professional self-(mis)understanding creates barriers to work with the service users in different ways.

The unconscious alignment with the institutional logics is what Foucault (1975) refers to as becoming institutionalised. Foucault considers it to be common that institutions become 'blind' to their own ways, as within institutions certain types of communication are defined as valid and true and it becomes accepted by individuals who are subjected to the institution as well as the workers within. In other words, truth is always truth within a certain conceptual framework with a particular way of viewing things. Foucault considers the concept of truth in institutions to be problematic and recommends that institutions should avoid making assumptions about having social constructions that they accept to be their truth. In the interviews, none of the Danish museum educators suggested that they were in need of additional skills to work with the mental health service users. In this context, training of staff might be an obvious need from an outside perspective, but the institutional truth presents a different outlook, that does not allow for, or bring focus on issues concerning professional development or training.

The Danish museums did not offer awareness training to the museum educators, which was contrary to the respective museums in the UK that offered various opportunities including: sign language, mental health awareness, access awareness, audio description and dementia

awareness. The institutional logics behind the lack of training opportunities in Denmark are difficult to determine, as there may be many reasons for this. One museum educator suggested it had to do with museum educators' status as freelance workers and therefore the museum did not invest in their professional development. However, creating training opportunities for staff is also linked to wider societal developments and initiatives. At the time of data collection in the UK, for example, the social inclusion agenda had been prominent for years and, as part of promoting social inclusion in culture, the National Social Inclusion Programme in the UK developed a comprehensive training package for museum/gallery staff (Stickley et al., 2008). The model was supported by the Museums and Libraries Archive, the Wallace Collection, the Tate and the Victoria and Albert Museum. A key principle of the training is the inclusion of the lived experiences of mental health service users, which is recognised as a significant part of the recovery process (Slade, 2009).

The experience at the Danish museums illustrates that while the museums' jurisdiction claims as experts on art knowledge were plentiful, the delivery and dissemination of such knowledge was inadequate. In the words of Abbott (1988), the museum educators were not able to comply with the given labour tasks and they did not attend the needs of their 'clients'. The museum educators were not adequately skilled to engage with the service user participants, which was part of their job.

Since the beginning of the 20th Century, museums have become focused on developing educational departments to work with groups on learning in the museum (Tran and King, 2007). However, in recent years the focus has been extended to developing learning opportunities for wider participation, and some museums have made commitments to engage

with non-traditional audiences in line with the 'new museology'[15] (McCall and Gray, 2013). The move from traditional ways of thinking towards new directions are described as changes from an 'old' to a 'new museology', and although this movement has reformed many museums, not all have made the transformation (McCall and Gray, 2013). If the institutional logics of the museum are embedded in the 'old' way of thinking, this could be the explanation as to why limited training opportunities are offered. Commitment to engagement and wider participation are often at superficial levels; while a museum may be committed to social change, it struggles to engage with its communities in real participatory ways and experiences difficulties in changing itself as well (McSweeney and Kavanagh, 2016).

As museums are facing challenges in their attempts to work with communities and satisfy multiple expectations which are political, economic and social (Watson, 2007), funders are also expecting outcomes that prove to be socially inclusive. There has been a shift in attitude by external funders, which is summarised as: "the museum that does not prove outcome to its community, is as socially irresponsible as the business that fails to show profit […]; it wastes society's resources" (Weil, 2002: 43). Thus, there are multiple expectations from museums in the UK, which is likely to create numerous and conflicting logics.

However, multiple and competing logics are common within institutions and organisations across a variety of fields, including: healthcare, (van den Broek et al. 2014, Dunn and Jones 2010); cultural industries, (Glynn and Lousbury, 2005); life sciences, (Murray, 2010) and

[15] New museology is an idea of the museum as an educational tool as part of the service of societal development (de Varine, 1985) and "at the center of this idea of a museum lie not things, but people" (de Varine, 1976:127). This way of thinking sees the museum as a democratic and educational institute that adapts an active and community museology. VARINE, H. D 1985. Notes en forme d'avant-propos *In:* NICOLAS, A. (ed.) *Nouvelles muséologies.* Marseille. VARINE, H. D. 1976. Le musée moderne: conditions et problèmes d'une rénovation *Museum* 28**,** 126-139.

social enterprises, (Dacin, 2011). Working with competing logics creates challenges for accomplishing work tasks (van den Broek et al., 2014), which this study also has illustrated

and anyone who wants to engage with interdisciplinary collaboration within arts should be aware that professions and institutions have their own sets of logics, which are often taken for granted and can create barriers to collaboration in arts and health.

In the JOAP project, an emphasis had been placed on briefing and training of the participating professionals prior to the visits. These preparations had helped to create some level of awareness and understanding of the roles and the professional identity of others. Professional identities are embedded in institutional logics and in interdisciplinary settings; professional identity should be addressed directly (King and Ross, 2003). Learning about each other's professional practices and values is vital for fruitful interdisciplinary work (Nancarrow et al., 2013, Suter et al., 2009). The findings illustrate that sharing professional knowledge was a key component of the JOAP project. The health professionals and the museum educators spoke positively about gaining knowledge of each other's profession and how some of that knowledge was useful in their own practice. A health professional commented on being inspired to use creative activities to support people in their recovery, and a museum educator commented on gaining new skills to work with people with health issues and that they had increased their knowledge about the health sector. A key factor for successful interdisciplinary projects is the opportunity to gain new knowledge and to share knowledge (Nancarrow et al., 2013).

Although most of the JOAP staff received some level of training prior to the project, it is difficult to determine if the criteria of role clarification were included, as they did not talk about it at any length in the interviews. To satisfy the criteria of role clarification, Orchard and Kabene (2005) suggest that an approach to role clarification should include a clear understanding of roles and expertise, confidence in own abilities, commitment to the values

and ethics of own discipline, and knowledge of their own disciplinary practice standards, as well as that of others. Such an approach would enable a better understanding of the various logics that are brought to the interdisciplinary setting (Orchard and Kabene, 2005) and clarify any jurisdictional issues (Abbott, 1988).

To share professional knowledge and comprehension of other's professional roles, it is imperative that the professionals are able to identify and demonstrate potency in their own roles (Bronstein, 2003, Caldwell and Atwal, 2003). The participants in the JOAP referred to their individual influences in the interviews. This was evident through the way that they spoke about their approaches to work; direct influence and taking risks is an example of this, which will be discussed in more detail in the next section.

An increased complexity of knowledge and skills is required to provide inclusive care for service users (Nancarrow et al., 2013). Knowledge sharing in the arts and health field could become the glue that helps build the field of practice and develop standards for future practitioners. However, sharing knowledge and documenting new thinking requires institutional logics that support working across sectors (Thornton, et al., 2013) and it necessitates developing ways of working with and within conflicting logics.

The findings illustrate that conflicting logics can exist on two levels in arts and health. The first level refers to the institutions that are involved, which in this context are the NHS and the museums in the UK and in Denmark. The NHS presents its own logics that are concerned with administration and care, while the institutional logics of museums are different and are presented through preservation and dissemination, among others. The second level of conflicting logics is found within the collaborative work between the two groups of professions, and the professions and the service users. Each profession arrives with their own perspectives, understanding and values that are manifested through education and work experience and are embedded in practice, which influence their ability to engage in

collaborative practice and how they work with the service users. Both levels of logics and conflicting logics are intertwined in structures, attitudes and socio-political expectations and each level has its own particular challenges to manage and presents a variety of challenges for the arts and health field.

For example, conflicting logics between the museum educators and the service users in Denmark led to discouraging experiences for some service users and reinforced some of the existing negative logics that the service users had about themselves. Many users of mental health facilities are subjected to negative stereotyping (Corrigan and Watson, 2002), and some of the experiences at the museum perpetuated this stigmatising from an institutional perspective. However, this is likely to be an unintended act on behalf of the museums that manifested itself from lack of knowledge and insufficient institutional logics to support a diversified audience.

Further differences in approaches to practice that were evident in the JOAP project are analysed in the following section, where I discuss risk and risk-taking in arts and health practice.

## 6.3 Approaches to risk in arts and health practice

The findings illustrate that there is a difference in approach to risk between the health professionals and the museum educators. Risk can be considered from various perspectives and, according to Markowitz (1991), all risk concepts have the element in common to make a distinction between reality and possibility. Perceptions of risk and risk reduction are based on assumptions that vary depending on which perspective it is viewed from (Bradbury, 1989).

The two positions that occupy each end of the risk spectrum are identified as the positivistic view and the social constructivist view of risk (Short, 1989). The positivistic view measures risk according to 'objective' probability and magnitude of harm. For example, in healthcare

safeguarding, the patient is a priority and a number of risk factors are identified in a given situation resulting in a prediction and, as the findings from this study illustrate, the health professionals gave much attention to the notion of risk and risk assessment in the JOAP project. If, on the other hand, risk is considered to be a cultural and social construction, managing risks would be done according to different criteria and would reflect social values (Renn, 1992). Through a social construct perspective, the calculation of risk involves factors such as own resilience and personality, as well as external mechanisms such as family and social environment. While it is difficult to determine where the participants' views on risk would feature on the risk spectrum, it is evident that the perspectives on risk differ between the professions and service users.

This is likely to be because the logics of the contrasting institutions are embedded in the beliefs and values of the institutional and professional discourses and are reflected in how the participants talk about risk through the lens of their professional identities.

Beck (1992) has argued that when it comes to risk, an institution's responsibility to society in the protection of the public outweighs their duty to the individual. Conventionally regarded, risk is a concern with potential impacts that can be positive or negative and the probability of impacts happening (Gratt, 1987). Bringing actual change to the way health services are planned and delivered can happen by taking risks in innovative ways (Titterton, 2005). Risk is a socially constructed phenomenon where the boundaries between rationality and hysteria are blurred (Beck, 1992). According to Rose (1998) and Slovic (2000), this drama is played out in mental healthcare more than in any other social arena. Subsequently, where different professions come together, as in this study, there is the potential for conflicting approaches to risk. This is highly relevant to arts and health practices that often bring together practitioners from varying disciplines.

Risk-averse practices within institutions are inevitable (Kondra and Hinings, 1998) and, given that health professionals are entrusted with caring for often vulnerable people, they are faced with daily dilemmas (Manuel and Crowe, 2014). All health professionals are bound by codes of conduct based upon ethical and moral philosophy, summarised as the requirement to 'do good' and to 'do no harm' (Beauchamp and Childress, 2012, Devettere, 2010, Macer, 1990). There is much contemporary debate about risk-averse practice; however in mental healthcare specifically, decisions are often made out of defensive practice rather than through adherence to moral codes (Szmukler and Rose, 2013, Mullen et al., 2008). By way of contrast, the arts are known to encourage risk, to move boundaries and challenge the culture of unquestioned obedience; for decades, artists have used various art forms to shock, develop, provoke and question public debate (Hughes, 1991). Artists have pushed boundaries in order to question politics, and promote new thinking and discourses by way of challenging the status quo (Taylor, 1995, Wood et al., 1993).

Museum educators, however, work within institutional systems and, similar to health professionals, they are bound by regulatory frameworks which exist within the logics of the museum (ICOM, 2013) that provides protocols on risks, often to protect the artefacts as well as the public. However, whereas healthcare professionals are bound by codes of conduct, rules and regulations exposing and subjecting them to legislation if they are found to be negligent, it is different for the museum educators, who are less likely to be prosecuted for doing harm than those in the health professions. Over the past decades the museum educator profession has developed into a distinct occupation. The definition of museum education has evolved radically since the 1930s when the role was largely confined to working with primary school children. Since then, educational functions within museums have developed and enlarged (Hooper-Greenhill, 1991) and professional networks and associations have emerged with guidelines for best practice; however there is no professional association or body to subscribe to (Tran and King, 2007). Abbott (1988) reminds us that the process of professionalisation is

not a simple process and involves the process of coalescence into a group, dealing with the complexities of ordered social processes, licensing, examination, ethical codes and so on. Although the organisation *Engage* represents gallery, museum, arts and educational professionals internationally, *Engage* does not have the legal structure that is usually required for a professional organisation.

In this study, several museum educators claimed to be less concerned about risk than the healthcare professionals. This might be explained by applying Abbott's concept of 'abstract knowledge' (Abbott, 1988) in this context. Both the museum educators and the health professionals bring their own 'abstract knowledge' to the field of practice. For the health professionals, their 'abstract knowledge' is bound up with their role as a professional healthcare provider in relation to the service user with whom they are working. This role implies responsibility, not only for the welfare of the individual, but also for the protection of the public. For example, a mental health professional would be able to make judgements about an individual's potential to harm oneself or others. By way of contrast, the 'abstract knowledge' of the museum educator is more to do with dissemination of the museum's collection and, in this context, through an educational method. However, it would need a separate study to judge whether the museum educators do actually take any greater risks than the health professionals or that the risks taken are simply different forms of risks, however, it is possible that through their own understanding the health professionals might believe that they are taking a greater risk by bringing the service users out of the hospital. Foucault (1980) argues that within frameworks of knowledge, different forms of expertise develop only for those experts to become blind to any flaws within that framework (Mills, 2004). In this context, perhaps both health professionals and museum educators are blinded and embedded in their respective institutional logics to an extent where it has become difficult to appreciate the other's perspectives, i.e. not understanding the risks that they individually took which the findings suggest.

The health professions' 'abstract knowledge' makes them aware of the service users' needs using a different form of 'abstract knowledge' to that of the museum educators. This difference of abstraction is likely to be the reason why the museum educators view themselves as less risk-averse in the JOAP project, while the health professional, who may know the services users better and understand the actual risks involved and therefore view themselves as the greater risk-takers. Furthermore, risk-averse practice might be particularly evident while working in unknown territory (Morgan, 2004). In the JOAP project, the health professionals were working in museums and not in their usual context of the hospital and they had to adapt to a new setting while remaining care providers for the service users.

The health professionals in this study began by being more conscious of risk at the outset of the project, but learnt to relax more as they became used to being outside their familiar environments. While wanting to take risks to improve the service users' experiences, being situated within regulatory frameworks makes it more difficult for them to take the risks they may wish to take. There is a suggestion that in risk management, professionals are often pulled in opposing directions (Stickley and Felton, 2006). Risk, and judgement about risk, is constructed from past experiences and becomes a hypothesis of the future. In a culture where the health service has to 'cover its back', risk assessment is focused on policy and procedure, which leads to defensive practices where practitioners are concerned with protecting themselves (Stickley and Felton, 2006). It also contributes to a culture where the ability to practise professionally is judged on how exactly risks are assessed (Repper and Perkins, 2003). Being out of their 'comfort zone' in the JOAP project might be the reason the health professionals had a stronger focus on risk-taking and assessments. For the museum educators, they are used to dealing with the public and do not necessarily consider individuals in terms of the risk they might pose to the institution and themselves. The institutional logics of the museum do not come from a practice of defensiveness. Museums are not traditionally places for critically ill people, people in recovery or a clinical setting. Museums are more usually

places that 'healthy' people visit and they are not dealing with the same levels of risks the hospital institution faces. In the museums, the primary safety concern has to do with the displays and the staff and visitors' interaction with the artefacts (Howie, 1987). This might explain why the museum educators appear to be more relaxed about risk-taking. One museum educator talked about being happy to allow a lack of structure and improvisation in the sessions, which may have contrasted with the health professionals, being more concerned with risk, who may wish to see more control.

In this study, the notion of professional control was discussed by the museum educators in terms of not necessarily knowing the needs of the vulnerable services users in the JOAP. Abbott (1988) identifies this as a form of professional control, which inevitably varied between the two professional groups. Professional control is embedded in the profession's claim of jurisdiction (Abbott, 1988) and the beliefs and values of the logics of the institution that is the ruling structure (Thornton and Ocasio, 1999).

Whilst discussing the project, the health professionals were not specifically questioned about risk; however, this was a common topic that was talked about. Collectively, it is clear that they were willing to take risks, but they described the institutional requirement of risk-assessments they conducted prior to the beginning of the project. When interviewed, they all appeared to value the project and recognised the potential for creative approaches in their practice and in service provision. There is growing interest amongst health professionals in arts programmes designed for people who use mental health services (Stickley and Hui, 2012).

The findings show that being involved in the project enabled growth and progress away from feeling uncomfortable with aspects of the risk-taking to recognising the benefits for the service users. Although it was also risky for the museums educators to work with vulnerable people, perhaps their lack of knowledge about the service users enabled them to be more explorative in their approach to the work with the service users. The importance of museums delivering

activities in partnership with health providers when working with vulnerable groups is discussed by Chatterjee and Camic (2013) and getting the right partners is emphasised by Dodd and Jones (2014).

The multiple logics that health professionals are subjected to in the health service make it a complex institutional setting to work within (Panche and Santos, 2010). On the one hand, the health professionals acknowledge that taking risks can benefit the services users and develop a more diverse health service. On the other hand, although mental health professionals are trained to and practice therapeutic risk-taking (Stickley and Felton, 2006), the risks in JOAP was beyond the usual nature, not only because the project was a collaboration with a non-health partner, but because it also involved taking vulnerable service users from the wards, transporting them and engaging in a public place that was not a health setting. Taking risks and providing safe environments for healthcare creates dilemmas for professionals, as satisfying one demand may require the violation of others (Pfeffer and Salancik, 1978). The comments from the health professionals show that the JOAP project required a significant level of risk-taking and a certain amount of willpower for senior health professionals to make it happen. It signifies a desire to push boundaries within the health professions and take risks, as advocated by Stickley and Felton (2006). It also signifies an evolution in the profession (Abbott, 1988), where health professionals are able to provide healthcare to service users from acute wards outside a traditional health setting.

However, taking risks in arts and health practices also includes other settings where health professionals are not necessarily present and the risks are more about the ethics in work practices and not procedural ethics. Ethics in practice is about handling some of the day-to-day situations, but these ethics in practice can also include the same procedures as in healthcare. For example, engagement in the arts can provoke strong emotions (Cox and Boydell, 2016) and create unintended outcomes; therefore measures to safeguard vulnerable service users as well as arts and health practitioners should be taken (Jensen, 2014).

Increasingly the fragmentation and the centralised structures of institutions lead to institutional logics that collide and impose conflicting demands on professions (Panche and Santos, 2010). While the NHS is controlled by public authorities and subjected to a business-like structure with multiple demands (Reay and Hinings, 2009), museums are also faced with multiple logics. Being required to meet multiple requests, such as new developments in policy, roles and practice, is described as 'new museology' by McCall and Gray (2013), which seeks to introduce a new philosophy of how museums can function in the relationship between the museums, society and the community within which they are situated. One of the implications of the multiple logics that the 'new museology' creates is role ambiguity. With ambiguous discourse, including empowerment and social inclusion (Harrison, 1993), and museums being generators for wellbeing, museum professionals are expected to be "all things to all people, with museums and museum staff operating within multiple demands and pressures …" (McCall and Gray, 2013: 10). Being caught between the institutional logics of the museum which are embedded in policies and power struggles (Foucault, 1980), and the professional logic of extending their roles within the museum (Munro, 2014), creates a role paradox for museum educators. From being disseminators of knowledge, moving towards engaging with vulnerable community groups requires additional professional skills. Given the complexities of the fields in terms of competing logics, as well as the array of different practitioners, Raw et al. (2012) calls for a theoretical framework to underpin the practice and guidelines and continued professional development of practitioners, as suggested by White (2010) and Jensen (2014).

As well as different approaches to risk, the contradictory nature of the JOAP project also highlights issues of multiple institutional and competing logics and the professionals being exposed to new roles that are ambiguous, which are discussed in the section below.

## 6.4 The paradox and ambiguity of new roles in arts and health collaborations

The findings show that while the health professionals and the museum educators involved in the study were navigating through multiple institutional logics and experienced competing logics, they also had to adapt to new roles. This was illustrated when the health professionals joined the service users in the arts activities at the museum and they became arts participants as well as being healthcare providers. Even when the UK museum educators were used to working with visitors from vulnerable groups, the service user participants in the JOAP project represented a particularly vulnerable group and required an extension of their function and skills as museum educators.

Adaption to 'new roles' and moving away from a familiar professional identity stretched the boundaries for both the health professionals and the museum educators. Although, according to King and Ross (2007: 54), professional identities have no "fixed label that comes ready-made with membership of a particular group", it was evident from the findings that the new roles and being on unfamiliar territory created some anxieties. One museum educator commented on not knowing all the health needs of the participating service users, while a health professional expressed concern at never having visited a gallery.

The health professionals experienced that their roles changed from the traditional role of providing care in a health setting to working with a group of vulnerable service users outside the ward within a museum where they were expected to participate in arts activities and were challenged by the unfamiliar setting. Likewise, the museum educators found themselves on new ground facilitating a group of services users (some were sectioned under the Mental

Health Act[16]) that they were unaccustomed to. One museum educator commented on it being difficult to work with the groups, as the health professionals came with their own anxieties about arts which had not been addressed. Being exposed to the 'new role' challenged both the professional identities (McCall and Gray, 2013) and the institutional logics of the institutions. Professional identities are restricted by cultural and historical expectations and values that are adapted through professional socialisation and repeated in interactions with other professionals (King and Ross, 2003), and reshuffling these expectations creates uncertainty. Having to work in settings where roles are not understood (Aston, 2011) can have a negative impact; supporting and developing an understanding should be the responsibility of both professions and both sectors (Moss, 2015).

The museum educators in Denmark were also exposed to new roles and facilitating sessions for an unfamiliar group, which created anxiety. The museum educators offered comments about not having received any training in dealing with visitors from vulnerable groups (unlike their UK counterparts). Having to consider the mental health needs of the service users was clearly something that they were not used to. In the interviews, the collective response from the museum educators indicated that they had not considered the health needs of the service users beyond that of other visitors. This is likely to be because of the lack of exposure to diverse and vulnerable groups, as well as not having had mental health awareness training.

Being exposed to new situations at work creates a certain level of professional vulnerability (Davenport and Hall, 2011). The health professionals took risks and moved outside their comfort zones. The museum educators in the UK participated in a project with very vulnerable service users, and in Denmark the museum educators facilitated unfamiliar groups

16 The Mental Health UK GOVERNMENT 1983. Mental Health Act (amended in 2007). http://www.legislation.gov.uk/ukpga/1983/20/contents: UK Government Act (1983) is a legislation that "covers the assessment, treatment and rights of individuals with a mental health disorder. Individuals detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others".http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained/Pages/TheMentalHealthAct.aspx

of visitors. Feeling vulnerable as a professional while simultaneously dealing with a vulnerable group is likely to have caused a sense of double vulnerability. Although nurses and other healthcare professionals are regularly exposed to situations with uncertainly by nature of their professions (Davenport and Hall, 2011), both the health professionals and the museum professionals found themselves in unknown situations and in unfamiliar territory with a group of vulnerable service users, which unsurprisingly led to the professionals feeling vulnerable.

Professional vulnerability has been conceptualised socially as a "negative state of being" (Glass and Kierrynn, 2004: 83). Negative connotations are often connected to vulnerability, which creates a stigma of shame for vulnerable individuals. This is especially true for institutions where logics about competiveness are strong and professional vulnerability can be increased by the working environment (Davenport and Hall, 2011). In the JOAP project, vulnerability was created by a new set of circumstances which the professionals were working in. However, other circumstances also expose vulnerability. In healthcare, literature about nursing, in particular, provides evidence that nurses working in stressful environments with a lack of time, power and control are more likely to suffer from distress (Roberts and Grubb, 2014, Austin, 2007). The JOAP project offered a setting which had all the potential to become a stressful situation for the professionals. Despite the setting, none of the health professionals commented about feeling stressed about the project, apart from the initial anxiety about risk-taking and risk assessments.

Negative feelings of vulnerability in a professional context can limit the ability to engage fully with the tasks and thereby compromise the relationship between the professional and the service users (Davenport and Hall, 2011). As well as having negative connotations, vulnerability can have positive overtones that can motivate and create resilience (Glass and Kierrynn, 2004). Health professionals showing their vulnerability to service users can, in certain situations, be beneficial, although further studies are called for. It has been asserted

that displaying vulnerability can enhance the relationship between the health professional and the services user (Malterud et al., 2009).

According to Gilbert and Stickley (2012), in order to be effective practitioners, healthcare professionals must recognise their own humanity, which includes their vulnerability, and (Barker, 1996) suggests that the recognition of one's own pain can be beneficial for professional development ,while the inability of this awareness can restrict their practice.

Although not simple, the important transition from being negative to vulnerability to becoming positive to it, requires the ability to take calculated risks and being open to realities, which in turn can lead to professional development (Malloch and Porter-O'Grady, 2009). This was demonstrated in the JOAP project by a health professional who started by being sceptical and uncertain about the museum visits. He later overcame his negative vulnerability and recognised that taking risks was positive and helped develop new approaches. Several health professionals commented on the use of arts activities in their future work with the service users, having established closer relationships with the service users through the JOAP project. Arts engagement can play an active role in creating connections and developing a shared interest can change the dynamic between staff and service user from a 'them' and 'us' mentality to a 'togetherness' (Colbert et al., 2013).

Being vulnerable is an emotional state and museums, similar to hospitals, can be emotional places. There are emotions in the interaction between objects and visitors (Munro, 2014) which have the potential to provoke and stimulate both positive and negative responses. Curators and conservators care for the objects that they work with and museum staff, in particular those involved with community inclusion and engagement, are exposed to emotional labour through their work with vulnerable groups. 'Emotion work' or 'emotional labour' is masked and managed by an appropriate performance to hide one's own feelings (Hochschild, 1983). Emotion work is poorly understood (Wharton, 2009) and in many occupations emotional labour is under-valued in institutional settings (England et al., 2012). The concept

of ‘emotional labour’ might be familiar among health professionals who deal with loss, terminally ill patients or in midwifery practices (Hunter and Smith, 2007), but less so among museum staff. However, anxieties about engagement with vulnerable groups are not uncommon amongst museum staff and, while the concept of engagement is framed in a certain way, the range of behaviours that exists in ‘real life’ is not necessarily accounted for in policy, leaving museum staff worried about doing damage by evoking painful emotions (Munro, 2014). In this way, both the concept of working in situations which require ‘emotional labour’ and that of emotional responses from participants, are areas that create a certain amount of professional vulnerability that is currently not addressed in the arts and health field.

Ambiguous roles within the museums and engaging with institutional logics that are in flux (Munro, 2014, McCall and Grey, 2013) make museum educators vulnerable when engaging with vulnerable groups. Some museum educators commented on being reassured by the presences of the health professionals, which is likely to have assisted them in feeling less vulnerable.

Service users with mental health issues benefit from museum visits/activities (McGuigan et al., 2015) if given adequate facilitation. Given an opportunity to become part of the museum by interaction with the display is positive (Kindleysides and Biglands, 2015). Some public museum and art galleries in the UK engage with service users with mental health problems in inclusive and inspiring ways (Wilson et al., 2015). The study found it to be different in Denmark. Findings from the pilot study and the main study suggest that the dialogue between the museum educators and the service users was not given adequate attention by the museums in Denmark. Ways of participation that consider the purpose, context and circumstances of the individual is important in promoting recovery (Secker et al., 2007) and support service users in feeling a sense of belonging and citizenship (Sagan, 2012, Stickley, 2005). A different approach is needed in Denmark to enable services users to feel included and to benefit from the visits, emphasising the need for adequate training.

In light of the findings, the ethical question about whether or not an institution should accept a booking if no qualified staff can facilitate the session should be raised. The International Council of Museums' ethical guidelines point out that the members of the museum profession have a duty to develop their educational roles and should, "render their professional service to others efficiently and to a high standard" (ICOM, 2013: 13). Whilst this is a vague statement, it is reasonable to conclude that the Danish museums did not offer a high standard of professional service in the context of engaging with the service users.

The museum educators in Denmark all commented that their introduction to their job at the museums had been in the style of 'learning as you go along' and arguably the institutions compromise the profession by not providing training. The importance of professional development to maintain certain standards and remaining competitive is observed by Abbott (1988: 57), who sees the academic knowledge systems in professions to have three tasks: "… legitimation, research and instruction…". If professions are incapable of keeping abreast of the constantly changing external environments, they will face serious competition from other professionals and consequently will lose legitimacy and the socially given professional jurisdiction (Abbott, 1988). The Danish museum educators were not given the opportunity to develop their skills in the changing environment of the museum (McCall and Grey, 2013). The museum educators are subjected to institutional logics that fail to recognise the needs of the profession and prevent the profession from becoming equipped to face developments in the sector. Not developing alongside the requirements of society has implications for a profession (Abbott, 1988).

In the role as researcher/observer, I was present on the museum trips in Denmark, which enabled a first-hand account of the events. Based on the observation, it can be concluded that the Danish museums involved in this study deliver mainstream, non-individualised sessions and, in some instances, a dialogue that some service users experienced as being disconnecting rather than inclusive. Having observed the sessions provides an insight perspective that varied

from some of the perspectives offered (or not offered) in the interviews by the museum educators. For example, there was one visit where the service users were particularly disengaged with both the artwork and with the museum educator. The same museum educator had little interaction with the service users during the workshop and the session was not rounded off. However, none of this was addressed in the interviews and the museum educator had experienced the session as being good.

In one of the workshops, the museum educator asked if it was all right to take photographs of the service user participants; the request was declined by the service users. With more sensitivity for and awareness of the services users, the request for photographs would not have been made in the first place. From an observer's viewpoint, this highlights the need for mental health awareness training among staff, as this may have provided the museum educators with more sensitivity to the needs of and skills to interact with the service users in a more constructive way.

While the findings show that being exposed to new roles caused levels of uncertainty and vulnerability among museum educators and health professionals, the findings also raised questions about territory, professional jurisdiction and maintaining control over an area of 'abstract knowledge', which is discussed in the section below.

## 6.5 Territory and hierarchies in arts and health practice

The concept of territory in the animal kingdom is often a key to survival and domains are defended from intruders or threats (Baldwin, 2007), which historically has also been the circumstances for humankind. However, arguably the battle for survival in the Western World has become more civilised and, in contrast to the animal kingdom where territories are fought for and killed over, territories of professions are marked by regulatory authorities, typically the

State. Nevertheless, territories are there to be taken and struggles over boundaries are created (Abbott, 1988).

The findings show that the interdisciplinary work of the JOAP project created a grey zone with no claimants, i.e. an area with no official claim of jurisdiction. The JOAP project presented possibilities for developing knowledge abstraction for both professions involved, as well as fostering possibilities for a new territory to be claimed. As identified in chapter four, jurisdiction is the connection between a profession and a task which, according to Abbott (1988), is changeable, and when knowledge changes or is developed, it is possible to push the barriers of jurisdiction. Abbott (1988) identifies the main mechanism of a shift in jurisdiction as the abstractions held by professions. He also makes a distinction between the formal and informal jurisdictional claims and it is within claims that are associated with performing tasks in practice that overlaps occur. Overlaps in dynamic structures of work such as the JOAP project are, in Abbott's (1988) view, where changes are initiated. This internal change is brought forward as a result of new knowledge. In the JOAP project, new knowledge was developed which, in turn, creates a platform for change of informal practice and is open to jurisdictional claims of knowledge and claims of territory.

Although the JOAP project was initiated by SLaM, the 'abstract knowledge' produced within the project does not belong to SLaM and is, therefore, there for the taking. This is also the case for other arts and health projects, as the arts and health area remains an area to be claimed. 'Unclaimed', 'unoccupied' or 'abandoned' territories present the possibility of 'new' and emerging areas of competence and performance. For example, in healthcare, health prevention and health promotion emerged in the late 1960s in the UK, adding 'new' areas to the existing healthcare field (Baldwin, 2007), just as in museums where 'new' areas also have emerged in terms of community involvement and participatory projects.

According to Baldwin (2007), the health system is concerned with territory and knowledge claims which have increased with the variety and numbers of medical technologies and, with more health professions, the health system is a multifaceted system. The concept of the doctor has been divided into various specialisms with their own claims to status, autonomy and monopoly, including a variety of professions and practitioners such as occupational therapists, surgeons, midwives, psychologists and other mental health practitioners. This has made the traditional power and territorial boundaries of medicine a dynamic area of change and tension and an area that is further complicated by social and political forces (Baldwin, 2007). The NHS is subjected to stringent economic measures (Chang, 2009), policies on patients (Greener and Mannion, 2009), development of safety and quality in care (Francis, 2013) and so on, making the NHS an institution with multiple territories. A health professional in the JOAP project commented on the NHS as being a 'political hot potato' with a constant stream of new initiatives to work with, creating multiple logics for the health staff to steer through (van den Broek et al., 2014).

Although not with the same level of public visibility as the NHS, museums are also subjected to political forces, with an obligation to offer inclusive practices and reach out to communities (McCall and Grey, 2013, Watson, 2007, Sandell, 2003). While this is a positive development and a step in the right direction to make museums more democratic places, developing inclusive practices requires knowledge and staff skills to deal with new target groups (Jensen et al., 2016, Stickley et al., 2008), which is not always sufficiently dealt with (Munro, 2014). Boundaries and territories of the work practices in museums has changed along with the introduction of 'new museology' (McCall and Grey, 2013) requiring museums to engage actively with communities and commit attention to inclusivity and, in some instances, developing initiatives with a focus on health and wellbeing (Dodd and Jones, 2015, Chatterjee and Nobel, 2013).

Working on unknown and yet unclaimed territory made both professional groups in the JOAP project respond in particular ways. Although the findings illustrate that the museum professionals and the health professionals essentially collaborated well, there was an undercurrent of a territorial battle present. An example is the withdrawal of one of the museums which effectively was about claims over 'abstract knowledge'. The health professional claimed to know the needs of the service users in a certain way, while the museum educator had a different approach and accordingly assumed they had a more 'appropriate' knowledge about the services users. The battle over territory resulted in the museum's withdrawal from the project with no real explanation, which, according to Panche and Santos (2013), indicates avoidance in dealing with competing logics and is a common way of dealing with situations where competing logics arise. Each profession claims to have certain knowledge that informs the best approach and, according to Abbott (1988), knowledge is the currency of competition and this situation suggests competition between the professions about expertise. He views the entire professional field as engaged in an ongoing struggle for control of the market and definitions are crucial in order to accrue professional status and distance from competing sectors.

Losing and gaining territory is illustrated in cases where it has not been possible to manage the rivalry of competing logics (Reay and Hinings, 2009). For example, British lawyers lost their business in the City of London to arbitrators because their clients no longer would accept and adapt to the lawyers' slow practice. In America, the medicine field found itself invaded by a combination of internal and external forces, from business administrators and other health professions, to insurance companies (Abbott, 1988). Jurisdiction is about occupation of a professional territory (Sikka and Willmott, 1995). The jurisdiction in the arts and health field remains separated into two areas, where the respective areas are the arts and arts practice and the other area is related to health.

One health professional comments that if the museum educators knew what they knew, i.e. had the same level of 'abstract knowledge' about the mental health illness, they would approach the service users in a different way. Although the health professional might be right, it is likely to be the lack of 'abstract knowledge' about health that enables the museum educators to approach their work with the service users in a certain way. However, it creates a paradox for the museum educators as it is essential to hold some knowledge and awareness about health in order not to make the same mistakes as the museum educators in Denmark, but too much knowledge might also present a hindrance (Jensen, 2014) and interfere with aspects of the creative process.

If professions, by definition, are allocated jurisdiction to control a body of knowledge and the practice associated with that expertise (Abbott, 1988), then potential threats towards the profession are mainly struggles over boundaries including issues about language and material, outsiders and insiders, what is ethical practice and so on. In that way, being involved in interdisciplinary collaborations could present a potential threat for a profession. Historically, the health professions have found methods of working in interdisciplinary ways and it has become the norm and an ideal where roles and responsibilities change according to the needs of the service users, the setting and demand of the situation (Baldwin, 2007). This suggests that there is a need for the health professions to be flexible in terms of adapting to the needs of the service users and recognise the need for less boundary control and sharing of knowledge abstraction. Although Baldwin is referring to interdisciplinary work within the health sector by health professionals, the notion that health professionals are flexible and able adapt to settings and situations challenges Abbott's (1988) theory about professions being controlling over territory.

Interdisciplinarity challenges professional territories and boundaries and an example of this is the ongoing struggle between midwives and doctors who have a long history of battling for jurisdiction in relation to childbirth (Witz, 1992). With different epistemological approaches to

the same area of focus (Hunter and Segrott, 2014), doctors fight to retain the boundaries and to keep the midwives out (Abbott, 1988). Both professions are engaged in boundary work and within the battle for territory; midwifery seeks to expand its professional territory (Hunter and Segrott, 2014). This supports Abbot's theory and illustrates an area of practice where the coexistence of different logics is at play; however, competing logics are not necessarily bad providing they can co-exist in order to accomplish the work (Reay and Hinings, 2009).

Arts and health literature has drawn attention to the challenges of arts professionals working in hospitals and other health settings (Moss 2015, Aston, 2011, White, 2009) and boundaries may not only be about protocols in clinical environments, but also about setting professional boundaries. Overstepping professional boundaries is illustrated in the JOAP project in an incident explained by a museum educator as a health professional having interfered and prevented a service user's progress in an art activity. The museum educator clearly felt that the health professional was unaware of the approach of the activity and, by preventing the service user's creative progress, a professional boundary was crossed.

In the JOAP project, both health professionals and museum educators gained new knowledge and extended their levels of knowledge abstraction. While health professionals gained knowledge about the arts and skills in how to engage service users in arts activities, the museum educators learned about the health needs of the services users. Knowledge abstraction is part of the claims for jurisdiction that professions are seeking to uphold (Abbott, 1988). In this way, the JOAP project presents a position where the professions, as argued by Abbott (1988), do boundary maintenance work in order to uphold jurisdiction. However, it also supports Baldwin's (2007) claim that health professionals show flexibility and are accustomed to working in interdisciplinary collaborations.

In the JOAP project, one health professional expressed concern about giving too much knowledge away. This was an indication of not wanting to leave the profession vulnerable to

intruders and seeking to maintain control (Abbott, 1988). Professions engage in some level of boundary maintenance, which could be disputes with neighbouring professions or by tactics intended to marginalise nonprofessionals influencing their territory (Abbot, 1988). If accepting that jurisdiction is central to any professional project, then it is not surprising that working in an interdisciplinary setting with another professional group would raise jurisdictional dilemmas. The JOAP project presents an interdisciplinary project where knowledge is drawn from two professions and each profession's 'abstract knowledge' is significant for the project, leaving both professions vulnerable to intruders and with boundary maintenance high on the agenda.

Within the scope of territorial boundaries and jurisdictional claims there are also hierarchical factors to consider. The findings from the JOAP project captured comments about hierarchical considerations, showing that there are hierarchies within the health sector as well as within the collaborations itself. These hierarchies created barriers for the project delivery on different levels. The health professionals commented on issues that were hierarchical as being a hindrance to collaborative progress. For example, junior health staff are not allowed to make decisions, which was commented on as it left them feeling disempowered and therefore disengaged. Hierarchies can assist institutions in solving issues of collective decision-making by giving top-heavy control to one or a few members, and although a top-down control helps institutions make decisions more effectively and avoid conflict over control (Van Vugt et al., 2008), it was not experienced as being beneficial, as the planning process was affected by health partners constantly seeking approval from further up in the system. It was, for example, difficult for a museum educator to plan and develop the project, as the health professionals would attend meetings without having a mandate to make decisions and it became a hindrance to the progress of the project. These findings highlight issues that are associated with smaller organisations working in collaboration with a large hierarchical institution.

The participants also offered comments on the absence of medical consultants in the workshops and the planning. Although aware of the project and its nature, the medical consultants did not contribute or involve themselves in the JOAP project, which was in contrast to the museums where senior members of staff were involved. While it is difficult to determine the reason for the absence of the medical consultants, it was noted by two of the museum educators and referred to as part of their perception of the hierarchical system within the NHS. Staff relations are important and "support is needed to implement any arts project in a hospital" (Moss, 2015: 13).

Traditionally, healthcare in the UK is a nationally-run institution (Light, 2003), whereas museums have more sovereignty and are subjected to less complicated decision-making processes than a hospital, which is part of a much larger structure. However, although not mentioned by the museum educators, hierarchical barriers within museums are also common (McCall and Gray, 2013). Museum staff working closely with collections see a loss of control over the museum function and direction and low importance is given to collection policy by the management. With little freedom given to curators to make exhibitions and display choices, as well as mechanisms of control that encourage defensive work strategies from management, this reinforces divisive structures and hierarchies within the museum (McCall and Gray, 2013).

Territories, jurisdiction and hierarchies are all present in fights for survival of the professions (Abbott, 1988) and for knowledge and power (Foucault, 1980). However, as in the earlier mentioned case about the battle between midwives and doctors, different epistemological approaches are also highlighted as a cause of some of the challenges in working together (Hunter and Segrott, 2014). Different epistemologies also underpinned the professions' approaches in the JOAP project, and although the health professionals and museum educators offered comments about the professions complementing each other and jointly providing a framework with expertise from both professions, it was also evident that the professions came

from different epistemological approaches and it was likely to be the explanation for some of the various methods used in the JOAP project.

Through a Foucaultian perspective it is recognised that institutions cannot work without exercising power, and the question of power is central to Foucault (1980). However, he does not see power as being localised or to belong to certain people, groups or classes and in this way, power cannot only be understood through economics, politics and social structures but can be found everywhere. Power produces norms, ideas and knowledge and the power struggles are about defining what the 'truth' is. Power relations are everywhere in society and, according to Foucault (1980), the question is, what purpose do they serve? In the JOAP, power is found within jurisdiction and the 'abstract knowledge' which essentially is about professional territory; while the jurisdiction in the arts and health field might remain separate to the respective professions, the nature of the interdisciplinary practice creates blurred lines, leading to power struggles between professions, as we have seen in examples where a museum withdrew from the collaboration and the nurse claimed a position of power.

As established in chapter four, arts and health straddles two disciplines and the arts and sciences belong to two different paradigms; therefore, the nature of interdisciplinary working in this field might be more complex than other interdisciplinary working collaborations where collaborators belong to the same paradigm. For example, in an interdisciplinary project in healthcare, there might be doctors, nurses and occupational therapists and, although they are from different disciplines and issues of power, institutional context, rationalities and norms might be at play (Lehn-Christiansen, 2016), the professionals are from the same institution and possibly from similar epistemological assumptions. Belonging to a certain profession means to see and understand oneself in a particular way, which also applies to how one views other professions. The question of professional identity is often overlooked in the discourse of the challenges in interdisciplinary work (Kilminster and Zukas, 2007) and clashes are often about values and beliefs. The findings illustrate this well in the situation when a service user started

an arts activity at the museum and was stopped by the health professional, who believed it was wrong to start, while the museum educator saw the premature start as enthusiasm and was encouraged by it. The professions are equipped with a special understanding of what 'a professional approach' is and what 'a good solution' is (Lehn-Christiansen, 2016), and the JOAP project included healthcare professionals from different disciplines and museum educators from different institutional contexts, which created a complex interdisciplinary context with challenges in both practice and theoretical approaches.

Historical constructions of professions illustrate that they are associated with gender, ethnicity and social class, which in turn means that power relations are not only about professional approaches but also about the profession's positions in society. The healthcare field is marked by many power battles about status, rights and areas of responsibility. According to Gannik (2005), the biomedical understanding of knowledge is dominant in healthcare and this prevailing approach also guides interdisciplinary work in the health sector (Lehn-Christiansen, 2016). This is noticeable in the comment from a nurse about others needing to listen to what they (the health professionals) say as they have 'more' knowledge and experience. The ward manager is clearly conscious of his special position in the interdisciplinary work. The comment indicates that, in his perception, the nurse should have the 'final' say and is in a position of power in the interdisciplinary hierarchy in the JOAP project.

Arguably, some of the challenges in the interdisciplinary work in arts and health might have to do with the fact that the practice is process-based where outcomes are difficult to premeditate and are often subjective, and that healthcare approaches are frequently within a solution-based framework. The more explorative frameworks of arts and health might suit arts and cultural professionals better than health professionals.

However, the interdisciplinary work of arts and health might, to some extent, bridge the world between the humanities and sciences that Snow (1959), half a century ago, suggested was broken down, which resulted in creating barriers in solving problems in the world. Arts and health offers an interdisciplinary solution to some of the complex health issues that the health sector cannot solve alone and, although the work presents a challenge for the professions involved, emerging fields commonly present challenges for professions and institutions.

Jurisdiction, territory and abstraction or epistemological assumptions evidently play a role in the work of arts and health that is worth paying attention to, not only when developing and planning activities, but also in the broader perspective of the discourse of the field.

Having considered the collaboration between the health professionals and the museum educators in relation to the findings from the JOAP project, in the next section I discuss recovery in terms of an interdisciplinary approach that can include arts activities (Spandler et al., 2007) and I draw attention to the relationship between services users, healthcare professionals and museum educators, as well as discuss the individual health benefits for service users to engage with arts activities.

## 6.6 Recovery and arts engagement

Recovery and the arts are considered in this final section of the chapter relating to the findings from the interviews with the service users. The findings illustrate that engagement in arts activities can have health and wellbeing benefits for people who use mental health services. The core principles of recovery and how they connect to arts practice and engagement are discussed in the light of the findings and existing literature, exploring the central function of the role of the professionals working with the service users.

Engaging in arts and cultural activities, including visits to museum and galleries, can have positive health and wellbeing benefits for mental health service users (McGuigan et al., 2015, Colbert et al., 2013). However, the institutional approaches of some of the museums in Denmark made the service users feel stigmatised and, instead of the intended positive experience, aspects of the visits became a negative experience for some service users. This in turn can have a negative effect on the recovery process. I discuss some of the reasons why this might be.

By encouraging individuals to take responsibility for their own mental health, the recovery model is consistent with the social model of health which attempts to address the broader influences on health including social, cultural, economic and environmental factors (Higgins, 2008). To address the whole person requires an approach that recognises that the person is an understanding body, rather than just a physiological body, and that perceptions and social experiences are integrated as a whole. The dualistic division of body and mind is reflected throughout the health system (Mehta, 2011), not only in terms of how service users are treated medically and personally, but also in the architecture, economics and technologies and the organisation of healthcare practices. The absence of a holistic approach promotes fragmented assessments and shortcomings in how people are treated medically and personally in the healthcare system (Wade and Halligan, 2004). If recovery is to be understood from a holistic perspective, where the person's unique story is at the core, then a critical view of the dominant biomedical model is needed. The biomedical model is often described as methodically reductionist, where larger parts are separated into smaller components to study individually (Marcum, 2008). The essential concept of the biomedical model is that human beings are best understood by separating the spiritual and mental from the physical, and then increasingly moving closer in and focusing on smaller and smaller organic parts, ending with the function of just one cell. From the biomedical model approach, Marcum (2008) suggests that the

patient is viewed as a physical body composed of various separate body elements that inhabits a machine world.

Historically, this perception has been about the visible organism and its function and parts and that everything can be reduced to such. However, by looking beyond the biomedical model it is necessary to view and understand humans from a holistic approach, which includes the psychological, spiritual and social aspects of an individual. The recovery model attempts to do so and its approach is focused on the active involvement of service users, where their voices are heard, rather than just assumed, by healthcare providers.

Within the mental health recovery approach, health professionals seek agreement on care and treatment in a respectful dialogue with service users, rather than operating on the expectation of service users' compliance with expert advice (Higgins, 2008, Mental Health Commission, 2005). However, it can be challenging for service users to be heard in regards to their own treatment, and the delivery of mental health recovery interventions are only as good as the professional delivering it.

The findings illustrate that there was awkward communication between the service users and the museum educator in Denmark, resulting in an off-putting experience for some of the service users. The Salutogenesis[17] model, developed by American sociologist Antonovsky (1987), offers a person-centered approach and is an "optimistic and humanistic philosophy" which links with the recovery model and can contribute to enhancing self-esteem and developing coping resources in times of difficulties (Stickley and Hoare, 2015: 71). The salutogenic approach helps build resilience and is described as a profound personal way of

[17] Salutogenesis is to be understood as the origin of health and is a stress resource concept with focus on resources. It looks at human resources and the ability to stay well in stressful situations and the opposite of pathogenic concepts with focus on the obstacles and deficits. The core areas of research are mental health promotion, life span, health literacy and healthy learning (Antonovsky, 1987).

thinking, being and acting (Lindström and Eriksson, 2005) and is centered on the discovery and use of personal resources from both within the person and the environment exploring the origin of health. It focuses on the factors that keep people healthy, especially in difficult circumstances, rather than emphasising the reasons for ill health. Using salutogenic principles has shown that coping improved significantly among people with mental health problems (Langeland et al., 2006); however, there is still little evidence of how salutogenic concepts can be facilitated to support people and communities. Adapting a 'salutogenic' approach could be a useful tool and framework for professionals working in arts and health, both as a lens through which to view health and recovery, and also as a direct application to practice.

In a systematic review and narrative synthesis on personal recovery in mental health, attempting to identity the human processes of recovery, (Leamy et al., 2011) describe part of their findings as CHIME (an acronym for: *Connectedness, Hope and Optimisim, Identity, Meaning in life* and *Empowerment*). This study is the first and only systematic review and narrative synthesis on the meaning of personal recovery.

This conceptual framework, which includes thirteen characteristics of the recovery journey, five recovery processes comprising CHIME, and a recovery stage description mapping onto a transtheoretical model of change, sought to inform some of the gaps in previous understandings of the stages and processes of recovery. The thirteen characteristics identified dimensions which capture experience and complexity of recovery (see Leamy et al., 2011 for details of the study). The findings of the Leamy et al. review claim to be able to contribute to the development of a measure of personal recovery, "providing a foundation for developing standardised recovery" (Leamy et al. 2011: 450). The implications for research and practice, apart from a better comprehension of the identified process and stages, is the provision of a coding framework providing keywords for use in secondary research, such as in this study.

Two of the CHIME categories are similar to findings in this study, which are empowerment and creating meaning in life; these themes are also recognised in other studies (see Secker et al., 2007 and Spandler et al., 2007). While empowerment has been described as the process of gaining control over one's life and having the ability to influence the structures in which one lives (Segal et al., 1995), creating meaning in life remains more subjective for the individual. However, in order to make a shift from empowerment being a service user experience to an actuality that is embodied in institutional logics and a wider societal approach to mental health, it is necessary to work towards transforming the distribution of power and resources, including the equal distribution of collective power and the empowerment of individuals and groups.

While individual and institutions may seek power, status, and economic advantage, the means and ends of their interests are both enabled and constrained by prevailing institutional logics (Giddens, 1984, Sewell, 1992). Arguably, the institutional logics of the museums created a relationship of power with the service users and placed the service users in a position of lacking power and voice. If decisions and outcomes are a result of the interplay between individual and institutional structure then such interplay has a powerful function (Jackall, 1988, Friedland and Alford, 1991, Thornton and Ocasio, 1999). The outcomes that are discussed in this section are concerned the museum visits and results of the interplay between the service users and the museum educators.

In a mental health context, empowerment refers to the level of choice, influence and control that users of mental health services can exercise over events in their lives. A way towards empowerment is the removal of formal or informal barriers and the transformation of power relations between individuals, communities, services and governments that are rooted in institutional logics. Empowerment is a multidimensional social process through which individuals and groups gain better understanding and control over their lives. Consequently, is

it is possible to enable change to the social and political environment to improve health-related life circumstances (Loss & Wiese, 2008).

People with mental health problems have historically lacked a voice and power, and not been involved in decision-making on mental health services and continue to be at risk of social exclusion and discrimination in all aspects of life (Callard and Rose, 2010). Power is central to concept of empowerment and a significant part of empowerment is to challenge some of the institutional or structural barriers and/or cultural norms.

For the individual, the empowerment process means overcoming a state of powerlessness and gaining control of one's life (WHO, 2006). The process starts with individually defined needs and ambitions and focuses on the development of capacities and resources that support it. The empowerment of individuals intends to help adopt self-determination and autonomy, exert more influence on social and political decision-making processes and gain increased self-esteem. Communities and institutions can be a support this process by establishing social networks and different sorts of social support that can encourage people through difficult transitions and periods of vulnerability in life.

Callard and Rose (2010) suggest that policy-makers should ensure that people with mental health problems have the power to set the agenda, make decisions and control resources. For the material, psychosocial, and political empowerment that underpins social well-being and equitable health, it is vital for individuals to be included in the society. Legislative and policy tools can support the empowerment of service users, including the United Nations Convention for the Rights of People with Disabilities[18]. The European Pact for Mental Health and Well-being[19] (2008: 3) notes that "people who have experienced mental health problems have valuable expertise and need to play an active role in planning and implementing actions", and

[18] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html
[19] European Pact for Mental Health and Well-being: http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf

calls on policy-makers and stakeholders to involve people with mental health problems and their families in relevant decision-making processes.

The WHO (2008: 1) further states that health is a fundamental human right and that:

> *empowerment of patients and their families, friends or other informal carers is a societal task that encourages all communities, employers, trade unions, schools and colleges, voluntary organizations to respect health and well-being of individuals and populations and act in ways that empower individuals and groups to respect their own and other people's rights to health and well-being.*

Backing a societal agenda of empowerment would require the logics of individuals and institutions to understanding the implication and commit such approach, as Rappaport (1981: 52) stated over 30 years ago that:

> *To be committed to an empowerment social agenda and to be consistent with that agenda in one's approach to social science theory, research, and action is to be committed to identifying, facilitating, or creating contexts in which heretofore silent and isolated people, those who are "outsiders" in various settings, organizations, and communities, gain understanding, voice and influence over decisions that affect their lives.*

An empowerment approach promotes the recognition and development of the service user's strengths, resources and skills and can contribute to a platform to promote more equal relationships that is enabled by institutional logics that support this agenda. As this study has shown, accessing cultural institutions can support feelings of empowerment for service users. The empowerment of mental health service users can include a higher degree of individual

empowerment, a stronger sense of belonging to the community, development of and participation in activities.

Recognising that mental health service users benefit from arts engagement in terms of the categories identified in CHIME also argues for the identification of the specific benefits: *a)* that arts engagement can play a vital role in the recovery process; *b)* journeys of recovery can be defined within broad categories (although the review is lacking a wider socio-environmental contextual approach); and *c)* it is possible to use art engagement as a tool in recovery, given that it is placed within a framework, as art engagement can add something unique to each personal and complex story and each journey, provided that it is facilitated adequately.

The knowledge and lived experiences of the service users is important in recovery (Leamy et al., 2011, Warne and McAndrew, 2007). The findings in the study show that the service users have a comprehensive understanding of the role that the arts and cultural activities have in their lives and this understanding makes them experts of their own engagement in the arts and places them in a position to contribute as an engaged expert in their recovery.

As this study has elicited the voices of the service users in relation to how they benefit or not from engagement in the arts and what influences might support or not support this process, the findings provide a contribution to support the use of art in mental health settings as part of a recovery process underpinned by CHIME as a theoretical framework, consideration of the implications of the implications of institutional logics and a salutogenesis approach.

The link between arts, health and recovery can be tracked to ancient Greece, where people came from across the country to visit the temples of Asclepius, who was the god of healing (Risse, 1990). Part of the healing process involved a prescription to attend a performance or comedy at the amphitheater (Chatterjee and Nobel, 2013) and poetry was also used for healing purposes (Belfiore, 2016). It illustrates that the Greeks recognised the impact that arts had on

healing and recovery. In terms of using arts in a present day recovery context, arts and health practices appear to seamlessly deliver elements identified in the CHIME framework (Leamy et al., 2011) and can satisfy each category in the recovery processes identified (*connectedness, hope and optimism, identity, meaning in life* and *empowerment*) and, given that the right people facilitate the process at the right time, arts participation can make a significant contribution to the recovery process.

The comments offered by the participating service users show that they are aware of the value that arts and cultural activities can bring to their lives in terms of life quality as well as health and wellbeing. Volumes of literature, as well as the findings from the pilot study, illustrate the benefits for service users with mental health problems of engaging in arts and cultural activities (e.g. Jensen et al., 2016, Cobert et al. 2013, Jensen, 2013, Sagan, 2013, Stickley, 2011, Secker et al. 2007, Spandler et al., 2007). The engagement in art activities is especially connected with its usefulness as part of the recovery approach. Recovery suggests a way of bringing in the individual's own resources as part of treatment and care as a fundamental aspect of recovery (Higgins, 2008). Therefore, the individual's life story, fears, hopes and unique social situation should be located at the core of the therapeutic process (Barker and Buchanan-Barker, 2005, Barker, 2003). Having access to arts engagements enables a creative process and a person-centered approach that values the uniqueness of the individual, which is important for the service users in this study. Being able to develop a creative identity and engaging in arts activities has positive wellbeing benefits and provides purpose or meaning to life (Brown and Kandirikirira, 2007). This approach emphasises health, wellness and strengths, rather than symptoms such as pathology and deficits, as well as including respecting the expertise gained by the lived experience of the service user.

Several service user participants commented on how arts engagement provides meaning in life. Noticeable is the comment offered by a service user describing how the act of drawing was used to make connections and sense of his day. Dissanayake (2002) discusses arts as

being functional, which is based on anthropological studies because of its ability to affect social systems and positions and by "impressing others, illustrating an important myth or precept" (2002: 61). Making propaganda and the values attached to art suggest that it contributes to "human evolutionary fitness" (Dissanayake, 2002: 62) and has survival value. The functionality ascribed to arts in mental health is illustrated by using art to make sense of the day as a tool for inspiration and motivation, and feeling good and relaxed, as described in the comments by the service users. Its physical, practical and psychological 'doing' is a functionality that had a positive impact on health and wellbeing for the participating service users.

Additionally, the comment offered by another service user describing how arts engagement had stopped her suicidal thoughts further illustrates that engagement in arts has the ability to create meaning in life (Sagan, 2012). It also corresponds with Dissanayake's (2002) point about engagement in arts as a contribution to survival and that it can be a vital element in rebuilding life and giving quality to the life of a service user (Spandler et al., 2007) and as a positive step in the recovery journey (Colbert et al., 2013).

The service users commented on the values that they attach to engaging in arts activities and beyond it, creating a sense of empowerment; some described the art engagement as a form of play. The artistic experience has been compared to play by Huizinga (1970), who in particular highlights the fun of playing, asserting: "it is precisely this fun-element that characterises the essence of play" (1970: 21). In addition, it has roots in the primary part of life which can also be seen in the animal kingdom. Huizinga further discusses the positive emotions associated with play as: "… play-mood is one of rapture and enthusiasm and is sacred or festive in accordance with this occasion. A feeling of exaltation and tension accompanies the action, mirth and relaxation follow" (1970: 154-5). Several service users also commented on aspects of relaxation and de-stressing when engaged in arts activities. Gadamer (1992) also recognises the relationship between art and play in the playful process of art practice itself. He claims

that by participating in play it takes the individual players out of themselves and they become drawn into something much larger than what is evident to a subjective consciousness (referring to the inner and private experiences). Dissanayake (2002) links play behaviour to making art, and explains that in some African societies there is one word that seems to loosely cover both activities. Despite an understanding of art practice and play as being different in Western society, Dissanayake (1992) argues that play is fairly spontaneous but it also has forms and rules which are similar to arts.

Freud (1948) saw play as a way of getting fulfilment, and Bruner (1972) has valued play for its ability to help with learning skills and social behaviour. Arguably, through play it is possible to create a positive space, and it was referred to by one service user as like entering 'another world' with new things happening leading to something else. Other comments were made about 'getting lost' in the making with no worries to be concerned about. These findings illustrate that engaging in arts activities allows a healthy disconnection from concerns and can combat negative thoughts, with health rewards such as relaxing, entering a flow and making new connections where none existed before. The links from engagement in arts activities to the recovery process is found in the distraction from distressing thoughts and being able to escape from an inner world with bad reflections (Colbert et al., 2013). Furthermore, the role of arts and cultural intervention can be that of facilitating a personal journey, as the arts also offers different perspectives on the experiences of people's difficulties (de Botton and Armstrong, 2013, Sixsmith and Kagan, 2005) and provides a platform for reflection. The recovery model presents principles that are useful for the relationship between service users, arts and cultural practitioners and health professionals as they place the service users at the center of the activity with the ability to co-direct the journey in a respectful partnership.

Arguably, the visits to the museums in Denmark created the opposite of empowerment and meaning in life for some of the service servicers, partly because of the unpreparedness of the

museum educators which caused unintentional outcomes; the institutional logics of not training the museum educators got in the way of the intended positive experiences. Staff at cultural institutions need suitable preparation and support when they engage in unfamiliar roles and "a background in the cultural sector is not a preparation for working with mental health related needs and behaviours" (Froggett and Roy, 2014: 25).

The barriers created between service users and professionals can prevent an open dialogue and jeopardise gaining valuable information about the individual to support a personal treatment plan. Although a more comprehensive understanding of the recovery-practice is on-going, the relationship between professionals and service users plays a critical role (Slade et al., 2012).

The interaction between the service users and the museums in Denmark illustrates some unintended negative effects. Numerous comments from the service users involved being spoken to as a child, which created negative experiences. Stigma towards people with mental health problems can be understood by stereotyping, discrimination and prejudice (Corrigan and Watson, 2002). Prejudice can be turned inwards, leading to self-discrimination, which in turn can become self-stigma and, with fear of rejection by others, people with mental health problems do not pursue life opportunities (Link et al., 2001).

Art museums, unlike hospitals and other health settings, tend to be non-stigmatising environments, argue Camic and Chatterjee (2013). The findings from this study suggest that this is not necessarily the case, as some service users felt stigmatised during the visits to the museums. As people who are identified as having mental health problems are at higher risk of being stigmatised, and in particular have a connection with the "stereotype of dangerousness provokes adverse reaction among the public" (Angermeyer and Matschinger, 2003: 308), anti-stigma interventions are important. Education and training are effective ways of combating stigma related to mental health problems (Corrigan and Watson, 2002), which further perpetuates the need for awareness training for staff at cultural institutions and can further

enhance a positive interaction between service users and professional staff. Furthermore, museums have a history of excluding the representation of stigmatised people in their collections, including homosexuals, bisexuals, transgender and disabled people (Silverman, 2010), neglecting an ethical responsibility to represent cultural diversity.

Levels of connectedness are associated with recovery (Leamy et al., 2011) and trusting relationships may provide opportunities for meaning and hope and a contribution to new perspectives. Embracing a relational perspective may support professionals in recognising mental health service users as individuals who are making sense of their life experiences and the process of connecting with other people (Eriksen et al., 2014). A positive step in a relational approach would be equipping professionals with skills that promote and encourage interaction with the service users that prompts feelings of value and inclusion.

From an institutional logics perspective, it is about promoting inclusion and the effectiveness of such, resting upon the ability to embrace an 'organising principle of programmatic organisational changes' (Sturdy and Grey, 2003) and is, to a certain extent, a function of organisational actors' "definition of the situation that they habitually project" (Goffman, 1956: 77). The norms and values of staff are not automatic products of responses of an objective institutional or organisational structure (Tlili, 2008), but it forms part of an organisational reality (Reed and Hughes, 1992) and has its own logics (Doolin, 2003). In this way, it is difficult to determine where the lack of inclusive practice is rooted within the institution; however, it seemingly starts where the institution fails to recognise the need for the staff's professional development and training opportunities as well as a lack of more inclusive operational logics.

Valuing the diversity of the community encourages cultural institutions to attract a different public. The social values and logics of the institutions are reflected in the commitment to diverse audiences, as developing collaborations and programmes require investment of staff time. Without institutional recognition, such additional investment of time can reflect in the

professional behaviour of staff, who might then see the interaction with unfamiliar visitors as an unwelcome distraction from primary tasks (Froggett and Roy, 2014). Diversifying the demographic profile requires cultural institutions to become sensitive to a diversity of needs, which requires that the relational skills of staff are developed within a framework with planning and support. Interlinking the health sector with the arts sector requires ongoing training in order to support individuals with a range of additional needs (Froggett and Roy, 2014).

In this way, interdisciplinary collaborations between health and the arts can promote recovery, given that the professionals involved understand recovery and, as a minimum, have basic mental health awareness.

## 6.7 Summary

In this chapter, I have discussed the findings through various theoretical lenses. This chapter has encapsulated and provided an understanding of the underlying professional and institutional approaches that are at play in the relationships between the health professionals, the museum educators and the service users, as well as exploring the mental health services users' engagement in arts.

Competing logics exist at a societal level, where the institutional orders and associated logics are defined as family, community, religion, state, market, professions and cooperation (Thornton et al., 2012). The instantiation of logics within institutions, professions and individuals are drawn from and nested within the societal-level logics (Besharov and Smith, 2014). As I have illustrated in this study, this can relate to how different professions apply the concept of risk management. I observed that the health professionals were more risk averse than the museum educators. Embodied in practice, institutional logics outline the rules of the game and provide an array of discourses that breeds a set of assumptions which are, however,

unwittingly conducted (Barley and Kunda, 1992). The work of professionals is embedded in the logics of the institution and, while professions have their own logics, these invariably become intertwined with the logics of the institutions. This adds to the particular complexities of the interdisciplinary field of arts and health.

These institutional logics are an historical pattern of material practices that are socially constructed based on values, assumptions, rules and beliefs (Thornton and Ocasio, 1999), whereas professions have logics that are variable from profession to profession, including codes of conduct and jurisdiction (Abbott, 1988). In this study, I understand that within the interdisciplinary collaboration, abstract knowledge and professional territory was evident as an operating factor.

Within the present climate of neoliberalism, professions have found themselves challenged in aligning their practice to this political ideology and economic model. Some have actively resisted, as I highlighted in the discussion concerning the UK junior doctors' clash with the government. One of the reasons for this is the contrast between the traditional professional practice and the neoliberal consensus concerning expert labour and professional practice (Leitch, 2014), where the economic framework becomes the overriding factor for professional practice. Health professionals employed by the NHS are experiencing more bureaucratic approaches which impact on their practice by having to spend time understanding systems and working towards frequently changing initiatives (Leicht, 2014). The focus on the economic framework also affects museum educators, who have to disseminate knowledge and deliver activities to a wide range of individual and communities as well as justifying their existence (Sandell, 2003). This supports Abbott's view that this change of focus detracts from their jurisdictional claims over expert knowledge (Abbot 1988).

According to Hall (2005), the logics of professions are also based on the values that are internalised and beliefs that are often unspoken. In this study I observed how the invisibility

of those logics creates barriers. NHS healthcare logics are, from the institutional perspective, concerned with management of the setting to enable healthcare services and cost effective outcomes (van den Broek, 2014). While traditionally museums' logics have been concerned with preservation, collections, knowledge development and dissemination, more recently they also include being settings that should be inclusive for a variety of individuals and communities and to produce measurable outcomes in terms of attendances, scope of collection and exhibitions and quality of participatory projects (McCall and Grey, 2013, Sandell, 2003).

If the professional tasks are not supported by the institutional logics, it is difficult to deliver a practice that is supportive of service users in arts and health collaborations. Although professions might be seen as influential crafters of institutions (Scott, 2008), it is often the logics of the institutions that are the driving force and can overrule the professionals' function (Barley and Kunda, 1992).

A connection between the CHIME framework (Leamy et al. 2011) for recovery and the findings in this study was highlighted. The CHIME categories 'empowerment' and 'meaning in life' are similar to the findings that services users linked with engaging in arts activities. I conclude that in order to work within the CHIME framework of supporting recovery in mental health, the institutional logics in the Danish museum need to change in order for the museum educators to acquire additional professional skills.

The clarity of roles brought by the institutions will support both the professionals and the service users and should also help address professional vulnerability in interdisciplinary work in unfamiliar situations and settings. This applies to both the UK and Denmark and, although the UK is more advanced in application of arts and health practice and can provide useful lessons for Denmark, this clarity of roles remains an overarching challenge for both countries.

This challenge could be met by adopting a pragmatic logic approach (Reay and Hinings, 2009) that would allow the stakeholders to maintain their professional identities while they

accomplish their work and meet their professional responsibilities (Abbott, 1988, Friedson, 1989).

# CHAPTER SEVEN: Conclusions

## 7.1 Introduction

In concluding this study, I am also ending a long journey. In this chapter, I offer my concluding thoughts. I consider the knowledge contribution this study has to offer the arts and health field, as well as reflecting on the strengths and limitations of the study. Furthermore, I present my reflexive thoughts about the study and offer recommendations for future research.

## 7.2 Concluding thoughts

The study sought to explore and understand the relationship between the stakeholders in arts and health practice, which included health professionals, museum educators and service users. This was achieved by asking the questions: *How do collaborations in arts and health practice work?*

The study has illustrated that the concept of professions in terms of the interdisciplinary work in arts and health has a significant impact on the delivery of projects in the field. The study provided insights into some of the issues arising in the interdisciplinary work that is specific to the arts and health field, illustrating that challenges have to do with different approaches and logics of institutions and practitioners. However, different logics also allow a space in which something new can be created and this is a significant part of developing the arts and health field. Below I consider how this might be addressed in terms that can strengthen and foster the field.

### 7.2.1 A new way of thinking

On the back of a global economic crisis and with a neo-liberalistic driven economy there is a need to develop a new balance of values and new ways of thinking and acting that will drive sustainable improvement in the delivery of healthcare and ensure that the value placed on health permeates every area of social, economic and political activities. This study contributes to this debate by attempting to understand the role of professionals in arts and health practice and the benefits for the service users. A step towards new ways of approaching health is to consider the arts as an inherent part of providing different health experiences in caring for the mental wellbeing and life quality of service users/patients. Embedding the arts in community health and at hospitals as health promotions, part of treatment, in recovery, and palliative care with the focus on patient-centred approaches, would enable more choices and a combination of ways to address health issues.

Offering arts activities for the sake of creativity or to satisfy a biological need, as Dissanayake (2002) argues, in primary and community health settings, can contribute to the life quality of individuals, as this study illustrated, if delivered in a supportive framework. This can also improve the health and wellbeing of communities (Clift and Camic, 2016, White, 2009). It also has economic benefits in terms of a reduced stay in hospital and fewer visits to the doctor (Bungay and Clift, 2010, Staricoff, 2004).

In the UK, the health sector has in recent years has apparently moved from a competitive model of commissioning toward a more dialogic and collaborative based commissioning model (NHS, 2014). This model emphasises shared benefits for the commissioner and the service provider and invites organisations and partnerships including the voluntary sectors to work to co-design new care models. This model stresses service user involvement and presents opportunities for service users to share experiences and to express what they think is beneficial for them and could develop new relations with service users and communities. This creates a

means by which arts and health can become part of the dialogue between commissioners and health service providers. However, commissioners are not likely to consider new projects that cannot demonstrate an evidence-based medical approach. Yet, with less focus on evidence-based practice, a recent report from the Care Quality Commission (2016) advocates the use of arts to find creative and innovative ways to enable people to have a richer life and provide a better service for older people.

In Denmark, the health services are increasingly working with the involvement of service users, patients and their relatives towards a more patient-centred approach. In hospitals, there are currently several hundred projects addressing aspects of involvement in own treatment plans, and local authorities are targeting their work towards integrating the needs of patients and services users in decision-making. User involvement in health care is on the health agenda and it is a political and academic priority which can create opportunities for arts and health in a Danish context.

A recent national healthcare strategy in Denmark (Ministeriet for Sundhed og Forebyggelse, 2015) includes the oversight of quality and safety, based around national quality targets, but with more freedom and support for frontline staff to make changes and improvements that matter to patients. This framework creates flexibility for healthcare staff to make changes and improvements that matter to services users and patients by accessing and using real-time data to make evidence-based improvement decisions. The big challenge, however, is how to engage with hospitals as institutions, and with the patients and service users, to create awareness of the possibilities and opportunities of connecting healthcare with the arts and deliver projects in order to develop an evidence-base for art and health in Denmark.

There is, however, also a danger that the arts and health agenda becomes instrumentalised and hijacked for various political agendas. For example, the Swedish AoP project was used to measure people's distance to the labour market (Stigmar et al., 2016) and as the outcome did

not show that the participants were closer to becoming part of the labour market, the project was regarded as not suitable for future funding, although the participants had benefited in other ways. Therefore, it is significant to consider the parameters by which projects are delivered and evaluated.

Although the evidence base for arts and health is growing, not all the arts and health practice fits into a RCT framework of measuring outcomes which is favoured by the health sector. In both the UK and Denmark there is a focus on patient-centred healthcare; that is, attempting to offer a health service where patients/service users are informed and engaged in their own treatment plans and the arts and health practice fits more easily into the patient-centred agenda.

Evidence-based medicine might offer the best available evidence about the most adequate treatment for patients/service users, but this is focused on disease, is not patient focused and relies on RCTs. One problem with RCTs is that patients/service users that do not fit into specific criteria are excluded because of age, being illiterate or having concurrent mental health issues (Bensing, 2000). In this way, RCTs are performed on homogenous patient groups without the wide diversity that 'real' life presents. The patient-centred approach considers the psychosocial issues, as well as the uniqueness of each patient/service user and provides patients with options which speak into arts and health practice. One of the strengths, therefore, of providing arts in a health setting, is the ability to engage with the individual and explore their preferences considering the social aspects that the medical model neglects.

### 7.2.2 A pragmatic delivery model

Through conceptualising arts and health practice as a field of interacting stakeholders, I found that there are different approaches of the professions and the institutions involved. These approaches are defined by multiple and potentially competing logics that impact on the

method and approach to practice. In order to deliver quality experiences for patients/service users within a supportive framework, we need to consider the impact of the underlying institutional logics and professional approaches. To ensure an effective operating model, we first need to address the difficulties of working with competing logics in order to operationalise the interdisciplinary practice in the field. Reay and Hinings (2009) suggest the concept of 'pragmatic collaboration', which describes mechanisms for stakeholders to work together and manage competing logics. In philosophy, pragmatism puts emphasis on the practical application of ideas, enabling action in order to test the ideas on human experiences. Furthermore, in pragmatism, thought is considered to be a tool or an instrument for problem solving, prediction and action (Gutek, 2014) which is crucial to arts and health practice. The 'pragmatic collaboration' model suggested by Reay and Hinings (2009) encourages the identity and independence of stakeholders that are following different logics to work together with co-existing competing logics. We have seen in this study the importance of maintaining professional identities and values while working in an interdisciplinary way. This approach embraces the value of disagreement and presents a model where "potentially conflicting values and beliefs can be managed openly rather than covertly" (Reay and Hinings, 2009: 646).

### 7.2.3 A bigger context

The study identified that in terms of recovery, arts engagement fits into the CHIME framework of recovery (Leamy et al., 2011), whereby different roles can be explored, spaces for meaning can be developed, self-acceptance cultivated and confidence supported, which are all necessary components of recovery. This identification provides a useful connection for further work in arts and mental health, based on a recovery-specific theoretical framework. Beyond the work with recovery, arts engagement serves a larger purpose as the arts has the ability to awaken our senses and helps us get in touch with parts of ourselves that might have

been neglected due to ill health or other challenging circumstances, and for this reason it needs to be recognised as having an intrinsic value to a patient-centred approach.

This study is also significant in terms of the recent developments in the arts and health field in the UK and the potentials in Denmark. Firstly, because it illustrates that in order to use arts activities in a positive way in healthcare delivery, it is essential that the staff involved have adequate skills to work in the settings, and that these skills are developed by fostering opportunities for professional development for the practitioners. In the UK, for example, it is possible to study for an MA in arts and health, and training is offered by various universities and practitioners. These opportunities are not available in Denmark.

Secondly, the health burden is growing and the WHO urges countries to ensure that policies and strategies consider mental health promotion, treatment and recovery (WHO, 2012), and the study offers alternative ways of dealing with the health issues by illustrating that arts engagement can increase wellbeing, provide meaning in life and create empowerment among service users. Arts on Prescription could be part of a portfolio of activities that is offered to individuals with health problems. As we see in the UK, social prescription schemes offer a broad range of opportunities, including cultural activities, such as AoP, books on prescription and museums on prescription (Thomson et al., 2015), and while some are funded by the health sector, others are not. However, arts and cultural initiatives should not be restricted to being delivered within the framework of AoP, but as an integrated and inherent part of healthcare and health promotion.

Arts and health also offers opportunities for political agendas that are on the periphery of a health agenda and can help address social issues that are about inclusion, improving life quality and creating social capital in communities. While this study has been in progress there have been developments in Denmark which have indicated a political curiosity towards the field of arts and health. This includes current government funding for a three year AoP pilot study. I was invited to share knowledge about the field as part of the official hearing that

would inform the Parliament. I hope those conversations will lead to more positive engagement in the arts and health by government, with constructive emphasis on an interdisciplinary approach in Denmark. In addition, I was invited to deliver a presentation to local politicians, from five different local authorities, who were exploring ways of using culture in a strategy for improving life quality for a range of residences. This shows a growing interest in the arts and health field at a local level and provides an interesting background to the political conversation about bridging culture with health for the first time.

I also presented the Danish pilot study, at a round-table discussion by the All Party Parliamentary Group in the House of Lords in the UK; this was in collaboration with the Danish MP, Carolina Magdalene Maier (spokesperson for health for the political party Alternativet). The before-mentioned round-table discussions are part of a wider inquiry into the role that arts and culture can play in generating health benefits in the UK.

## 7.3 Contribution to existing knowledge

This study seeks to make a three-fold contribution to the existing research concerning arts and health practice. Firstly, to date there is no existing research concerning museum educators' interaction with mental health service users in Denmark; secondly, there has been no focused study on mental health service users' benefits from engagement in arts activities in Denmark; and thirdly, to date no study has specifically addressed the interface of the different professional paradigms working together in arts and health practice.

The first stage of the study focused on users of mental health services visiting museums in Denmark. The findings showed that participants found arts activities motivating and inspiring and they considered that arts engagement had therapeutic benefits, such as empowerment, and was 'a way of life'. These findings add to the existing knowledge about the mental health benefits of arts engagement to people who use services, which has not previously been

covered in a Danish context. Additionally, a connection between arts engagement and the CHIME model of recovery had not previously been made.

The potential benefits from the museum visits were not optimised, and in certain cases the experiences became negative as the dialogue with the museum educators was awkward. There is a need for training and awareness for museum educators, but also for a focus on the potential benefits of using arts activities in health settings and for health promotion in Denmark.

The study also contributes to knowledge in terms of interdisciplinary collaboration in the arts and health field by highlighting previously unexplored interdisciplinary working between professions and institutions. I identified that the professional approach and institutional logics play a significant part in the interdisciplinary interaction in arts and health collaboration and that these logics are embedded in practice and institutions.

## 7.4 Strengths and limitations of the study

With regards to the strengths and limitations of the study, there is much to consider. As the field of arts and health itself is vast, the literature review is somewhat limited as there were many concepts to consider and every turn opened up new paths and considerations. My choices were made from what I considered relevant to this study and I acknowledge that other options could have been considered.

I could have viewed through different lenses and other theoretical considerations could have been applied. I am satisfied with the chosen theories, as they add transparency to some problematic areas of collaboration in arts and health practice underpinned by two different paradigms working together. As no literature considering arts and health as an interdisciplinary practice exists, it was beneficial to draw upon the theoretical aspects of logics that are concerned with institutions and the complexities within those, as well as

understanding the interaction between the professions through the lens of theory of professions.

The voices of the service users were important and in this respect I feel they added to the authenticity of the study, highlighting that certain skills beyond art knowledge are necessary in the work with service users. The service users' voices also contributed to existing knowledge about the benefits of engaging in arts activities and their effects on daily life.

My own interdisciplinary background has been a strength as well as a limitation to the study. I believe that it has provided me with an understanding of both professions; however, it has also blinded me. Foucault argued that within frameworks of knowledge, different forms of expertise develop that then become blind to themselves and their flaws (Mills, 2004). In this way, within disciplinary regimes, such as those found in hospitals, universities, schools or any other institution, the individual is subjected to the position where struggle against these practices and procedures is pointless, as they become so entrenched in the individual themselves. That is to say that an individual becomes part of the system which they operate within, willingly or unwillingly, and will therefore lose some sense of perspective, just like my own 'blindness' in this study. For example, in arts and health there is a common-sense understanding that arts engagement is beneficial and good for your health and wellbeing. Such logic can create a 'blindness' as workers are embedded in the field and this can make it difficult to see and understand other people's apprehension and questions towards the practice. This perspective enables us to understand that norms and logics that are accepted are often beyond our perception, which creates a self-discipline that does not require an external force, and I accept that as a condition in my study.

If I were to conduct a similar study, I would place more emphasis on the human relationship that was created in the process of the JOAP project between the health professionals and the service users. Asking more 'why' questions to the participants may have provided a greater opportunity for the participants to reflect upon their relationships with each other.

## 7.5 The research journey

I began this journey with a wish to combine my practical knowledge and working experience of arts and health practice with theoretical considerations in order to better understand the mechanisms in the interdisciplinary setting. I also hoped to create a platform for disseminating knowledge about the field in a Danish context. The journey, at times, has been confusing, difficult and it was challenged by external factors and my own pre-existing notions of the field. This has taken me through various theoretical considerations before arriving at an approach that I feel satisfied with, and an understanding of what I was attempting to examine and describe.

The research process has given me a better insight into arts and health practice and, in particular, into the health sector in the UK. I have gained new understandings of the work of health professionals, which has created a curiosity for future research in the health sector. Prior to the study, I had my own prejudices and assumptions about the health profession. I was unaware of the full extent of the professional codes of conduct, the institutional logics and the jurisdiction within which they are obliged to function. This was highlighted when I fully understood the risks the health professionals were accepting by taking service users out of acute hospital wards for the JOAP project.

Reflecting on the study, I have acquired further insight, enabling me to approach future projects in a different way, both in terms of development and research. I have learnt that even with all the hours available, it was not possible to be all the things I wanted to be and with hindsight, I would have spent less time writing articles while conducting the study. Conducting this study has challenged me intellectually, financially and emotionally but has enabled me to grow as an individual and as a researcher. I feel an immense gratitude to have had the privilege to conduct this study.

Throughout the research journey, I have attempted to apply reflexivity to all my actions. Reflexivity enables examination of oneself as a researcher or the "human as instrument" (Guba and Lincoln, 1981), which was an essential part of this study. The starting point and position of this research can be traced back to me as an individual and follows me throughout the research journey. My background has influenced the choice that I have made along the way and as I stated in chapter one, my choice of methodology comes from a basic belief that through studying peoples' experiences it is possible to explore a human or a social problem. According to Malterud (2001), the background and position of a researcher will influence the choice in research subject, the methods of investigation, the most appropriate findings and how the study is concluded.

Therefore, being the inquirer and analyst requires knowing myself within the research process itself. Implicitly, my paradigm contains my identity and the values attached to the researcher identity. In this study, I am partly the storyteller, partly the researcher, partly my own history as a Caucasian Northern European female, arts and health practitioner and, to some extent, also the future I anticipate. The storyteller conveys the story of the arts and health and its stakeholders, the researcher gathers information, analyses and draws conclusions, and my own history has shaped the foundation for this study to build upon.

In order to be reflexive, it is necessary to talk about presuppositions, experiences and reflections, as I did in the introduction to this study, because without this the research outcome will be regarded as having the 'characteristics of objects'; providing an acknowledgement of my 'conceptual baggage' is significant. I acknowledge that my own experience, values and knowledge influenced my study and therefore it is not value-free, but I aimed to achieve an 'empathic neutrality' approach (Davies and Dodd, 2002).

In practical terms this means I continuously asked myself questions about the nature of research. This included: the visits to the museums (not choosing the museums based on

previous knowledge); how to remain non-judgmental and to appear neutral in all situations (not to agree with the service users about their experience of the interaction at the museums, or to hold a preference in the different approaches of staff in the JOAP project); my relationship with the service users (maintain a researcher role); and the line of study that I used to elicit answers (not to ask leading or closed questions).

I found myself constantly trying to see myself as someone from the outside entering new territory with an open, questioning mind and without pre-set assumptions and ideas of how it all worked. It was much easier to do so when interviewing the health professionals in the UK, as I was at the hospital and interviewed them in wards that I had never been on and the territory was new to me. In Denmark, I was on familiar ground which made it more difficult to think of myself as someone from the outside. Furthermore, while conducting the interviews with healthcare staff at SLaM, I found that it was easier to remain in the researcher role than it was interviewing service users in Denmark. This, I understood to be because I had not previously had conversations with health professionals about art engagement, whereas I have spent years talking to service users about their engagement in the arts. For this reason, it might be that the interviews with the service users were slightly less formal. However, being aware of these issues made it easier to make strategies to remain open-minded.

In the course of conducting the interviews with the health professionals, some talked about the need to have control, which I initially considered to be stereotypical behaviour of health professionals. However, upon reflection, it became clearer that this had more to do with the regulatory framework within which they work, rather than the individuals wanting to exercise control. Health professionals are trained and are required to undertake risk assessments, and I directed my discussions accordingly.

I also became frustrated with the apparent lack of awareness of vulnerable groups among the museum educators in Denmark, and the theories helped me understand this issue in a more constructive manner.

Methodologically, I feel that the research question has been answered successfully. The qualitative approach allowed me to capture the individuals' experiences and perceptions, which I regard as essential in understanding the layers in the interdisciplinary work of arts and health practice. I believe that this study has been successful in making some of these complex layers transparent and adding to existing knowledge, as well as being a focal point for the beginning of my journey as a researcher.

I see myself having 'shed' various 'layers' through this journey, each as different points but it is not until now, where the journey is coming to a close, that I am closer to fully understanding what a PhD study is about both from a personal and a professional perspective. This journey has been difficult but very enriching work on many levels.

## 7.6 Recommendations for the field

More research needs to be conducted to explore possibilities in arts and health practice to create opportunities and a wider political and public understanding of the field. It is through research that we better understand human health and the development of interdisciplinary collaborations (Sigurdson, 2014). The study poses further questions about interdisciplinary work and about cultural institutions working with the health sector. It was, for example, apparent that the professionals in this study had little knowledge about each other's professions and professional tasks. The international field of arts and health practice could benefit from further research with a focus on the 'interdisciplinarity' of the field and to explore the interdisciplinary interplay between the professions and institutions.

In terms of different opportunities that the field presents in the UK and in Denmark, it is clear that there are many people in the UK who are committed to develop the field, with many projects, academic research and networks throughout the country, as well as political interest from across political parties. In Denmark, with a field that is still to establish itself, there are many opportunities to develop interdisciplinary relationships between the health sector and the cultural sector.

In order to understand, explore and establish a field of arts and health practice requires wider political support and a commitment that provides funding for research. Furthermore, it necessitates political lobbying from stakeholders and to address the silo-thinking mentality between governmental departments, enabling arts and health as part of cross-party political discourse. Such discourse would support a better public understanding of the field and provide examples of implementation and benefits. By engaging with the international knowledge and drawing on the existing expertise, it is possible to create a practice and discourse without repeating some of the mistakes that have been made.

I have attempted to take part in developing an arts and health discourse through writing articles and other publications. For example, I initiated a project to map the arts and health activities in Denmark, as well as co-authoring a publication about arts and health in a Danish context to provide background and inspiration for politicians, practitioners and the wider population.

In Denmark, the museums had not found out about the mental health needs of the participants prior to the visit, which illustrates that more awareness is needed and training needs must be identified to work with vulnerable individuals. Therefore, in order to use the untapped potential for museums to engage with healthcare, a larger scale study to identify the training needs for cultural professionals is needed. In addition, to work interdisciplinary a period of negotiation and 'getting to know' each other in the light of a professional and institutional

context is helpful to iron out any concerns and to share existing knowledge prior to project delivery. Furthermore, having large scale comprehensive studies about the positive/negative effect of arts engagement would also benefit the Danish discourse.

Moreover, there are lessons to be learned from the arts and health field in the UK from which Denmark could benefit, especially with a focus towards academia. As mentioned in chapter one, several universities have institutes dedicated to research and development in this field. Aalborg University has made a commitment to establish a centre for arts and health research, which could become a central platform for developing a field in Denmark; acting as a focal point, we might avoid a fragmented field and the obvious opportunities to make links with academic institutions abroad should be pursued.

The field of arts and health practice has much potential in addressing some of health issues that challenges the health sector and as we have seen in this study, arts engagement can benefit both staff and service users. My vision for an arts and health field in Denmark is to inspire cross-sectoral dialogues and discourses that could inform an interdisciplinary approach offering arts actives in social and health settings and for the connection between arts engagement, health and wellbeing to be commonly valued and understood across sectors.

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# APPENDICES

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B. Ethics approval
C. R&D approval SLaM

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A. Protocol HKI
B. Protocol JOAP

## Appendix III

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A. Consent form – DK
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## Appendix VI

Extracts from interview

# Appendix I

A. Ethics approval

B. Ethics approval

C. R&D approval SLaM

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**Faculty of Medicine and Health Sciences**

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19th December 2013

Anita Jensen
PhD Student
c/o Dr Theodore Stickley
Academic Lead & Associate Professor of Mental Health
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Institute of Mental Health
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Dear Anita

**Ethics Reference No:** OVSP12122013 SoHS IMH**- please always quote**
**Study Title**: Arts, Health and Wellbeing
**Chief Investigator:** Dr Theodore Stickley, Academic Lead & Associate Professor of Mental Health, Nursing, School of Health Sciences
**Lead Investigator/Student:** Anita Jensen, PhD Student, School of Health Sciences, Faculty of Medicine and Health Sciences.
**Duration of Study:** 02.2014-08.2014 18mths **No of Subjects:** 12

Thank you for your recent application which was considered by the Committee at its meeting on 12th December 2013 and the following documents were received:

- FMHS Application form dated 11/25/2013
- Arts, Health and Wellbeing Protocol- 25/11/2013
- Arts, Health and Wellbeing Information Sheet version 4: 25/11/13
- Arts, Health and Wellbeing, Recruitment Poster, version 1.0, 25/11/13
- Arts, Health and Wellbeing, Interview Consent Form, version 1.0, 25/11/13
- Arts, Health and Wellbeing, Question Guide for Interview, version 1.0, 25/11/13

These have been reviewed and are satisfactory and the study is approved.

A Favourable opinion is given on the understanding that all appropriate ethical and regulatory permissions are respected and followed in accordance with all local laws of the country in which the study is being conducted and those required by the host organisation/s involved.

Please can you submit copies of letters/emails of approval and permission from Hans Knudsen Institute and relevant bodies in Denmark when these are available for our records.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

2. You must notify the Chair of any serious or unexpected event.

3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely



**Dr Clodagh Dugdale**
**Chair, Nottingham University Medical School Research Ethics Committee**

# Faculty of Medicine and Health Sciences Research Ethics Committee Membership 2013/2014

*denotes attendance at 12th December 2013

| | |
|---|---|
| Chair | Dr Clodagh Dugdale, Lecturer in Sports and Exercise Medicine, Division of Rheumatology, Orthopaedic and Dermatology, School of Medicine.* |
| **School** | **Representative** |
| School of Life Sciences | Dr Vince Wilson, Reader and Basic Scientist, Pharmacology<br>Dr Liz Simpson, Chief Experimental Officer, Metabolic and Molecular Physiology.* |
| School of Medicine | Dr David Turner, Clinical Associate Professor in Microbiology, Division of Medical Sciences and Graduate Entry Medicine<br>Dr Kimberly Edwards, Director of Postgraduate Courses/Epidemiologist, Division of Rheumatology Orthopaedics and Dermatology.* |
| School of Medicine | Dr Gillian Doody, Clinical Associate Professor & Reader in General Adult Psychiatry, Division of Psychiatry and Applied Psychology.<br>Dr Neil S. Coulson,Associate Professor in Health Psychology, Division of Rehabilitation & Ageing. |
| School of Medicine-Non Clinical | Dr Philip Clark, Laboratory Manager, Pre-Clinical Cancer Studies, Division of Oncology<br>Dr Charlotte Billington, Research Fellow, Division of Respiratory Medicine<br>Dr Debbie Palmer-Green, Research Fellow, Division of Rheumatology Orthopaedics and Dermatology.* |
| School of Medicine Derby | Dr Caroline Chapman, Associate Professor, Breast Surgery, Division of Medical Sciences and Graduate Entry Medicine.*<br>Dr Saoirse O'Sullivan, Associate Professor in Vascular Medicine, Division of Medical Sciences and Graduate Entry Medicine Derby.* |
| School of Medicine - Clinical | Dr Paul Maddison, Consultant Neurologist/Honorary Clinical Associate Professor, Queen's Medical Centre, NUH* |
| Division of Primary Care | Dr Daren Forward, Consultant Orthopaedic Trauma Surgeon, Honorary Consultant Lecturer<br>Dr Richard Knox, General Practitioner/ Part-time Lecturer<br>Dr Edward Tyrrell, General Practitioner/Part-time Lecturer<br>Dr Jaspal Taggar, General Practitioner/Part-time Lecturer*<br>Division of Primary Care, QMC Campus |
| School of Health Sciences | Dr Stephen Timmons, Associate Professor/Senior Lecturer, Division of Nursing.* |
| Lay (Out of Faculty) | Professor Nigel White, Professor of Public International Law, School of Law, University of Nottingham.<br>Lydia Davies-Bright, PhD Student, School of Law.<br>Dr Emma Hall, Research Fellow, SPMMRC, School of Physics and Astronomy.*<br>Mary Beirne, Retired Mental Health Nurse, Birmingham and Solihull Mental Health Foundation Trust. |
| Medical Students nominated by Medical student Society | To be appointed. |
| Postgraduate Student Member | Peter Collins, PhD Student, Division of Psychiatry and Applied Psychology.* |
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**Faculty of Medicine and Health Sciences**

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6th July 2014

Anita Jensen
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Dear Anita

**Ethics Reference No:** OVSP12122013 SoHS IMH**- please always quote**
**Study Title**: Arts, Health and Wellbeing
**Chief Investigator:** Dr Theodore Stickley, Academic Lead & Associate Professor of Mental Health, Nursing, School of Health Sciences
**Lead Investigator/Student:** Anita Jensen, PhD Student, School of Health Sciences, Faculty of Medicine and Health Sciences.
**Duration of Study:** 02.2014-08.2014 18mths **No of Subjects:** 12

Thank you for your letter dated 16th June 2014 notifying the Committee of amendment no 1: 17.06.2014 as follows:

- To conduct further data collection with the same group of people in a different location. This will involve taking service users on visits to cultural institutions and conducting semi-structured interviews using the same protocol unchanged.

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

1. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

2. You must notify the Chair of any serious or unexpected event.

3. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

4. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely



**Dr Clodagh Dugdale**
**Chair, Faculty of Medicine & Health Sciences Research Ethics Committee**

Institute of Psychiatry, Psychology & Neuroscience

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KING'S College LONDON

Dr Theodore Stickley
School of Health Science
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NG7 2TU

06 January 2015

Dear Dr Stickley

**Trust Approval: R&D2015/001**
**Title: Arts, Health & Wellbeing. An examination of the relationship between the central stakeholders in delivery of arts/cultural projects that can benefit people with mental health issues**
**REC Reference: 013112014 14097 SoHS MH**

I am writing to confirm approval for the above research project at South London and Maudsley NHS Foundation Trust. This approval relates to work in the Mental Health of Older Adults and Dementia CAG and to the specific protocol and informed consent procedures described in your R&D Form. Any deviation from this document will be deemed to invalidate this approval. Your approval number has been quoted above and should be used at all times when contacting this office about this project.

Amendments, including extending to other Trust directorates will require further approval from this Trust and where appropriate the relevant Research Ethics Committee. Amendments should be submitted to this R&D Office by completion of an R&D Amendment form together with any supporting documents. A copy of this is attached (R and D Amendment Form V3.doc), but is also available on the R&D Office website.
King's College London - Research and development approval

I note that The University of Nottingham will be taking on the role of Sponsor for this study.

Approval is provided on the basis that you agree to adhere to the Department of Health's Research Governance requirements including:

- Ethical approval must be in place prior to the commencement of this project.
- As Chief Investigator and/or Principal Investigator for this study you have familiarised yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122427.pdf.

- Compliance with all policies and procedures of the Trust which relate to research, and with all relevant requirements of the Research Governance Framework. In particular the Trust Confidentiality Policy. http://www.slam.nhs.uk/media/107386/confidentiality%20policy.pdf
- Co-operating with the Trust R&D Office's regular monitoring and auditing of all approved research projects as required by the research governance framework, including complying with ad hoc requests for information.
- Informing the Trust's Health and Safety Coordinators and/or the Complaints Department or of any adverse events or complaints, from participants recruited from within this Trust, which occurs in relation to this study in line with Trust policies. Contact details are available from the R&D Office if required.
- Sending a copy of any reports or publications which result from this study to the Trust Departments involved in the study if requested.
- Honorary Contracts must be in place prior to patient contact for all relevant members of the research team. Advice on this will be provided by the R&D Office at the point of obtaining R&D approval and on an ongoing basis for new members of staff joining the research team.
- Sending a copy of the annual reports and end of project notification submitted to ethics.

Failure to abide by the above requirements may result in the withdrawal of the Trust's approval for this research.

If you wish to discuss any aspect of this research approval with the R&D Office, please contact Jenny Liebscher jennifer.liebscher@kcl.ac.uk in the first instance.

I wish you every success with this study.

Yours sincerely

**Adriana Fanigliulo**
**Research Governance Facilitator**
**SLaM/IoPPN R&D Office**

Enc. R&D Approval Amendment Form

# Appendix II

A. Protocol HKI

B. Protocol JOAP

**Arts, Health & Wellbeing**
**PhD Student Research Protocol**
**Chief Investigator and supervisor: Dr Theodore Stickley**
**PhD Student, Anita Jensen**
**November 2013**

## Background

In 1988, the Department of Health published '*Arts and Healthcare',* (Moss, 1988) which laid the foundations for the development of the arts in health. In the Report of the Policy Action Team 10, (Department for Culture Media and Sport, 1999) it was argued that participation in the arts and sport would help to improve a community's performance on the four identified key indicators of neighbourhood renewal: health, crime, employment and education. However, the report observed that whilst there was much anecdotal evidence of the effectiveness of the arts and sports promoting community development, there was little in terms of research evidence. In its response to PAT 10, the Arts Council, concurred that the arts could indeed contribute to the social inclusion agenda (Arts Council of England, 2000).

The Health Development Agency (HDA) published the results of its national survey reviewing, "…good practice in community-based arts projects and initiatives which impact upon health and well-being" (HDA, 2000:1). Having distributed questionnaires to 250 arts and health projects around the UK, 90 completed questionnaires were returned. Other than a useful mapping exercise, it is difficult to draw any conclusions from the findings relating to health improvement as respondents were asked to tick boxes on issues such as '*promotes healthy lifestyle* and '*develops people's self-esteem'*. The report itself acknowledges: "Evidence for these benefits was predominantly anecdotal and no projects had designed rigorous instruments of measurement" (HDA, 2000:17). Attempts at 'rigorous instruments of measurement' would come later with the implementation of the Department for Culture Media and Sport (DCMS) programme in 2005. In 2000, the National Network for the Arts and Health was founded. Prior to this date, there was no national focal point for those involved in the arts and health (Dose, 2006).

In 2004, the Arts Council published its own research into the social benefits of engagement in the arts (Jermyn, 2004) by examining participation in various funded projects. This study reports a list of benefits of engagement with arts. However, the validity of the research becomes questionable in the light that it is conducted on behalf of the Arts Council that also funded the majority of the projects. The method involved participants ticking boxes regarding the benefits of the various projects. It is quite understandable that people will report positive benefits on engagement with a project that they enjoy, in the full knowledge that positive research will help justify the funding for further enjoyable projects in the future. The Department of Health also initiated local implementations of the Action Plan for Social Inclusion (Social Exclusion Unit, 2004) with regards to the arts and mental health.

These initiative ran concurrently with a consultation for the arts and health initiated by the Department of Health in collaboration with Arts Council England which culminated in two significant publications: "Arts, Health and Well-being" and is introduced as a framework for arts and health (Arts Council England, 2007), "Report of the Review of Arts and Health Working Group" that endorses the arts in health agenda (Department of Health, 2007). Thus,

the arts and health agenda has, for the first time, become nationally recognised at governmental level and this mandate was verbally confirmed by the Secretary of State for Health on the 11th September 2008 when he gave a keynote speech supporting the Arts & Health agenda. Both the Arts Council England (2007) and the Department of Health (2007) have called for further research to bolster the evidence-base for the arts and health agenda.

**Researching the arts in health**

While "the arts" is widely accepted as a form of therapy, its usefulness in promoting health to the general population remains largely unacknowledged in the healthcare arena and within its allied research base. The Department of Health (2007) claim that there are over 1,000 studies supporting the health benefits of the arts, although the same document acknowledges that the majority of these are more to do with healthcare environments than participation.

Some maintain that arts alone are not therapeutic, but how they are delivered and the social context is critical to its effectiveness (Macnaughton et al., 2005; White, 2006). A number of studies illustrate the point. Reynolds (2000) found that half of the ageing women involved in a textile project took up creative textile work following long-term illness. These women also attributed increased well-being to their textile work. Naturally, there was also a social component to their work. Social and well-being benefits of community arts have also been identified by Fisher and Specht (1999) with older people and Reynolds and Prior (2003) with women coping with disability. In their 12-month study of 212 older people, Greaves and Farbus (2006) found a range of psychosocial and physical health benefits amongst older people involved in an arts programme. They identified the key benefits related to a sense of belonging to a social group and the building of self-confidence and self-efficacy and was evidenced by improved and mood and physical well-being declared by the participants.

Simonton (2000) observes that generally, research into creativity has been focused upon the origins of creativity and its relationship with personality. Specific research into the arts, creativity and its benefits for physical and mental health is in its infancy in a hypothesising/generating stage (Reynolds, 2005). Reynolds (2005) also identifies four specific areas of arts and health research: the influence of creative occupations on health, creativity and ageing, creativity and chronic illness and linking physical health outcomes with creativity. For each of these, examples are offered of small-scale research studies that illustrate the health benefits of creative expression. Clearly, research into the social benefits of the arts is limited. In a community arts programme promoting mental health Parr (2006) interviewed 35 participants; for many, engagement with the arts activities provided stability for their lives and contributed to social well-being in terms of forming and sustaining relationships with other participants. These results strengthen the 'bonding' personal capital argument for community arts (Putnam, 2000). Whilst this community of artists may have been strengthened, the notion of 'outsiders' to mainstream art predominated. Specific social benefits are further identified by the participants of her study although these are arguably more to do with 'bonding' than 'bridging'. However, specific examples are offered of the effectiveness of exhibitions and collaborations with local (non-health based) community arts groups and artists: "…feeling welcome and confident to sit in cafes and bars with other artists and workers, being invited to attend other gallery openings and having access to mainstream exhibition space for the work of project participants". (Parr, 2006:25).

In her review of the arts and health literature, Staricoff (2004) examined health and medical literature published between 1990 and 2004 in order to explore the relationship of the arts to healthcare, and the influence and effects of the arts on health. The aim of the study was to "Strengthen existing anecdotal and qualitative information demonstrating the

impact that the arts can have on health" (Staricoff, 2004:4). She identifies approximately 264 studies in the fourteen-year period to inform the discussion of the subject. This excludes the number of cited studies that address biological and psychological hypotheses concerning the arts and health. The review did not seek to be the definitive evidence base for arts in health interventions although it clearly provided the most comprehensive review of the literature to date. The review identified that there remain many areas for further exploration. Two examples cited were: "…the emerging evidence around the use of arts interventions in community settings to improve health; and work that is concerned with the first hand engagement of artists with patients and staff in healthcare settings" (Staricoff, 2004:4).

In summary, Staricoff (2004) has identified the following as evidence of the value of the arts to well-being:

- inducing positive physiological and psychological changes in clinical outcomes
- reducing drug consumption
- shortening length of stay in hospital
- increasing job satisfaction
- promoting better doctor-patient relationships
- improving mental healthcare
- developing health practitioners' empathy across gender and cultural diversity

A number of evaluation studies of community-based participation projects have been conducted, although the Health Development Agency (2000) concluded, that it was not possible to give exact details of improved health, particularly in the light of the fact that so few projects directly provide information on health, or social matters related to health, which are based on formal instruments of measurement. Furthermore, control groups for such projects are so difficult to establish (Staricoff, 2006).

The scope of national arts and health delivery is far more wide reaching than is reflected in subsequent research and this by no means completes the picture. It is the aim of many projects to attempt to establish a variety of support for people with mental health problems to improve both their creativity and well-being. The range of practice and discovery taking place in this area, contributes to the wider health promotion agenda and development of participatory arts. Research suggests that many of the projects attempt to address their work strategically, rather than focussing on the arts activity alone. This in turn demonstrates that the work becomes part of an integrated service, delivered alongside professionals in other sectors with the common aim to improve health. Above all, they illustrate how project delivery can connect with regional and national commitments.

The benefits of community arts are reported in a recent Government commissioned research publication: "*Mental health, social inclusion and arts: developing the evidence base*", (Anglia Ruskin University and the University of Central Lancashire, 2007). The study relates to participatory arts and mental health work in England with people with mental health needs aged 16 to 65 and does not therefore include art therapy. Results showed significant improvements in empowerment, mental health and social inclusion. Improvements in empowerment and mental health were greater for participants identified as having 'clinically significant' mental health problems at baseline and those who did not report a recent new stress in their lives at follow up than for the comparative groups. There was a significant decrease in the proportion of participants identified as frequent and

regular service users, but there was no change in medication use or use of specific services, other than a decrease in use of overnight stays. There were no differences in occupational activity or education, but a third of participants did think their involvement with their project had increased their future employment and education opportunities.

To the extent that improvements could be attributed to arts participation, the greater improvement in empowerment and mental health amongst people with poorer mental health at baseline indicates that arts projects can benefit people with a range of mental health needs, including those with significant mental health difficulties.

In the past few years there has been an emphasis on extending the arts and health conversation to an international level. The conference Culture, Health and Wellbeing in Bristol this summer (2013) attracted people from 20 different countries which emphasises that there is a significant international interest in arts and health. In the USA, Society for Arts in Healthcare has rebranded itself as Global Alliances for Arts and Health and become the first organisation to imply global reach. Parkinson & White (2013) argue an international conversation relating to public health and national cultural polities in different countries.

**Local background to the study and rationale**

Hans Knudsen Institute (HKI) based in Copenhagen was established in 1872 created by Reverend Hans Knudsen (1813-1886) based on the philosophy that disabled people should have equal right to a working life. This paved the way for the social economy business which HKI is today playing an active role in social and employment policy efforts for the weakest in society. Services users are funded by local authorise to attend HKI either on long term basis, to be assessed for employability or attending courses to learn new skills.

HKI offers a range of creative activity to service users with mental health issues where the majority are in receipt of disability living allowance and considered not able to find employment. Offering creative activities to this group of service users aims to:

1. Combat isolation and support networks
2. Improve communication skills
3. Provide a therapeutic and creative approach

The study will be a pilot-project and form part of an industrial Ph. D. which is a partnership between University of Nottingham, HKI, Roskilde University (DK) and Anita Jensen Ph.D. Student.

**Research Aim**
The project aims to discover if people, who are participating in HKI's programme of visual arts activity, experience any health benefits.

**Objectives**

- To examine how the findings from a qualitative research study of participants of the HKI programme relates to the previous research conducted within the area of arts and health;
- To consider the findings in the current international conversation in arts and health;
- To consider the implications for health and social care in Denmark;

- To build upon existing research and to offer personal accounts of experiencing participatory arts activities; the impacts and effects this may have upon health and well-being.
- To inform the latter stages of a PhD project

**Methodology**
It is proposed that semi-structured interviews will be used to elicit people's experiences of their engagement with arts activities at HKI. Full information will be given and proper consent will be obtained from participants who wish to take part in the research. One-to-one interviews will be conducted by the researcher (Anita Jensen). All interviews will be digitally recorded and transcribed, and participants will be offered the opportunity of reading the transcriptions. All the data will be analysed using qualitative analysis framework to understand how people who have participated in arts activities experience benefits to their wellbeing/health.

**Study Design**
A qualitative approach will be employed. This approach provides a framework which is: understanding rather than explanation; acknowledges the situated location of interpretation; recognises the role of language and historicity in interpretation; views inquiry as conversation; and is comfortable with ambiguity. Using semi-structured interviews is an interpretive research approach located in the philosophical framework of hermeneutics. Its application in the social sciences places the text in the broader social context and the person's life situation and environment are relevant to the understanding of the text (Bryman, 2001).

Qualitative research acknowledges that diverse perspectives do exist and seeks to identify, map and explore the multiple perspectives of individuals and groups within their social setting. However, accepting that diverse perspectives exist does not negate the idea of an external reality that can be captured. The implication is that we can enhance understanding by exploring and conveying a full picture of this diverse and multi-faceted reality. If it is recognised that there is no one reality and that all perspectives are a product of time and place, then closer understanding will be gained by a research approach which seeks to capture and explain this change.

For the purpose of this research, the inquiry will be based on interviews about specific aspects of people's experiences and wellbeing in relation to participating in art activity. The interviews will provide the medium for data collection. This will allow for the detailed exploration of individuals' perspectives on participating in art. It will involve the investigation of the experiences, attitudes and behaviours that shape the values of a number of participants involved in a common phenomenon.

**Recruitment/Sample**
There will be approximately 12 people engaging with the whole programme of work. Programme co-ordinators, arts facilitators and support workers will also be asked if they wish to participate in the study where appropriate. It is envisaged that a poster will be placed on the walls of each of the rooms where the arts activities are being conducted. The posters will invite participants to take part in the research. The researcher will also visit the art studio and introduce the research programme to the participants. Interested participants will schedule an interview time with the researcher at a mutually convenient time.

Each prospective participant will be given an information sheet to read and there will be ample opportunity for them to ask questions of the researcher. Once any questions have been addressed and the person decides whether to be interviewed for the research, either the person will be free to withdraw from the study or engage with the first interview. Prior to the interview the participant will be asked to read, complete and sign the consent form.

Written information will be provided for research participants, informing them about the research project, what their role will be and how the information will be collected, stored and analysed. Being involved in interviews creates the possibility that sensitive issues may arise for discussion. However, participants will never be under any pressure to talk about issues or reveal information about themselves that they prefer to keep private. The researcher (Anita Jensen) has over 10 years' experience working with mental health service users and will be available to talk through any issues which participants may have found distressing in private and in confidence. Furthermore, staff at HKI (social workers, the arts facilitator and psychologists) will be available on site at the time of the interviews and will offer support as and when appropriate.

Each of the interviews will take place where there are other healthcare professionals nearby. No unnecessary risks will be taken in this research. If for whatever reason a participant becomes distressed in the course of the research, the interview will be suspended and appropriate support will be made available to the person as and when required.

It is envisaged that interviews will be conducted within a private room at the place where the participant will engage with the arts activities.

**Ethical approval**
The study will not be initiated before the protocol, consent forms and participant information sheets have received approval / favourable opinion from the Faculty of Medicine & Health Sciences, Medical School Research Ethics Committee. The study will be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, 1996; the principles of Good Clinical Practice, and the Department of Health Research Governance Framework for Health and Social care, 2005.

**Informed consent and participant information**
The process for obtaining participant informed consent or assent and parent / guardian informed consent will be in accordance with the REC guidance, and Good Clinical Practice (GCP) and any other regulatory requirements that might be introduced. The investigator or their nominee and the participant or other legally authorised representative shall both sign and date the Consent Form before the person can participate in the study.

The participants will receive a copy of the signed and dated forms and the original will be retained in the Study records. The decision regarding participation in the study is entirely voluntary. The investigator or their nominee shall emphasise to them that consent regarding study participation may be withdrawn at any time without penalty or affecting the quality or quantity of their future medical care, or loss of benefits to which the participant is otherwise entitled. No study-specific interventions will be done before informed consent has been obtained. The investigator will inform the participant of any relevant information that becomes available during the course of the study, and will discuss with them, whether they wish to continue with the study. If applicable, they will be asked to sign revised consent forms. If subsequent to consenting to participate in the research project, a respondent is

deemed to have lost the capacity to appropriately engage with the research and withdraws from the study on this basis, but later wishes to re-engage with the study, a process of re-consenting will be conducted with the individual. This will involve the use of the information sheet and completion of the consent forms.

**Source Documents**
Source documents shall be filed at the investigator's site and may include but are not limited to, consent forms, study records, field notes, interview transcriptions and audio records. A case report for, (CRF) may also completely serve as its own source data. Only study staff shall have access to study documentation other than the regulatory requirements listed below.

**Direct access to source data / documents**
The CRF and all source documents shall made be available at all times for review by the Chief Investigator and inspection by relevant regulatory authorities.

**Data Protection**
All study staff and investigators will endeavor to protect the rights of the study's participants to privacy and informed consent, and will adhere to the Data Protection Act, 1998. The CRF will only collect the minimum required information for the purposes of the trial. CRFs will be held securely, in a locked room, or locked cupboard or cabinet. Access to the information will be limited to the trial staff and investigators and any relevant regulatory authorities (see above). Computer held data including the study database will be held securely and password protected. All data will be stored on a secure dedicated web server. Access will be restricted by user identifiers and passwords (encrypted using a one way encryption method).

**Confidentiality/Data Protection.**
Once data has been digitally recorded, recordings will be transcribed and all participants given pseudonyms of which, the researchers will keep a list on a password protected computer. All digital recordings will also be kept locked within Unis premises. Participants will be given opportunity to read their transcriptions and given opportunity to withdraw from the study. Participants will be made aware (via the information sheet and consent form) that should they withdraw the data collected to date cannot be erased and may still be used in the final analysis.

**Record Retention and Archiving**
In compliance with the ICH/GCP guidelines, regulations and in accordance with the University Of Nottingham Research Code Of Conduct, the Chief or local Principal Investigator will maintain all records and documents regarding the conduct of the study. These will be retained for at least 7 years or for longer if required. If the responsible investigator is no longer able to maintain the study records, a second person will be nominated to take over this responsibility. The study documents held by the researcher shall be finally archived at secure archive facilities at the University of Nottingham. This archive shall include all study databases and associated meta-data encryption codes.

**Statement of Confidentiality**
Individual participant personal information obtained as a result of this study are considered confidential and disclosure to third parties is prohibited with the exceptions noted above. Participant confidentiality will be further ensured by utilising identification code numbers to correspond to treatment data in the computer files.

**Timescale**
Eighteen months duration commencing February 2013

**Costs**
There are no costs involved in the research. The local authority already covers the participants travel costs and the researchers time forms part of the PhD research programme

**Dissemination**
At the completion of the project, the reported findings will be included in the thesis "Art, Health and Wellbeing - a psycho-socio inquiry into art and health and its stakeholders". A report will be compiled and presented to the participants, as well as all relevant stakeholders. The findings will also be presented at conferences and may be written up for publication.

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# Arts, Health & Wellbeing. An examination of the relationship between central stakeholders in the delivery of arts/cultural projects that can benefit people with mental health issues.

**Draft 2 / Final Version 1.0**
**10-10-2014**

**Short title:** *Arts, Health & Wellbeing*

**IRAS Project ID:** 162673

**Study Sponsor:** University of Nottingham

**Sponsor reference:** 14097

**Funding Source:** *Ministry of Higher Education & Science, Denmark*



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## SYNOPSIS

| | |
|---|---|
| Title | Arts, Health & Wellbeing. An examination of the relationship between stakeholders in the delivery of arts/cultural projects that can benefit people with mental health issues. |
| Short title | Arts, Health & Wellbeing. |
| Chief Investigator | Dr. Theodore Stickley |
| Objectives | • To examine what views health professionals have about the role of arts in healthcare<br>• To examine what views arts professionals hold about the health needs of service user<br>• To study the roles and responsibilities associated with arts and health<br>• To explore relationships between arts professionals, health professionals and service users in arts and health |
| Study Configuration | The study will take place at South London and Maudsley NHS Trust as well as Tate Modern, Tate Britain, Horniman Museum, Dulwich Picture Gallery and the Cinema Museum |
| Setting | NHS Primary Care Trust and community settings |
| Number of participants | Up to 20 healthy volunteers<br>(10 NHS employees and 10 arts professionals – no service users will participate in the study) |
| Eligibility criteria | Health and arts staff having worked on Journey of Appreciation Programme (JOAP) |
| Description of interventions | Semi-structured interviews |
| Duration of study | Jan. 2015 – August 2016. Up to 2 hours per participant |
| Methods of analysis | Qualitative – thematic analysis |



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# ABBREVIATIONS

| | |
|---|---|
| CI | Chief Investigator overall |
| CRF | Case Report Form |
| GCP | Good Clinical Practice |
| JOAP | Journey of Appreciation Programme |
| NHS | National Health Service |
| PI | Principal Investigator at a local centre |
| PIS | Participant Information Sheet |
| REC | Research Ethics Committee |
| R&D | Research and Development department |
| SLAM | South London & Maudsley NHS Trust |
| UoN | University of Nottingham |



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# STUDY BACKGROUND INFORMATION AND RATIONALE

**Background**

In 1988, the Department of Health published '*Arts and Healthcare',* (Moss, 1988) which laid the foundations for the development of arts practices in healthcare settings. In the Report of the Policy Action Team 10, (Department for Culture Media and Sport, 1999) it was argued that participation in the arts and sport would help to improve a community's performance on the four identified key indicators of neighbourhood renewal: health, crime, employment and education. However, the report observed that whilst there was much anecdotal evidence of the effectiveness of the arts and sports promoting community development, there was little in terms of research evidence. In its response to PAT 10, the Arts Council, concurred that the arts could indeed contribute to the social inclusion agenda (Arts Council of England, 2000).

The Health Development Agency (HDA) published the results of its national survey reviewing, "…good practice in community-based arts projects and initiatives which impact upon health and well-being" (HDA, 2000:1). Having distributed questionnaires to 250 arts and health projects around the UK, 90 completed questionnaires were returned. Other than a useful mapping exercise, it is difficult to draw any conclusions from the findings relating to health improvement as respondents were asked to tick boxes on issues such as '*promotes healthy lifestyle* and '*develops people's self-esteem'*. The report itself acknowledges: "Evidence for these benefits was predominantly anecdotal and no projects had designed rigorous instruments of measurement" (HDA, 2000:17). Attempts at 'rigorous instruments of measurement' would come later with the implementation of the Department for Culture Media and Sport (DCMS) programme in 2005. In 2000, the National Network for the Arts and Health was founded. Prior to this date, there was no national focal point for those involved in the arts and health (Dose, 2006).

In 2004, the Arts Council published its own research into the social benefits of engagement in the arts (Jermyn, 2004) by examining participation in various funded projects. This study reports a list of benefits of engagement with arts. However, the validity of the research becomes questionable in the light that it is conducted on behalf of the Arts Council that also funded the majority of the projects. The method involved participants ticking boxes regarding the benefits of the various projects. The Department of Health also initiated local implementations of the Action Plan for Social Inclusion (Social Exclusion Unit, 2004) with regards to the arts and mental health.

These initiatives ran concurrently with a consultation for the arts and health initiated by the Department of Health in collaboration with Arts Council England which culminated in two significant publications: "Arts, Health and Well-being" and is introduced as a framework for arts and health (Arts Council England, 2007), "Report of the Review of Arts and Health Working Group" that endorses the arts in health agenda (Department of Health, 2007). Thus, the arts and health agenda had, for the first time, become nationally recognised at governmental level and this mandate was verbally confirmed by the Secretary of State for Health on the 11th September 2008 when he gave a keynote speech supporting the Arts & Health agenda. Both the Arts Council England (2007) and the Department of Health (2007) have called for further research to bolster the evidence-base for the arts and health agenda.

**Researching the arts in health**

While "the arts" is widely accepted as a form of therapy, its usefulness in promoting health to the general population remains largely unacknowledged in the healthcare arena and within its allied research base. The Department of Health (2007) claim that there are over 1,000 studies supporting the health benefits of the arts, although the same document acknowledges that the majority of these are more to do with healthcare environments than participation.



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Simonton (2000) observes that generally, research into creativity has been focused upon the origins of creativity and its relationship with personality. Specific research into the arts, creativity and its benefits for physical and mental health is in its infancy in a hypothesising/generating stage (Reynolds, 2005). Reynolds (2005) also identifies four specific areas of arts and health research: the influence of creative occupations on health, creativity and ageing, creativity and chronic illness and linking physical health outcomes with creativity. For each of these, examples are offered of small-scale research studies that illustrate the health benefits of creative expression. Clearly, research into the social benefits of the arts is limited. In a community arts programme promoting mental health Parr (2006) interviewed 35 participants; may reported that engagement with the arts activities provided stability for their lives and contributed to social well-being in terms of forming and sustaining relationships with other participants. These results strengthen the 'bonding' personal capital argument for community arts (Putnam, 2000). Whilst this community of artists may have been strengthened, the notion of 'outsiders' to mainstream art predominated. Specific social benefits are further identified by the participants of her study although these are arguably more to do with 'bonding' than 'bridging'. However, specific examples are offered of the effectiveness of exhibitions and collaborations with local (non-health based) community arts groups and artists: "…feeling welcome and confident to sit in cafes and bars with other artists and workers, being invited to attend other gallery openings and having access to mainstream exhibition space for the work of project participants" (Parr, 2006:25).

In her review of the arts and health literature, Staricoff (2004) examined health and medical literature published between 1990 and 2004 in order to explore the relationship of the arts to healthcare, and the influence and effects of the arts on health. The aim of the study was to "Strengthen existing anecdotal and qualitative information demonstrating the impact that the arts can have on health" (Staricoff, 2004:4). She identifies approximately 264 studies in the fourteen-year period to inform the discussion of the subject. This excludes the number of cited studies that address biological and psychological hypotheses concerning the arts and health. The review did not seek to be the definitive evidence base for arts in health interventions although it clearly provided the most comprehensive review of the literature to date. The review identified that there remain many areas for further exploration. Two examples cited were: "…the emerging evidence around the use of arts interventions in community settings to improve health; and work that is concerned with the first hand engagement of artists with patients and staff in healthcare settings" (Staricoff, 2004:4).

In respect of the latter, Staricoff (2004) has identified the following as evidence of the value of the arts to well-being:

- inducing positive physiological and psychological changes in clinical outcomes
- reducing drug consumption
- shortening length of stay in hospital
- increasing job satisfaction
- promoting better doctor-patient relationships
- improving mental healthcare
- developing health practitioners' empathy across gender and cultural diversity

A number of evaluation studies of community-based participation projects have been conducted, although the Health Development Agency (2000) concluded, that it was not possible to give exact details of improved health, particularly in the light of the fact that so few projects directly provide information on health, or social matters related to health, which



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are based on formal instruments of measurement. Furthermore, control groups for such projects are so difficult to establish (Staricoff, 2004).

The scope of national arts and health delivery is far more wide reaching than is reflected in subsequent research and this by no means completes the picture. It is the aim of many projects to attempt to establish a variety of support for people with mental health problems to improve both their creativity and well-being. The range of practice and discovery taking place in this area, contributes to the wider health promotion agenda and development of participatory arts. Research suggests that many of the projects attempt to address their work strategically, rather than focussing on the arts activity alone. This in turn demonstrates that the work becomes part of an integrated service, delivered alongside professionals in other sectors with the common aim to improve health. Above all, they illustrate how project delivery can connect with regional and national commitments.

The benefits of community arts are reported in a recent Government commissioned research publication: "*Mental health, social inclusion and arts: developing the evidence base*", (Anglia Ruskin University and the University of Central Lancashire, 2007). The study relates to participatory arts and mental health work in England with people with mental health needs aged 16 to 65 and does not therefore include art therapy. Results showed significant improvements in empowerment, mental health and social inclusion. Improvements in empowerment and mental health were greater for participants identified as having 'clinically significant' mental health problems at baseline and those who did not report a recent new stress in their lives at follow up than for the comparative groups. There was a significant decrease in the proportion of participants identified as frequent and regular service users, but there was no change in medication use or use of specific services, other than a decrease in use of overnight stays. There were no differences in occupational activity or education, but a third of participants did think their involvement with their project had increased their future employment and education opportunities.

To the extent that improvements could be attributed to arts participation, the greater improvement in empowerment and mental health amongst people with poorer mental health at baseline indicates that arts projects can benefit people with a range of mental health needs, including those with significant mental health difficulties.

In the past few years there has been an emphasis on extending the arts and health conversation to an international level. The conference Culture, Health and Wellbeing in Bristol in 2013 attracted people from 20 different countries which emphasises that there is a significant international interest in arts and health. In the USA, Society for Arts in Healthcare has rebranded itself as Global Alliances for Arts and Health and become the first organisation to imply global reach. Parkinson & White (2013) argue an international conversation relating to public health and national cultural polities in different countries.

**Rationale**

Research across an international arena suggests that engagement in arts and culture activity can have a significant positive impact for people with a range of mental health and physical health problems and is widely used in a variety of settings in Britain, Ireland, Australia, Canada and the USA (Cox et al., 2010, Sonke et al., 2009, Wikoff, 2004, ACI, 2010, Wreford, 2010). Over the past two decades positive outcomes have supported developing trends towards using art and culture in the wider health sector. In the countries mentioned, it is now commonplace to find art programs both within hospital settings and embedded into other health care settings such as day-care centres, out-patients, hospices and homes for the elderly (Sonke et al., 2009, Wikoff, 2004, ACI, 2010, Cox et al., 2010, Wreford, 2010, Stickley and Hui, 2012). Indeed, in 2004, 48 per cent of US hospitals had established arts programmes (Wikoff, 2004), and in Britain a large proportion of hospitals have ad hoc art



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activities as well as art departments (Art for Health, 2011). Moreover, numerous studies show that supplementing medicine with art and cultural activity can improve the health and wellbeing of people with mental and/or physical health problems (Daykin et al., 2007, Camic, 1999, Stickley & Hui, 2012, Spandler et al., 2007, White, 2009) emphasising the a growing body of evidence supporting the contribution of arts to healthcare.

In an attempt to create a context for the art sector to work interdisciplinary with the health sector with more defined roles for the practical involvement of museums and galleries in public health, Camic and Chatterjee (2013) presented a framework for stakeholders to collaborate. The link between museums, health and wellbeing has been highlighted by Silverman (2010) and supported by Chatterjee and Noble (2013) stating that museums could be valuable places for fostering social interaction and encouraging incorporation of social networking in their access/outreach programmes.

This research project will be based on the assumption that engagement with the arts can and does address a range of health and social issues, including wellbeing, a sense of purpose and empowerment. Based on this assumption the research will explore and examine interdisciplinary collaborations in the context of arts and health. However, the work in this interconnected field between the art sector and the health sector is challenging; methodological approaches to projects that satisfy both sectors are problematic and different languages are often spoken. Interdiciplinarity or 'transdiciplinarity' as coined by Jean Piaget in 1970, to signify a 'new space of knowledge' intersecting two or more disciplines can be difficult and "individuals and institutions can construct barriers to successful transdisciplinary working" (Timmons et al., In press) this research aims to make connections between the art sector and the health sector that can optimise the interdiciplinarity in arts and health by exploring relationships between arts professionals, health professionals and service users in arts and health.

# STUDY OBJECTIVES AND PURPOSE

## PURPOSE

The purpose of this research is to increase understanding of the relationship between stakeholders in arts and health in order to contribute to health promotion through the role of arts and cultural activity.

## PRIMARY OBJECTIVE

To understand the optimal format for the stakeholders to collaborate (health sector, art sector and service users)

## SECONDARY OBJECTIVES

- To examine what views health professionals have about the role of arts in healthcare
- To examine what views arts professionals hold about the needs of service user
- To study the roles and responsibilities associated with arts and health
- To explore relationships between arts professionals, health professionals and service users in arts and health



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# STUDY DESIGN

## STUDY CONFIGURATION

The study will be based on a one-to-one semi-structured interviews. The interviews will take place at: South London & Maudsley NHS Trust, Tate Modern, Tate Britain, the Horniman Museum, Dulwich Picture Gallery and the Cinema Museum or on Skype. As described in the rationale, museum and galleries can play a role in increasing health of service users by delivering art activities for wellbeing, promote recovery and combat social isolation. This has been the role of the museums/galleries involved in the JOAP project (a multi-partnership, engaging in-patient service users and staff in museum and gallery visits with follow-up creative and therapeutic workshop. JOAP is a Maudsley Charity funded three-year programme).

## STUDY MANAGEMENT

The student will be responsible for liasing with South London and Maudsley NHS Trust and the other locations, disseminating information about the research, providing information for the participants and obtaining consent form participants. The student is furthermore responsible for conducting the interviews, transcribing the data, the analysis of the data and the final write up under the supervision of the academic supervisors.

The Chief Investigator has overall responsibility for the study and shall oversee all study management.

The data custodian will be the Chief Investigator.

## DURATION OF THE STUDY AND PARTICIPANT INVOLVEMENT

Study Duration: It is anticipated that that study will begin in January 2015 and close in August 2016

Participant Duration: It is anticipated that the participants will be involved in the study a maximum of 2 hours. This time is from the initial point of contact till the end of the interview.

### End of the Study

The end of the study will be the last interview of the last participant.

## SELECTION AND WITHDRAWAL OF PARTICIPANTS

### Recruitment

Participants will be recruited from the JOAP project and are healthy volunteers. The JOAP project is a partnership between South London & Maudsley NHS Trust, Tate Modern, Tate Britain, Horniman Museum, Dulwich Picture Gallery and the Cinema Museum.

From South London & Maudsley NHS Trust the recruited participants will healthcare staff that has worked on the JOAP project

From Tate Modern, Tate Britain, Horniman Museum, Dulwich Picture Gallery and the Cinema Museum the recruited participants will be arts professionals that have worked on the JOAP project.



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No service users/patients are recruited for this study.

The initial approach will be from a member of the Occupational Therapy team and information about the study will sent to potential participants in an email invitation to participate.

The investigator or their nominee, e.g. from the research team or a member of the participant's usual care team, will inform the participant or their nominated representative (other individual or other body with appropriate jurisdiction), of all aspects pertaining to participation in the study.

Only English speaking people will be included.

## Eligibility criteria

For healthcare staff:

- Capability to give written informed consent
- Currently working or worked as a member of healthcare staff on the JOAP
- Available for a semi-structured interview for approx. 1,5 hours
- English speaking

For arts/museum staff:

- Capability to give written informed consent
- Currently working or worked as a member of art sector staff on the JOAP
- Available for a semi-structured interview for approx. 1,5 hours
- English speaking

## Inclusion criteria

For healthcare staff:

- Healthcare staff who has worked on the JOAP
- Age 18-65
- Participants who are able to give written informed consent

For arts/museum staff:

- Arts sector staff who has worked on the JOAP
- Age 18-65
- Participants who are able to give written informed consent

## Exclusion criteria for both participant groups

- Staff that no longer work for the organisations involved in the JOAP



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## Expected duration of participant participation

Study participants will be participating in the study for approximately 2 hours.

## Participant Withdrawal

Participants may be withdrawn from the study either at their own request or at the discretion of the Investigator. Participants will be made aware (via the information sheet and consent form) that should they withdraw once the data analysis has been completed the data collected to date cannot be erased and may still be used in the final analysis.

## Informed consent

All participants will provide written informed consent. The Consent Form will be signed and dated by the participant before they enter the study. The Investigator will explain the details of the study and provide a Participant Information Sheet, ensuring that the participant has sufficient time to consider participating or not. The Investigator will answer any questions that the participant has concerning study participation.

Informed consent will be collected from each participant before they are interviewed. One copy of this will be kept by the participant and one will be kept by the Investigator.

Should there be any subsequent amendment to the final protocol, which might affect a participant's participation in the study, continuing consent will be obtained using an amended Consent Form which will be signed by the participant.

### STUDY REGIMEN

Procedures are as following:

1. Participants will receive information about the project.
2. Participants will receive consent forms
3. Prior to the interview participants will receive a question guide
4. A semi-structured interview will take place (first and final visit)
5. Transcription of the interview
6. Analysis of the data

The semi-structured interviews will be recorded using an audio recorder and transcribed verbatim. The recordings and transcriptions will be treated as source data and personal identifiers will be removed. Once transcribed the data will be archived in accordance with University policy and data protection rules and regulation.

The interviews will take place at:
a) SLAM with the healthcare staff
b) the museums involved: Horniman Museum, Tate Modern, Tate Britain, Dulwich Picture Gallery and the Cinema Museum with arts/museum staff
c) if not possible/convenient to conduct the interviews at the above mentioned locations, participants will offered an interview on Skype. Confidentiality will be maintained by conducting the Skype interviews in a private room.

## Compliance



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Volunteer participants will be expected to be interviewed by the researcher once. They will be free to withdraw at any time prior the writing up of the analysis and thesis.

### Criteria for terminating the study

The study will be terminated if no participants are recruited.

## ANALYSES

### Methods

The study will use qualitative thematic analysis.

### Sample size and justification

The sample size will be up to 20 people who will each be interviewed for up to 1, 5 hours. These interviews will be digitally recorded and transcribed. Together with other data generated by my research, this will be ample for my Ph.D. studies. Each interview is expected to provide rich qualitative data and validity will not be increased with a greater number of participants.

## ADVERSE EVENTS

The occurrence of an adverse event as a result of participation within this study is not expected and no adverse event data will be collected.

## ETHICAL AND REGULATORY ASPECTS

It is not anticipated that any sensitive or personal information will be disclosed. No unnecessary risks will be taken in this research. If for whatever reason a participant becomes distressed in the course of the research, the interview will be suspended. It is envisaged that interviews will be conducted within a private room.

### ETHICS COMMITTEE AND REGULATORY APPROVALS

The study will not be initiated before the protocol, consent forms and participant information sheets have received approval / favourable opinion from the Research Ethics Committee (REC), and the respective National Health Service (NHS) Research & Development (R&D) department. Should a protocol amendment be made that requires REC approval, the changes in the protocol will not be instituted until the amendment and revised informed consent forms and participant information sheets (if appropriate) have been reviewed and received approval / favourable opinion from the REC and R&D departments. A protocol amendment intended to eliminate an apparent immediate hazard to participants may be implemented immediately providing that the REC are notified as soon as possible and an approval is requested. Minor protocol amendments only for logistical or administrative changes may be implemented immediately; and the REC will be informed.



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The study will be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, 1996; the principles of Good Clinical Practice, and the Department of Health Research Governance Framework for Health and Social care, 2005.

## INFORMED CONSENT AND PARTICIPANT INFORMATION

The process for obtaining participant informed consent will be in accordance with the REC guidance, and Good Clinical Practice (GCP) and any other regulatory requirements that might be introduced. The investigator and the participant shall both sign and date the Consent Form before the person can participate in the study.

The participants will receive a copy of the signed and dated forms and the original will be retained in the Study records. A second copy will be filed in the participant's medical notes and a signed and dated note made in the notes that informed consent was obtained for the study.

The decision regarding participation in the study is entirely voluntary. The investigator or their nominee shall emphasize to them that consent regarding study participation may be withdrawn at any time without penalty or affecting the quality or quantity of their future medical care, or loss of benefits to which the participant is otherwise entitled. No study-specific interventions will be done before informed consent has been obtained.

The investigator will inform the participant of any relevant information that becomes available during the course of the study, and will discuss with them, whether they wish to continue with the study. If applicable they will be asked to sign revised consent forms.

If the Consent Form is amended during the study, the investigator shall follow all applicable regulatory requirements pertaining to approval of the amended Consent Form by the REC and use of the amended form (including for ongoing participants).

## RECORDS

### Case Report Forms

Each participant will be assigned a study identity code number, for use on CRFs, other study documents and the electronic database. The documents and database will also use a number stating with 001 followed by their initials. Data of birth will not be available.

CRFs will be treated as confidential documents and held securely in accordance with regulations. CRFs shall be restricted to those personnel approved by the Chief or local Investigator and recorded as such in the study records.

All paper forms shall be filled in using black ballpoint pen. Errors shall be lined out but not obliterated by using correction fluid and the correction inserted, initialled and dated.
The Chief or local Investigator shall sign a declaration ensuring accuracy of data recorded in the CRF.

### Source documents

Source documents shall be filed at the investigator's site and may include but are not limited to, consent forms, study records, field notes, interview transcriptions and audio records. A



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CRF may also completely serve as its own source data. Only study staff shall have access to study documentation other than the regulatory requirements listed below.

### Direct access to source data / documents

The CRF and all source documents shall made be available at all times for review by the Chief Investigator, Sponsor's designee and inspection by relevant regulatory authorities.

### DATA PROTECTION

All study staff and investigators will endeavour to protect the rights of the study's participants to privacy and informed consent, and will adhere to the Data Protection Act, 1998. The CRF will only collect the minimum required information for the purposes of the study. CRFs will be held securely, in a locked room, or locked cupboard or cabinet. Access to the information will be limited to the study staff and investigators and any relevant regulatory authorities (see above). Computer held data including the study database will be held securely and password protected. All data will be stored on a secure dedicated web server. Access will be restricted by user identifiers and passwords (encrypted using a one way encryption method).

Information about the study in the participant's medical records / hospital notes will be treated confidentially in the same way as all other confidential medical information.

Electronic data will be backed up every 24 hours to both local and remote media in encrypted format.

## QUALITY ASSURANCE & AUDIT

### INSURANCE AND INDEMNITY

Insurance and indemnity for clinical study participants and study staff is covered within the NHS Indemnity Arrangements for clinical negligence claims in the NHS, issued under cover of HSG (96)48. There are no special compensation arrangements, but study participants may have recourse through the NHS complaints procedures.

The University of Nottingham as research Sponsor indemnifies its staff, research participants and research protocols with both public liability insurance and clinical trials insurance. These policies include provision for indemnity in the event of a successful litigious claim for proven non-negligent harm.

### STUDY CONDUCT

Study conduct may be subject to systems audit for inclusion of essential documents; permissions to conduct the study; CVs of study staff and training received; local document control procedures; consent procedures and recruitment logs; adherence to procedures defined in the protocol (e.g. inclusion / exclusion criteria, timeliness of visits); accountability of study materials and equipment calibration logs.

### STUDY DATA

Monitoring of study data shall include confirmation of informed consent; source data verification; data storage and data transfer procedures; local quality control checks and procedures, back-up and disaster recovery of any local databases and validation of data



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manipulation. The Study Coordinator/Academic Supervisor or where required, a nominated designee of the Sponsor, shall carry out monitoring of study data as an ongoing activity.

Entries on CRFs will be verified by inspection against the source data. A sample of CRFs (10% or as per the study risk assessment) will be checked on a regular basis for verification of all entries made. In addition the subsequent capture of the data on the study database will be checked. Where corrections are required these will carry a full audit trail and justification.

Study data and evidence of monitoring and systems audits will be made available for inspection by the REC as required.

### RECORD RETENTION AND ARCHIVING

In compliance with the ICH/GCP guidelines, regulations and in accordance with the University of Nottingham Code of Research Conduct and Research Ethics, the Chief or local Principal Investigator will maintain all records and documents regarding the conduct of the study. These will be retained for at least 7 years or for longer if required. If the responsible investigator is no longer able to maintain the study records, a second person will be nominated to take over this responsibility.

The study documents held by the Chief Investigator on behalf of the Sponsor shall be finally archived at secure archive facilities at the University of Nottingham. This archive shall include all anonymised audio recordings, study databases and associated meta-data encryption codes.

### DISCONTINUATION OF THE STUDY BY THE SPONSOR

The Sponsor reserves the right to discontinue this study at any time for failure to meet expected enrolment goals, for safety or any other administrative reasons. The Sponsor shall take advice as appropriate in making this decision.

### STATEMENT OF CONFIDENTIALITY

Individual participant medical or personal information obtained as a result of this study are considered confidential and disclosure to third parties is prohibited with the exceptions noted above.

Participant confidentiality will be further ensured by utilising identification code numbers to correspond to treatment data in the computer files.

If information is disclosed during the study that could pose a risk of harm to the participant or others, the researcher will discuss this with the CI and where appropriate report accordingly.

Data generated as a result of this study will be available for inspection on request by the participating physicians, the University of Nottingham representatives, the REC, local R&D Departments and the regulatory authorities.

## PUBLICATION AND DISSEMINATION POLICY

At the completion of the project, the reported findings will be included in the thesis “Art, Health and Wellbeing”. A report will be compiled and presented to the participants, as well as all relevant stakeholders. The findings will also be presented at conferences and may be written up for publication.



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The estimated finishing time for the thesis is Oct. 2016. Other dissemination of findings from the study may happen before and after the completion of the thesis.

Participants be anonymised and will not be identified in any publications.

## USER AND PUBLIC INVOLVEMENT

As this is a Ph.D. study there has been no user involvement in the development of this study.

## STUDY FINANCES

### Funding source

This study is funded by the Danish Government, Hans Knudsen Instituttet, DK and self financing and part of a Ph.D. research study.

### Participant stipends and payments

Participants will not be paid to participate in the study.



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## SIGNATURE PAGES

Signatories to Protocol:

**Chief Investigator:** (name) Dr. Theodore Stickley



Signature:

Date: 10.10.2014



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# Appendix III

A. Participant information sheet- pilot study

B. Participant information sheet- HKI

C. Participant information sheet- JOAP

**University of Nottingham,**
**School of Nursing, Midwifery**
**and Physiotherapy,**
**B Floor, Queen's Medical Centre**
**Nottingham**
**NG7 2HA**

# Information Sheet

## Arts, Health & Wellbeing: A Qualitative Exploration

**Name of Investigator:** Anita Jensen, School of Nursing, Midwifery and Physiotherapy, University of Nottingham

**Supervisor:** Theodore Stickley, School of Nursing, Midwifery and Physiotherapy, University of Nottingham

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Feel free to ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not. If you decide to take part you may keep this leaflet. Thank you for reading this.

**What is the purpose of the study?**

This study aims to explore if there is a connection between participating in art activity and improved health/wellbeing.

**Why Have I been asked to take part in this study?**

You have been asked to take part in this study as you may have experience which would be insightful to this research.

**Do I have to take part?**

No. Involvement in the research is entirely voluntary, and it is up to you to decide whether or not to take part. If you do decide to take part you will be given a copy of this information sheet for your reference. You will be asked to give your written consent at the start of the study, and will be given a copy of this to keep. However, you are still free to withdraw at any time and without giving any reasons.

**What does the study involve?**

This study will involve you taking part in a one to one interview with the investigator for a maximum of 45 mins. You will be asked about your relationship with art and if it has any health benefits for you.

**What do I have to do**?

You will be asked to take part in a semi structured interview lasting up to half an hour. A list of questions will be given to you prior to the interview.

**Where will the research take place?**

Research interviews will normally take place within private meeting rooms at locations convenient to you (Hans Knudsen Institute). Interviews will last between 20-30 minutes, though their length will depend on how much you want to say.

**What are the possible disadvantages and risks of taking part?**

Should you choose to take part in the interview, some sensitive issues may be discussed. You will not be pressure to explore any area you are uncomfortable about and will not be expected to continue with the interview, should you feel uncomfortable. The investigator, (Anita Jensen), will be able to discuss any issues you may have had during the interview in confidence at the end.

**What are the benefits of taking part in this study?**

Your participation is likely to help an understating of a possible link between participating in art activity and health/wellbeing. This could potentially give further insight to ways in which to develop the field of arts and health.

**What if something goes wrong?/Who can I complain to.**

In case you have a complaint on your treatment by a member of staff or anything to do with the study, you can initially approach the lead investigator. If this achieves no satisfactory outcome, you should then contact the Ethics Committee Secretary, Mrs Louise Sabir, Division of Therapeutics and Molecular Medicine, D Floor, South Block, Queen's Medical Centre, Nottingham, NG7 2UH. Telephone 0115 8231063. E-mail louise.sabir@nottingham.ac.uk."

**Will my taking part in this study be kept confidential?**

Yes. All information which is collected about you during the course of the research will be kept confidential. Names will not be used in any publication of data or analysis, and any audio recordings of the interview will be kept in a locked cupboard, and erased as soon as the data has been transcribed. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

**What will happen to the results of the research study?**

When the results from this study have been written up, each participant will be allowed to see this. If you wish to withdraw your contribution to the results, you may still do so, although this may have negative outcomes for the study.

**Who is organising the research?**

This research is supported by the School of Nursing, Midwifery and Physiotherapy at the University of Nottingham.

**Who has reviewed the study?**

This study has been reviewed and approved by the University of Nottingham Medical School Ethics Committee.

**Right to Refuse or Withdraw**

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect your job or job-related evaluations in any way. You may stop participating in the interview at any time that you wish without your job being affected. I will give you an opportunity at the end of the interview/discussion to review your remarks, and you can ask to modify or remove portions of those, if you do not agree with my notes or if I did not understand you correctly.

**Contact for Further Information**

Anita Jensen, Lead Investigator: anj@hki.dk
Tel: 60191276

Thank you for taking the time to read through this information sheet, your input is greatly received.

Participant Information Sheet
(Draft Version 1 / Final version 1.0: 10.10.2014)

Title of Study: **Arts, Health & Wellbeing**

Name of Researcher(s): Chief Investigator, Dr. Theodore Stickley, Health Sciences, Nottingham University. Co-researcher, Ph.D. Student Anita Jensen

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

**What is the purpose of the study?**

This study aims to explore the relationship between the stakeholders (arts professionals, health professionals and service users) in the delivery of arts/cultural projects that can benefit people with mental health issues.

**Why have I been invited?**

You are being invited to take part because you have experience which would be insightful to this research including your facilitation of the visit of service users from Hans Knudsen Institute to the museum. We are inviting 4 participants like you to take part

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

**What will happen to me if I take part?**

You will be asked to take part in a semi structured interview lasting up to 1,5 hours. A list of guiding questions will be given to you prior to the interview. You will be asked questions about your experience of facilitating the educational session for service users from Hans Knudsen Institute. The researcher will contact you and arrange a convenient time for the interview to take place. With your permission the interview will be audio recorded and I will take some notes using a digital recording device. After the interview the recording will then be transcribed verbatim, all personal identifiers will be removed and then rechecked by the researcher. Audio recordings and interview transcripts will be assigned a unique study code that will not identify you in any way. However detailed written notes can be taken instead if you prefer the interview not to be audio recorded.

**Expenses and payments**

Participants will not be paid to participate in the study

**What are the possible disadvantages and risks of taking part?**

Should you choose to take part in the interview, some sensitive issues may be discussed. You will not be pressure to explore any area you are uncomfortable about and will not be expected to continue with the interview, should you feel uncomfortable. You can ask me to stop the recording at any time. If you decide you wish to withdraw during the interview I will delete the recording straightaway. The researcher, (Anita Jensen), will be able to discuss any issues you may have had during the interview in confidence at the end.

**What are the possible benefits of taking part?**

We cannot promise the study will help you but the information we get from this study may help to help to gain an understanding of the relationship between stakeholders in arts and health projects.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting secretary for the ethic committee Louise Sabir, School of Medicine Education Centre, B Floor, Queen's Medical Centre, Nottingham, NG7 2UH.Phone: 0044 115 8 231 063. E-mail louise.sabir@nottingham.ac.uk

**Will my taking part in the study be kept confidential?**

Yes. All information which is collected about you during the course of the research will be kept confidential. We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (work address, telephone number) will be kept for maximum 12 months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions

will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

**What will happen if I don't want to carry on with the study?**

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

**What will happen to the results of the research study?**

When the results from this study have been written up, each participant will be allowed to see this. Names will not be used in any publication of data or analysis.

**Who is organising and funding the research?**

This research is being organised by the University of Nottingham and funded by the Danish Ministry of Higher Education and Sciences.

**Who has reviewed the study?**

This study has been reviewed and given favourable opinion by the Faculty Ethic Committee at University of Nottingham.

**Further information and contact details**

**Chief Investigator**
Dr. Theodore Stickley
Academic Lead and Associate Professor of Mental Health
Institute of Mental Health
University of Nottingham
Innovation Park
Triumph Park
Nottingham
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Participant Information Sheet
(Draft Version 1 / Final version 1.0: 06.01.2015)

Title of Study: **Arts, Health & Wellbeing**

Name of Researcher(s): Chief Investigator, Dr. Theodore Stickley, Health Sciences, Nottingham University. Co-researcher, Ph.D. Student Anita Jensen

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

**What is the purpose of the study?**
This study aims to explore the relationship between the stakeholders (arts professionals, health professionals and service users) in the delivery of arts/cultural projects that can benefit people with mental health issues.

**Why have I been invited?**

You are being invited to take part because you have experience which would be insightful to this research including your participation in the JOAP project (a multi-partnership, engaging in-patient service users and staff in museum and gallery visits with follow-up creative and therapeutic workshop). We are inviting 20 participants like you to take part

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

**What will happen to me if I take part?**

You will be asked to take part in a semi structured interview lasting up to 1,5 hours. A list of guiding questions will be given to you prior to the interview. You will be asked questions about your involvement in the JOAP project. The researcher will contact you and arrange a convenient time for the interview to take place.

**Expenses and payments**

Participants will not be paid to participate in the study

**What are the possible disadvantages and risks of taking part?**

Should you choose to take part in the interview, some sensitive issues may be discussed. You will not be pressure to explore any area you are uncomfortable about and will not be expected to continue with the interview, should you feel uncomfortable. The researcher, (Anita Jensen), will be able to discuss any issues you may have had during the interview in confidence at the end.

**What are the possible benefits of taking part?**

We cannot promise the study will help you but the information we get from this study may help to help to gain an understanding of the relationship between stakeholders in arts and health projects.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Complaints Department, Maudsley Hospital, 111 Denmark Hill, London. SE5 8AZ, Telephone: 020 3228 2444/2499. Email: Complaints@slam.nhs.uk

**Will my taking part in the study be kept confidential?**

Yes. All information which is collected about you during the course of the research will be kept confidential. We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (work address, telephone number) will be kept for maximum 12 months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

**What will happen if I don't want to carry on with the study?**

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

**What will happen to the results of the research study?**

When the results from this study have been written up, each participant will be allowed to see this. Names will not be used in any publication of data or analysis.

**Who is organising and funding the research?**

This research is being organised by the University of Nottingham and is being funded by the Danish Ministry of Higher Education and Sciences.

**Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Research and Development at South London and Maudsley NHS Trust, Faculty Ethic Committee at University of Nottingham.

**Further information and contact details**

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# Appendix IV

A. Question Guide - pilot study

B. Question Guide - service users

C. Question Guide - museum educators (DK)

D. Question Guide - JOAP

**Question guide for**

**Arts, Health & Wellbeing study (pilot study)**

Interviews will take place at Hans Knudsen Instituttet in Denmark

1. How long have you been at HKI?
2. Why do you use the art studio?
3. What do you think about while you paint/draw/sculpt?
4. Tell me about your relationship with creativity
5. This programme is designed to bring health/wellbeing benefits. In what way do you think participating in arts activity can help you?

**Question guide for interviews for Arts, Health & Wellbeing study**

Interviews will take place at Hans Knudsen Instituttet in Denmark

**Introduction:**

- Introduce interviewer
- Explain the aims and purpose of the study and give a brief description of the interview structure.
- Ensure participants have read the information sheet
- Discuss digital recording of the interview and confidentiality
- Opportunity for participant to ask any question
- Complete the consent form and give a copy to participant

**Questions:**

1. What does it mean for you to visit a museum/gallery?
2. Which was the most significant visit? What made it significant?
3. Which visit was less significant? Why?
4. What do you think about the museum educators?
5. How do you think that the museum educators communicated and interacted with you?
6. What do you think arts activity can do for you?
7. Can visiting museums/galleries play a role increasing your sense of wellbeing? How?
8. What are you general thoughts/reflections about the visits?
9. Do you think that you mental health needs were understood by the museum educators?
10. In general, do you think that your mental health needs are understood by health professionals?

**Follow-up question:**

What is important for you when you visit a museum/gallery?

What is your relationship with the arts?

What was important for you in relationship to museum educators?

What do you think could have been done better?

Can you say more about that?

How does it look?

Can you describe it differently?

Is there a feeling that can describe it?

Is there anything else you would like to add?

**Short debrief:**

The interviewer will now explain the interview is now officially over and there are no more questions. They will state when the project will be ending and that if after this date, it gets published that we will let them know. The volunteers will be thanked for their participation, and asked if they would like to have a more in depth debrief, for example if what has been discussed has made them feel particularly emotional. Even if they decline the debrief at the time, it will be reinforced that we can arrange for one if on reflection they feel they would like to talk to someone. The interviewer will ensure that participants are not left distressed, and we can signpost them to individuals with expertise in this topic area if they require extra support.

# Interview guide

## Introduction:

- Introduce interviewer
- Explain the aims and purpose of the study and give a brief description of the interview structure.
- Ensure Participants have read the information sheet
- Discuss digital recording of the interview and confidentiality
- Opportunity for participant to ask any question
- Complete the consent form and give a copy to participant

## Questions:

1. What is your role at the museum?
2. Have you received any formal training in order to conduct your duties as guide/workshop facilitator?
3. Do you feel skilled to do your job?
4. Would you say you have any training needs?
5. What are your experiences with marginalised groups?
6. Are you aware of any needs that service users with mental health issues might have?
7. What was your general experience of the visit of the service users from HKI
8. How did you feel facilitating the group?
9. Was there anything you were not informed about prior to the visit have would have been useful to know?

Participants will never be under any pressure to talk about issues or reveal information about themselves that they prefer to keep private. No unnecessary risks will be taken in this research. If for whatever reason a participant becomes distressed in the course of the research, the interview will be suspended and appropriate support will be made available to the person as and when required.

## Short Debrief:

The interviewer will now explain the interview is now officially over and there are no more questions. They will state when the project will be ending and that if after this date, it gets published that we will let them know. The volunteers will be thanked for their participation, and asked if they would like to have a more in depth debrief, for example if what has been discussed has made them feel particularly emotional. Even if they decline the debrief at the time, it will be reinforced that we can arrange for one if on reflection they feel they would like to talk to someone. The interviewer will ensure that participants are not left distressed, and we can signpost them to individuals with expertise in this topic area if they require extra support.

# Interview Guide for JOAP participants

## Introduction:

- Introduce interviewer
- Explain the aims and purpose of the study and give a brief description of the interview structure.
- Ensure participants have read the information sheet
- Discuss digital recording of the interview and confidentiality
- Opportunity for participant to ask any question
- Complete the consent form and give a copy to participant

## Questions:

1. Can you describe your role in the JOAP project?
2. Please tell me about your role and responsibility in the project?
3. What training have you had for your role?
4. Why does your role matter? What is important about your role?
5. How do you feel that you contributed to the project?
6. How may you have benefitted/not benefitted from participating in the project?
7. Tell me about your experiences with the service users
8. How do you think the visits have benefitted/not benefitted the service users?
9. How do you view/understand the needs of the service users?
10. What are your views on the role of arts in healthcare?
11. How did/do you think arts professionals and healthcare professionals work(ed) together?
12. What needs to happen to make a collaboration work?
13. What gets in the way?
14. How do you see the future for arts and health projects?
15. Who do you think should coordinate collaborations in arts and health? The health sector, the arts sector or a third option?
16. Is there anything else you would like to add?

Participants will never be under any pressure to talk about issues or reveal information about themselves that they prefer to keep private. No unnecessary risks will be taken in this research. If for whatever reason a participant becomes distressed in the course of the research, the interview will be suspended and appropriate support will be made available to the person as and when required.

The interviewer will explain that something of concern is revealed that the interviewer will report it to the appropriate authority.

**Short debrief:**

The interviewer will now explain the interview is now officially over and there are no more questions. They will state when the project will be ending and that if after this date, it gets published that we will let them know. The volunteers will be thanked for their participation, and asked if they would like to have a more in depth debrief, for example if what has been discussed has made them feel particularly emotional. Even if they decline the debrief at the time, it will be reinforced that we can arrange for one if on reflection they feel they would like to talk to someone. The interviewer will ensure that participants are not left distressed, and we can signpost them to individuals with expertise in this topic area if they require extra support.

# Appendix V

A. Consent form – DK

B. Consent form - UK

**CONSENT FORM**

**Title of Study:** Arts, Health & Wellbeing

**Ethics Ref No:** OVSP12122013 SoHS IMH

**Name of Researcher**: Chief Investigator, Dr. Theodore Stickley. Co-reseacher, Ph.D. student, Anita Jensen

## Name of Participant:

**Please initial box**

1. I confirm that I have read and understand the information sheet version number ……dated..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview will be audio recorded using an audio recorder and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that all data will be anonymous and confidential with the exception of information being revealed during the interview which is of concern and may need reporting i.e. potential risks to another person or to myself or criminal behaviour. ☐
6. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred is will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed. ☐
7. I agree to take part in the above study. ☐

| _____ | _____ | _____ |
|---|---|---|
| Name of Participant | Date | Signature |
| _____ | _____ | _____ |
| Name of Person taking consent | Date | Signature |

2 copies: 1 for participant, 1 for the project notes.

The University of Nottingham

South London and Maudsley NHS
NHS Foundation Trust

# CONSENT FORM
## Final version 1.0: 06.01.2015

**Title of Study:** Arts, Health & Wellbeing

**REC ref:** 013112014 14097 SoHS MH

**Name of Researcher**: Chief Investigator, Dr. Theodore Stickley. Co-reseacher, Ph.D. student, Anita Jensen

**Name of Participant:** **Please initial box**

1. I confirm that I have read and understand the information sheet version number ……dated..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
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7. I agree to take part in the above study. ☐

| _____ | _____ | _____ |
|---|---|---|
| Name of Participant | Date | Signature |
| _____ | _____ | _____ |
| Name of Person taking consent | Date | Signature |

2 copies: 1 for participant, 1 for the project notes.

# Appendix VI

Extracts from interview with health professional

## Appendix VI

## Extracts of an interview with a health professional

AJ: Can you describe your role in the JOAP project please?

HEALTH10: I came to the project ... I was a little bit later joining the project than some of the other members of the team. In fact, all of the time I was the professional supervisor of the project lead [NAME OF STAFF] I was her supervisor. So I had a role there because obviously I had quite a big impact on her work and her capacity. As a project progressed I took the role of chairing the JOAP steering group and I also towards the end of my involvement I took it more of a role in terms of dealing with finances. I then undertook the in house first year evaluation. I just became more involved in maybe not so much the management but more the direction of the project. It was a gradual process probably assumed rather than ... clearly given to me as probably something I involved myself in.

AJ: It was something you did because you also enjoyed it?

HEALTH10: Yes I enjoyed it. I was curious, I was interested but I ... We may talk about this in a moment as I think I've touched on informally with you before. I was also keen to ensure that it was contained was always quite concerned that it was growing somewhat. So part of my interest, I absolutely positive about it was to make it, to keep it containable and manageable as a project or piece of work.

AJ: Can you tell me a bit about your role and responsibility in the project?

HEALTH10: My role, so I was the lead occupational therapist. I was the chair of the steering group and I also took a lead on the evaluation of the project. I was also the manager of the project lead.

AJ: What training have you had for your role?

HEALTH10: Depends. The project or in general?

AJ: Both.

HEALTH10: Okay. Goodness, I guess I supervised staff for over 15 years. I've had quite a lot of project management experience. I've managed previous service development projects. I also during the JOAP project I was in the process of completing my PhD which was of the evaluation of a service development project. Specifically for the evaluation I think about this, sort of specific training I had for that but I guess more generally it's probably that broader experience of managing projects really.

I was also maybe not training but was a member of the service executive, for the the local service. As a member of the executive team I was able to think about or

understand the project in the context of other developments. Other issues we're approaching ... Which I guess the people who are directly involved they didn't automatically know, I brought that exposure to that information that they needed to run the project. That was obviously something that was helpful in terms of outside world.

AJ: Why does your role matter and what was important about it?

HEALTH10: The thought about my role in relation to that project I felt there was always a lot of passion and enthusiasm by those most directly involved in the project. Also challenges in terms of making the project work on the wards. That is what I brought ... Was a slight distance from the operational part of it. The support that also maybe help in trying to think about how the project team saw difficulties. Maybe a balancing helping them to see maybe what the other issues or priorities might be on the ward. Hopefully not necessarily as troubleshooting but helping the project ... Helping those involved to think about how best or particularly in terms of the internal work, less so with the external agencies or partner agencies but is was much more about supporting success internally and almost ... bridging the gap isn't the right word but being able to help us out to carry that between the project team and the wider in-patient, particularly the in-patient teams.

I did quite a bit of liaison with the charity who funded the project and also the finance department. I guess that sorted ... Maybe filling, sometimes filling the gap in terms of experience between the project lead and other people were very clinically experienced. …maybe less so in terms of wider organisational world. I guess I felt that's what I did. I brought in a different perspective and I ... if I sound negative it's not meant to be but I think I was passionate about JOAP, less emotional about it but hopefully was able to be there for a slight more balanced view sometimes with things.

AJ: What was the important element of your role in that do you think if you have to mention to or something? What comes to mind?

HEALTH10: Okay so I think that it would be highlighting the priorities of the other stakeholders ... The internal stakeholders involved in the project so for example, what else would the ward managers being asked to do at the same time that they were being asked to give things for JOAP? What was the climate? There were lots of financial pressures and clinical pressures on the wards, on the ward managers. I guess reminded so really trying to hold on to and to bringing them to perspective to think about ... To help those involved in the project think about what they were doing fitted with the priorities of other people but also what was realistic in light of those other priorities on the wards.

I guess there was a risk sometimes that the project was very focused in its own aims. It didn't sufficiently always pay attention to the needs of those working within it (the wider service) and I think that was my role to highlight that. Therefore

the project was more successful because it could take those things into consideration. It wasn't just, "I wasn't there as a ward ... I'm not a ward manager ... That's not my background but I was ..." Unless you listen to those concerns and those other pressures it was potentially undermining for the project. I guess I would say that was the most important things and doing things like mitigating or navigating some of the organizational constraints safely.

For example the way in which it was financed was different from the way in which normal NHS things are funded. Just acting as a liaison point…..or explaining some of those things. Although we didn't completely do it, we did quite an informal first year evaluation. I guess it led completely ... I've worked with other people but I led that and we had the planning a more in depth evaluation at the end of the second year where we'll be going to employ a part time research worker so. For other reasons those plans didn't materialize but those ... I guess bringing that specific those things brought value to evaluation or something where I felt I had ... I hope to share some expertise.

AJ: How do you feel that you contributed? I know that's partly what you have said now but is that any areas where you feel that you contributed?

HEALTH10: I guess it's that slightly supporting role, background it definitely wasn't star of the JOAP. I was just support for the people who were and hopefully just helped to keep it all tracked and keep it realistic and keep it proactive and doable. A supporting role in the background, really. I would imagine the people that you've spoken to wouldn't say I'd done anything. I've seen a lot of discussion in one to one supervisions so not all of it you can see by everybody. Personally I would say it consumed quite a lot of my time that or …… officially I did not have a big role so it's bit, yes, a supporting role.

AJ: Okay, and how have you benefited or not benefited from participating in the project?

HEALTH10: I…….It was interesting for me ... I guess my background is not naturally drawn. I do not have an arts background and certainly I think when I do the evaluation in the first year I was really struck high some of people's outlooks and views about being involved. It gave me an exposure to something that I had not been directly involved in before ... That was useful. Sometimes I felt it didn't benefit ... I think I spent a decent portion amount of time given to it although not officially involved. Probably it was essential issue with JOAP. It became quite big and unwieldy that affected ... That had an impact certainly on the project lead and her capacity for her other parts of her job and it took my time.

Actually sometimes, it was quite problematic and trying to keep it manageable was quite a task really. It did seem to consume time and energy.

I guess that was that was one the real challenges. I think that my observation would be that is the challenge for everybody involved in the running of it really and that was something that was quite difficult to manage really.

AJ: Why do you think it grew so big?

HEALTH10: I think there was clearly that passion from those involved. There's something about the individuals involved being very naturally people who were up for doing different things. I think they were a number of unintended but helpful things. Some of the gallery staff or connections with the gallery to make the things happen back on the ward or it was visit. I can't entirely remember who it was by some advocacy or service user group commented on the ward environment being quite bleak.

Then an associated aim of JOAP became ... They called it art in the bedrooms but trying to get some good high quality art in the bedrooms but that wasn't part of original project plans. Things added to it I think because it was a project. I don't know if I should say this, don't make them quote this as more of an information but it almost became ... We didn't spend quite as much money month by month as we thought we would. There was quite a lot of resource that was available for things but of course actually that took to people's time to work out ... We had slightly more money than we needed.

AJ: Yeah.

HEALTH10: There was time looking at, "What should we get equipment? Should we take on this extra development." The flexibility of the money or the funding ... It sounds like a disadvantage but then recently it's a disadvantage because it on top of a number of other things. I think that combination of things but probably something about the people involved who were just keen to ... I guess it came a bit self fulfilling. They could see the benefits and then they wanted to do more of it. That was the tension really.

AJ: Okay. Can you tell me a bit your experience with the service users although you haven't been involved directly in delivery and then you did the evaluation. There must have been some contact with the service users there?

HEALTH10: Yeah. I did the evaluation on one of the wards and I spoke to a couple and interviewed a number of service users who'd been on a visit at the previous study. I was really struck by what powerful experience it had been. I was also very struck on how they talked about staff although I was struck with what staff described and what service users described was very similar. I think that's the benefit were for both staff personally benefited or personally enjoyed so the idea of a joint experience. I might say there's probably record a sense of more learning at the more educational benefit than maybe perhaps before that I had recognized.

Again that was one the staff and the service users were learning together. The sense of it mutually positive experience. Mutual learning. I was also struck by the fact that because staff would support the service use of one to one. There was quite a lot of intimacy between a service user and a staff on those visits in a way that's uncommon. I think certainly in an in-patients unit…. something happened during those visits that was quite intimate, quite appropriately intimate a meaningful quite personal and above such users and staff took value from that. I guess the other thing stating the obvious is just that it was a very different experience rather normally people's experience generally in the ward. It was quite unique really in terms of an experience.

AJ: How do you think that the visits have benefitted or not benefitted the service users?

HEALTH10: Okay so I think, what would the benefits be? Benefits would be firstly the learning the opportunity to the learning. I think secondly the opportunity to connect with staff that one to one for period of time. For doing a joint activity so sometimes on an inpatient ward you might have a member of staff who is ... We call it a one to one so somebody is on a special observation. You will get that one to one so this intimacy through having that time together being quite a structured way. I would say that was the benefit.

Sorry I should have said this earlier I think there was a benefit in terms of getting off the wards going somewhere really nice generally. I think this is true for staff but luxury might be too far but a nice cup of coffee, a nice biscuit, a nice venue it was done well ... The visits were good, well delivered, properly done really well . There seems there's something special really. I guess so what does that imply? It's okay to be taken care of. Not just care of but treated in a ... Treated as though you matter seems to have come across and again it's the staff. There's a lot about what was useful for the service users also being useful to the staff in my opinion.

AJ: How do you think art activities have impacted?

HEALTH10: Okay so I think...

AJ: On the service users?

HEALTH10: Yeah sure. I think there was the ... There was a learning about something that you didn't know about. Again the focus times in the gallery that sort of sensed that there was an investment from the members of gallery staff. The transfer of knowledge or information. Personally I didn't speak to anybody who had done an actual activity on the talk about that the take would be. I didn't hear anybody say, "Oh, I did this activity afterwards and this is how it is." I think that's just my lack of knowledge or lack of exposure rather than me saying the benefits. I knew that several of the wards there are from art activities and they do things with the art. I guess I just wasn't there to really be able to comment on the ward value that it’s

brought, that's what they did but I just can't say … Other than it just went on. It went beyond the visit but beyond that that would be a bit hard to say.

AJ: How do you view or understand the needs of the service users?

HEALTH10: Okay. It's difficult because I guess they're different varied group. There also the older people who are in patient ... Recovering in patient care so that state obvious ... They had either been quite unwell or they're unwell. The thing I was struck with the visits were that they did manage ... They didn't just take for lack of a better word the wellest people, the safest people on the unit so they took some people who were sectioned under the mental health act or people who you may not typically think are people who should have left the wards. People did have quite a complex needs; needed quite a bit of supervision... They required that one to one support.

I guess there was a feeling.. For some people I guess there's a need around just getting of the ward. There was this man who haven't been off the ward for a long time so start the value for him was about getting off the ward and doing something. I don't think it was just getting off the ward and going to the cafe around the corner. In the care of it I think people ... On the wards I think I mentioned before I think they don't always have sufficient focus and attention from the nursing staff. I think their needs are not always understood and heard and listened to. Obviously the idea was that the nurses started a life story... The people doing the visit out of the visits and I think personally that's really important that sort of work was done. Not urging the question here but I do think JOAP allowed that to happen. Allows that the building of that relationship over that work being done. I guess what they need is their needs to be understood and it is not always as an individual but JOAP offered that.

AJ: What are your views on the role of arts in health care?

HEALTH10: I think it can a beneficial contribution and I guess because it allows you to access people in a way that if ... In a little bit creative because it's art a varieties of ways really so it can be a really helpful way to I don't know. It instigates learning or reflection or creativity. I think using, what do I think? I think it has a real strength and certainly I can see through the opportunity to build on that so to build more formally or connect people more formally with art. I think it's sometimes quite a risky step; it's either down-graded or not done very well really.

I think sometimes as health professionals we don't necessarily have the skills to engage in that area as well I know that's one of the things that you think about is unique about the JOAP. Bringing in ... Recognizing that and bringing the expertise in from those who have that. I think it's got a really valuable contribution. I guess I would say I don't know that it's for everybody but I think it would be ... I guess if we went back to a blank piece of paper and you could start a project on an acute mental health unit. It probably has the ability to surprise and to capture. It offers

something that other therapeutic approaches just may not catch it so I think it ... sorry if I am a bit woffily …..but it brings ... It's another approach and another set of tools that could be really helpful for some people.

AJ: Can arts be therapeutically then?

HEALTH10: Yeah I would say so. I would say so yes.

AJ: How do you think your arts professionals and the health care professionals work together? Do you have them work directly but what you have some feedback I think you know how well it works?

HEALTH10: Yes. Just so I'm clear you need the people in the gallery...

AJ: Yes absolutely.

HEALTH10: There are some really constructive relationships they're built up. My observations were that those they did work. Apart from [NAME OF MUSEUM] but we come back to that. I thought the positive relationships built up. I guess I was struck by the fact that they were built over sometime they if they took ... As all relationships do but they got better. They offered more benefits the longer the relationship went on. There was collaboration, a working together and when the things occasionally did not go as well as planned there was an opportunity to come together and to it work out. There seem to be some honesty about what didn't work well or what do I need to be done differently. Again it's when from outside but my sense is that there was a recognition on both sides of the expertise that each party brought and created together. I thought they were healthy alliances really. You're going to be ... I like to thinking you're interviewing the galleries are you?

AJ: Yes I am.

HEALTH10: The [NAME OF MUSEUM] have. You're going to approach them aren't you?

AJ: I have an interview set up for Friday, yes.

HEALTH10: This Friday?

AJ: Yes.

HEALTH10: I don't know what went on there. I think there was one unsuccessful visit ... You'll probably have a clear idea probably from talking to people like [NAME OF STAFF] but also from talking to the gallery that something didn't work. As an outsider it you simply ... There wasn't the opportunity to come together to resolve differences. For someone who lives locally I think the [NAME OF MUSEUM] is very snooty and I would wonder how much they were really able to embrace our service users. We're talking about a not very sexy group of people who really have that substantial

mental health problems I'm also involved in any of this I don't know the individuals. It certainly fits with stereotype of a snooty gallery who just wants to do sexy things whereas [NAME OF OTHER MUSEUM] is sexy place but it seemed to be able to go beyond that so I don't know. Really because I wasn't involved and it would be fascinating. I guess ultimately you would know more than we do or you would find out what factor seemed to make the difference. I guess [NAME OF MUSEUM] just felt we didn't listen. I'm sure there would be two sides but I don't know what stopped that conversation happening. It most not have worked for some time for them to think it's now time for them to pull out.

AJ: What gets in the way? I know you've talked about some of the issues that can get in the way. Can you mention a couple more that you might think can get in the way?

HEALTH10: Okay sorry I was just trying to think. We talked of what gets in the ways and we talked about problems not being dealt with equally, openly. Many are just speculating here I would wonder so lots about visits were brought quite some time in advance so each visit took an awful lot of work before the visit took place. We had to do things like risk assessment to an individual. Staff did a site visit to check out the safety between the environments. I don't know whether that was ever a problem to the gallery not to say they didn't have to do any preparing. They needed for the visit to take place on a scheduled day but it was a lot less work on their behalf than it was on ours. Again it's that sort of openness about what you both need and the ability to communicate there.

All our risk assessment stuff is something that potentially something outside the arts agenda, which indeed, we made clear that we had to do that therefore in order to do a visit.