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RESEARCH PAPER

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Supporting staff wellbeing in healthcare settings through multi-levelled creative psychological intervention – a feasibility study

Vicky Karkou^a, Emma Perris^a, Joanna Omylinska-Thurston^b, Tania Konstant^c, Lee-Anne Widnall^d, Shirley Brocklehurst^c, Ken Fletcher^c, Chloe Hird^e and Jane Hutton^e

^aResearch Centre for Arts and Wellbeing, Faculty of Health, Social Care and Medicine, Edge Hill University, Ormskirk, UK; ^bSchool of Health Sciences, University of Salford, Salford, UK; ^cResearch Centre for Arts and Wellbeing, Edge Hill University, Ormskirk, UK; ^dFaculty of Health, Social Care and Medicine, Edge Hill University, Ormskirk, UK; ^eDepartment of Clinical Health Psychology, Liverpool University Hospitals NHS Foundation Trust, Liverpool, UK

ABSTRACT

Background: There is growing evidence that the arts and arts-based therapies can support the wellbeing of healthcare workers. However, there are few large trials, limiting the use of such therapies in routine practice.

Aim: To establish the feasibility of introducing a multi-levelled, evidence-based creative psychological intervention delivered by qualified arts psychotherapists and targeting the wellbeing of NHS clinical staff.

Methods: This is a feasibility study with pre/post mixed methods design, the first to explore the value of an evidence-based, multi-levelled creative psychological package targeting the diverse needs of clinical staff within different healthcare settings. The intervention was adapted from a 12-session group therapy titled Arts for the Blues into a three-level package that included: (i) one-off drop-in sessions to release tension, (ii) workshops for staff development, (iii) group sessions for psychological support. It was delivered by qualified arts psychotherapists (i.e., art, drama and dance movement psychotherapists) and used brief evaluation forms, arts-based data and standardised outcome measures to establish acceptability.

Results: Findings indicate difficulties with recruitment, but the 49 participants placed high value on the different levels offered. All the outcome measures used identified positive change and indicated medium to large effects of the multi-levelled intervention on improvement of wellbeing and resilience, as well as reduction of distress, anxiety, depression and trauma.

Conclusions: Although the small sample does not allow the generalisation of results, the study suggests that this multi-levelled creative psychological intervention offers acceptable support.

Implications for practice/policy/research: Further research is needed to establish the effectiveness of this intervention with specific teams of professionals. However, the diverse options proposed in this intervention need to be considered further for routine practice, expanding on current job descriptions for art psychotherapists.

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KEYWORDS

Healthcare staff; clinical staff; wellbeing; distress; resilience; arts therapies; creative psychological intervention; Arts for the Blues

Plain-language summary

Pressures on healthcare services mean that healthcare workers need support for their wellbeing. It is possible that the arts and arts therapies can offer this support, but we need to conduct more research to be certain.

In this study we wanted to see if clinical staff working in health services liked a new creative intervention we developed based on our review of the research literature. We modified this intervention from the Arts for the Blues model, a 12-session group therapy that uses a mixture of different artistic forms. We used this new model to support the wellbeing of clinical staff in a large hospital in the North West of England. We did this in three different ways:

1. Creative activities for the whole organisation to release tension (up to 30 min)
2. Creative psychoeducational workshops with teams for staff development (up to 4 h)
3. Creative psychotherapy sessions with individuals in a group for psychological support (up to 18 h).

Arts psychotherapists, including art psychotherapists, designed the content of this work and facilitated their delivery.

We collected information from 49 clinical staff before and after each of these activities through questionnaires and a brief evaluation form. Although clinical staff were very busy, they liked the different options of the intervention and their wellbeing scores improved.

We need to do further research with a larger number of participants. However, the findings so far show that art psychotherapists can work not only with patients, but also with other healthcare workers to improve their wellbeing.

Introduction

There are increasing concerns for the wellbeing of healthcare workers, which have been extensively discussed during the COVID-19 pandemic. During that time, Denning et al. (2021) revealed that 67% of 3537 international healthcare workers scored highly on burnout, 20% for anxiety, and 11% for depression. A significant predictor of burnout included patient-facing roles. Similarly, in England, Ford (2020) and McKinley et al. (2020) saw over 30% of nurses and 30% of doctors experiencing burnout. NHS Digital (2023) reported that 5% of the NHS workforce are on sick leave at any given time; work-related stress and mental health problems being the most common reasons.

Arguably, COVID-19 brought to the surface a longstanding problem within healthcare services in the UK. Studies conducted before the pandemic reported that NHS staff showed high levels of stress, exhaustion and burnout (Wilkinson, 2015) with direct impact on the quality of care provided (Chana et al., 2015; Orton et al., 2012). Hall et al. (2016) for example, found a direct correlation between poor wellbeing and burnout amongst healthcare staff on the one hand and worse patient safety on the other, highlighting the importance of research in this area.

Much literature on the wellbeing of the healthcare workforce borrows from military language including the risk of 'moral injury' (Williamson et al., 2021) or 'moral distress' (Cacchione, 2020), which comes when staff are prevented from doing what they feel is ethically or morally correct. Moral distress is linked with suicidal thoughts, depression, anxiety, flashbacks or post-traumatic stress disorder (Williamson et al., 2021), and further exacerbated because the professional identity of healthcare workers includes being of service to others. British Psychological Society (BPS, 2020) talks about the 'heroic' role of healthcare workers preventing them from seeking support; doing so can be associated with them being perceived as incompetent and/or being humiliated in front of colleagues. Some staff may be able to demonstrate resilience, bouncing back from the crisis without additional help. However, leaving the individuals to survive distress on their own is not enough. Appropriate interventions are needed that can offer effective support.

Maben and Bridges (2020) argue responsibility (or blame) for distress should not be placed on individual staff as a way of letting organisations 'off the hook'. Supportive and psychologically safe environments are crucial post-pandemic; distress related to COVID-19 may still be emerging, along with a clear need for diverse interventions (Schwartz et al., 2020).

Similarly, in England the Health and Wellbeing NHS National Framework (NHS England, 2021) suggests: (i) improving personal health and wellbeing; (ii) encouraging relationships that foster wellness; (iii) creating an environment that supports the wellbeing of staff. These priorities imply different levels of support (i.e. personal, relational and environmental). Connections between services, networks, social activities and health and wellbeing champions are important structures strengthening positive relationships. Also important are facilities for rest and reflection (e.g., 'wobble' rooms dedicated to support staff take a break when they have a difficult incident of shift; such rooms were set up during the pandemic in several hospitals

around the country), alongside counselling, mental health training, mindfulness apps, occupational health and physiotherapy.

Nevertheless, most interventions in the research literature support individuals only (Cohen et al., 2023). Arguments for multi-levelled interventions (Clauser et al., 2012; Cleary et al., 2012) have not been taken on board, ignoring the power of the environment over individuals and the need for systemic approaches to wellbeing. Furthermore, the potential of the arts and arts therapies to support the wellbeing of staff remains largely untapped.

Our previous systematic literature review and meta-analysis (Aithal et al., 2022) covered 41 studies (2232 participants) using the arts to support the mental health of helping professionals, including healthcare workers, social workers and teachers. Arts interventions had an overall moderate effect size for mental health outcomes with particularly positive impacts on anxiety, stress and organisational factors like job satisfaction and workplace engagement. Depression and burnout were also reduced. The interventions varied in terms of artistic modality, type of engagement, intensity and depth and the presence or absence of a qualified practitioner. They were categorised into: (i) low-level engagement, often a one-off artistic activity for a large number of people (tier 1 and tier 1 plus); (ii) medium-level engagement, in a series of workshops (tier 2); (iii) higher-level engagement, over a longer period (tier 3). Despite promising results, however, arts-based interventions remain largely unavailable for clinical staff in most NHS trusts in the UK.

A more recent systematic literature review on art therapy-based interventions (Tjasink et al., 2023) reported similar impacts on the wellbeing of healthcare workers including positive outcomes for common mental health issues as well as reduction of work-related stress and burnout. Although this study looked at visual art therapy interventions only, an emphasis on groups was interesting (95% of the reviewed studies) as well as the presence of a qualified art psychotherapist (70% of the reviewed studies). Evidence-based creative interventions delivered by qualified arts psychotherapists may therefore be a promising way forward not yet sufficiently utilised within health services.

Aim and research questions

The aim of the current study was:

To establish the feasibility of introducing a multi-levelled, evidence-based creative psychological intervention delivered by qualified arts psychotherapists and targeting the wellbeing of NHS clinical staff.

The research questions of the study were:

1. What is the perceived value of a multi-levelled, evidence-based creative psychological intervention targeting the wellbeing of NHS clinical staff at an individual, teams and organisational level?
2. How feasible is the use of this multi-levelled intervention in terms of referral processes, number of participants and appropriateness of the research methods used?

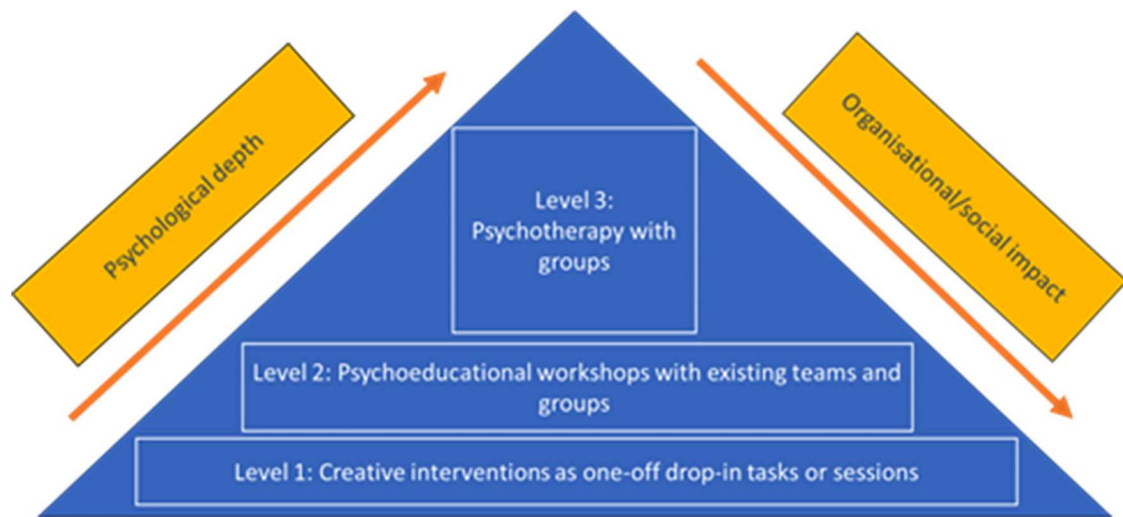


Figure 1. Multi-levelled approach model.

Methods

Study design

The study took place between October 2022 and May 2023 and followed a pre/post mixed methods study design (Creswell, 2021). It involved the first round of data collection implementing the recommendations from our data synthesis (Aithal et al., 2022) with clinical staff working in health settings. We followed the Medical Research Council guidance (Skivington et al., 2021) on evaluating complex interventions, placing this study as a first empirical step to further research. This feasibility study offered opportunities to test the evidence-based learning acquired from our systematic literature review, utilise prior clinical experience and refine the intervention and study design for further and larger studies in this field.

Ethics

Ethical permission was obtained from HRA and approved by West of Scotland Research Ethics Committee 5 (IRAS ID: 311004). All participants gave written, informed consent before taking part and were signposted to further support where applicable.

Study setting

The study took place at a large NHS Foundation Trust in the North West of England, one of the largest trusts in the UK with around 13,000 members of staff. The Trust offers treatment and support for primarily physical conditions in four different hospitals across one of the largest cities in the region, in an area of significant deprivation. During the pandemic, it was the main COVID site for the city, hospitalising all those affected by COVID-19 in need of intensive care. The Trust also offers general psychological support to patients affected by physical conditions such as respiratory, heart or cancer concerns. Alongside this it offers psychological support for staff, receiving 800 referrals a year. This study's creative psychological intervention package was integrated into the wider psychological services available for staff.

Intervention description

The intervention used in this study adapted the Arts for the Blues, an evidenced-based creative group therapy intervention (Omylinska-Thurston et al., 2021) used with patients, to an intervention suitable for NHS clinical staff. The Arts for the Blues has been developed based on a systematic literature review on helpful factors and effective practices in the major talking therapies available in the NHS. It utilises arts psychotherapy literature and associated practical experience. It has been tested with staff and patients over an extensive research period. The common use of the model involves twelve sessions comprising eight key ingredients (encouraging active engagement, learning skills, developing relationships, expressing emotions, processing at a deeper level, gaining understanding, experimenting with different ways of being and integrating useful material) and four phases (introduction, building personal and group strengths, addressing personal and group challenges, closure). The different ingredients are delivered through creative activities (e.g., drawing, visual art-making, collage, movement, rhythm or dance, song or music-making, role playing and drama, creative writing and/or poetry). This manualised approach was first used in primary mental health services for adults (Karkou et al., 2022a) and in schools with children at risk of developing mental health problems (Moula et al., 2020). Since then it has also been used with a wide range of different populations (i.e., children and young people using mental health services, adults receiving support from charities, parents and caregivers of children with autism, mothers and babies, adults with experiences of domestic abuse). It is therefore perceived as adaptable for various populations while being flexible in delivery.

In this case, instead of offering the intervention only as a 12-session-long group therapy to those struggling with their mental health, the intervention was offered at three levels (see Figure 1), using different ingredients for different levels as follows:

Level 1: creative tasks/sessions for the whole organisation

Opportunities were offered to release tension, decompress and prevent the development of mental health issues,

promoting wellbeing at an organisational level. It involved one-off creative tasks or sessions lasting up to 30 min. Participants were invited to work with Arts for the Blues ingredients including:

- *encouraging active engagement;*
- *learning skills;*
- *expressing emotions.*

Level 2: creative psychoeducational workshops with teams

Staff teams joined workshops to boost morale, support wellbeing, improve resilience, targeting positive improvements including building (or re-building) teams. Group workshops lasted two to four hours, addressing up to six of the Arts for the Blues ingredients:

- *encouraging active engagement;*
- *learning skills;*
- *developing relationships;*
- *expressing emotions;*
- *experimenting with different ways of being;*
- *integrating useful material.*

Level 3: creative psychotherapy sessions with individuals in a group

Psychological support was offered in the form of group therapy to staff who were on sick leave due to stress or had been referred for psychological support due to symptoms of depression, anxiety or trauma. It involved in-depth, small group sessions twice a week, for an hour and a half, over six weeks (18 h) targeting change at an individual level. All eight ingredients of the Arts for the Blues model were covered, including:

- *Processing at a deeper level; and*
- *gaining understanding.*

(See description of the Arts for the Blues model for full list).

At all levels, activities were designed and sessions were facilitated by arts psychotherapists (art, drama and dance movement psychotherapists), retaining psychological intentions and ensuring safe use of the arts throughout the study.

Participants

Participants were recruited using convenience sampling (Jacobson, 2020) following different processes for each level. For example, for level 1, which was open to all clinical staff in the Trust, participants were recruited via internal communications; the staff wellbeing hubs also promoted these drop-in sessions. Level 2 involved clinical teams identified by psychology staff; agreement from service managers was sought prior to these teams entering the study. For level 3, which involved working with those at risk or needing psychological support, recruitment also took place through the staff psychology team; during triage, the study's group therapy option was offered to all the people they saw for an initial assessment.

Measurements and materials

Qualitative methods involved the following:

Level 1, 2 & 3:

A brief evaluation form was used to capture the participants' perceived value of engaging in this study by identifying helpful and unhelpful aspects. Arts-based data was also collected during sessions to support participants' experiences.

Quantitative data involved the following:

Levels 1, 2 & 3:

A one-item scale Moral Distress Thermometer (Wocial and Weaver, 2013) was used. The scale is presented in the form of a thermometer (scale 0 = no distress – 10 = high distress), capturing levels of moral distress in a short time. The use of a thermometer as a metaphor also intended to bridge the outcome measures with the creative components of the intervention.

Level 2:

The Brief Resilient Coping Scale (BRCS) (Sinclair & Wallston, 2004) and the World Health Organisation-Five Well-Being Index (WHO-5) (Topp et al., 2015) measuring resilience and wellbeing respectively were used. These two self-completed tools intended to capture positive changes targeted at this level.

Level 3:

Participants completed additional questionnaires including the Patient Health Questionnaire-9 (PHQ-9) (Kroenke et al., 2001), the Generalised Anxiety Disorder-7 (GAD-7) (Spitzer et al., 2006) and the Post Traumatic Stress Disorder Checklist for DSM-5 (PCL-5) (Weathers et al., 2018). These three self-completed questionnaires are commonly used in primary mental health services measuring depression, anxiety and symptoms of post-traumatic stress disorder respectively. Given that this level involved the delivery of group therapy to clinical staff who were struggling with their mental health, capturing improvements in their levels of distress was perceived as important.

For each level, the level of engagement in generating research data was proportionate to the aim of the particular level, the depth of involvement and the time commitment required from participants. A summary of data collected is presented in Table 1.

Data analysis

Quantitative data was reported in the form of frequencies, means and standard deviations. The sensitivity of the methods to capture change were considered using the Wilcoxon Signed Rank Test for non-parametric data including medians, ranges, z scores, levels of significance (*p* values) and effect sizes (*r* scores).

Thematic analysis (Braun & Clarke, 2021) was used on qualitative data to capture participants' perceived value of

Table 1. Methods of data collection according to intervention level.

Intervention				Method of data collection		
Level	Aim	Type of intervention	Duration	Time of data collection	Type of information collected	Tool used
Level 1 (organisational)	To release tension	1 or 2 creative activity/ies	Up to 30 min	Before and after	Moral distress	Moral Distress Thermometer
				During	Experiences of activity/ies	Pictures of creative work
				After	Perceived value of activity/ies	Brief evaluation form
Level 2 (teams)	To support team building	1 or 2 workshop/s	2–4 h	During	Experiences of workshops	Pictures of creative work
				After	Perceived value of workshop/s	Brief evaluation form
				Before and after	Moral distress	Moral distress Thermometer
Level 3 (individual)	To offer therapy	12-sessions-group therapy	18 h	Before and After	Resilience	BRCS
				Before and after	Wellbeing	WHO-5
				During	Experiences of group therapy	Pictures of creative work
				After	Perceived value of group therapy	Brief evaluation form
				Before and after	Moral distress	Moral Distress Thermometer
				Before and after	Depression	PHQ-9
				Before and after	Anxiety	GAD-7
				Before and after	Trauma	PCL-5

the study, while arts-based data collected during sessions were presented as supporting evidence of their experience. Key findings from the thematic analysis along with relevant anonymised participant quotes became a verbatim theatre piece following Wadworth-Hervey's (2000) invitation for synthesising findings into an artistic piece.

Results

Recruitment was not easy despite the overall warm response to the creative nature of the intervention. Initial recruitment strategies needed to be refined, and several meetings were conducted with key staff to encourage participation. Specifically:

Level 1:

Staff were interested but struggled to find time to engage during their shift. When managers gave staff time to engage (e.g., at a health and wellbeing event) larger numbers were able to participate.

Level 2:

Interest was equally high, but even where teams had been referred not all staff were given time to attend. Where teams did take part, higher numbers participated when given enough notice to change clinic schedules. To increase participation, we offered online delivery to teams who could work flexibly.

Level 3:

Referrals were taken through the staff psychology service triage. Great efforts were made by the triage clinician to offer the sessions across their caseload.

A total of 54 participants took part in the study and 49 completed most measures before and after the intervention as follows (Table 2).

Level 1:

Thirty four completed the intervention, 29 of whom completed the pre- and post-measures across three hospital sites. Five completed the intervention but not the pre- and post-measures and thus were excluded from the findings.

Level 2:

Two clinical teams totalling 16 participants took part; 14 completed all the pre- and post-outcome measures.

Level 3:

Twenty-seven expressed an interest in taking part. After initial contact, ten participants completed consent and pre-intervention measures, four completed therapy, post-intervention measures, and qualitative and arts-based evaluation. Of the six who did not complete four did not attend any sessions, possibly due to the time between referral and the group starting. Two attended one session each, one voluntarily did not continue (not feeling ready to engage with any form of therapy), the other stopped responding maybe due to clashing shifts.

Quantitative results

A full list of quantitative results is presented in Table 3.

Table 2. Study participants.

Levels	Clinical staff			Total
	Mixed (e.g. nurses, health assistants, medics, health professionals)	Critical care team	Psychologists	
Level 1	29			29
Level 2		7	9	16
Level 3	4			4
Total	33	7	9	49

Table 3. Quantitative results from all levels (descriptive statistics and Wilcoxon Signed Rank Test and effect sizes).

Outcome measure	Before intervention					After intervention					Differences		
	<i>n</i>	<i>x</i>	SD	Md	Range	<i>n</i>	<i>x</i>	SD	Md	Range	<i>z</i>	<i>p</i>	<i>r</i>
Level 1													
Moral distress	29	5.5	2.5	5	8	29	3.1	2.1	2.5	8	−4.561	<.001**	0.60
Level 2													
Moral distress	16	2.0	2.1	2	8	14	1.5	1.6	1.5	5	−1.207	.227	0.31
WHO-5	16	14.5	4.6	15.5	13	16	15.9	4.4	18	13	−2.248	0.025*	0.40
BRCS	16	14.5	2.3	15	10	16	15.2	2.2	15	9	−2.021	0.043*	0.36
Level 3													
Moral distress	4	4.4	2.8	7.5	4	4	2.5	2	2	4	−1.841	0.660	0.91
GAD-7	4	18.7	1.2	19	3	4	6	6	5	12	−1.826	0.068	0.65
PHQ-9	4	19.5	4.8	19	10	4	8	7.5	8	14	−1.826	0.068	0.65
PCL-5	3	53.3	9.3	56	18	4	21.5	23.1	21	41	−1.604	0.109	0.65
All participants													
Moral distress	49	4.4	2.8	4	10	47	2.5	2	2	8	−4.919	<.001	0.91

n = frequencies; *x* = mean; SD = standard deviation; Md = median; * $p < 0.05$; ** $p < 0.001$; *r* = effect size.

The Moral Distress Thermometer showed reduced total scores for all the participants in the study, with statistically significant changes accepted at $p < 0.0001$ ($z = -4.919$) from before (Md = 4) to after (Md = 2) the intervention (see Table 3). Based on these scores, the effect of the intervention was calculated ($r = 0.91$). Based on Cohen's (1988) thresholds, as $r > 0.5$, the effect size was 'large'. At level 1, statistically significant positive changes were observed in favour of the intervention (before: Md = 5; after: Md = 2.5; $z = -4.561$; $p < .001$) with a large effect size ($r = .60$).

Results from the other levels showed significant improvements on scores of wellbeing and resilience (level 2) and reduced symptoms of anxiety, depression and post-traumatic stress (level 3). Although the latter did not show statistically significant differences, mainly due to the small number of participants, the scores indicate clinically significant changes. GAD-7 scores changed from severe (Md = 19) to mild anxiety (Md = 5); PHQ-9 scores from severe (Md = 19) to mild depression (Md = 8); PCL-5 shifted from Md = 56 to Md = 21, a clinically significant change in PTSD symptoms. All outcome measures used were sensitive enough to capture change. They also indicated either medium or large effects sizes, with *r* varying from 0.3 to 0.9.

Overall, participants found the outcome measures easy to use. They particularly appreciated the Moral Distress Thermometer for its brevity and its reference to 'psychological fever'.

Qualitative and arts-based findings

Rich information was gathered in the form of qualitative data relating to the perceived value of the different levels of intervention experienced by participants.

Level 1:

Participants were involved in self-contained creative activities at staff-wellbeing hubs at two large general hospitals and during a staff health and wellbeing event at a third hospital. Activities included colouring spaces they created with sticky tape (see Figure 2), placing a viewfinder over text to create their own poems, and listening and responding to a pre-recorded body scan that encouraged mark-making on a body outline. The time-limited creative tasks (they could choose 1 or 2 from 4 or 5 different activities) included clear instructions explained by two qualified arts psychotherapists (an art psychotherapist and a dramatherapist).

Participants reported that engaging in such short creative tasks was helpful in several ways. For example, they claimed that the creative tasks provided a *mental break* from their work. Concentrating on a non-work task allowed participants to reflect on their own needs without impacting on their considerable workload. One of the participants said:

It was good to spend a few minutes away from work but the [short] timeframe allowed me not to worry about the impact of me being away from work. (L1R1)



Invitation: a. place tape over card; b. fill gaps using pastels; c. remove tape.

Figure 2. Example of a creative activity used at level 1. Invitation: (a) place tape over card; (b) fill gaps using pastels; (c) remove tape.

Participants enjoyed taking part in the activities, and they had fun engaging in activities that led to their *mood* being *lifted*:

[I] enjoyed the time [and] feel happier following it. Excellent, very mood lifting. (L1A10)

Fun – not done anything like that since I was little. (L1A6)

Creative tasks from this level appeared to have a positive effect on participants' perceived stress, *releasing tension*. A short time away from work allowed them to pause and relax briefly. They reported:

It helped me to zone out and relax my body. (L1BG3)

A 5 min [...] break during a 13hr shift is very helpful and releases pressure off my shoulders. (L1BG8)

Even if these experiences were short, they offered opportunities for them to *learn different and new* things. Some participants felt equipped with new skills, which, as one stated, they could 'try to implement [...] in my every day' (L1BG8).

Participants also noted some unhelpful aspects of being part of this level. For example, time pressures from work continued, making it difficult to concentrate on the task. Participants were distracted by their own stress, as well as by environmental factors such as noise from the corridor and people entering the room. Even with the brevity of the methods of data collection on this level, some staff appeared tired and reluctant to complete forms. Participants also acknowledged that the activities were too short to alleviate problems since work pressures continued:

'Feeling rushed to complete due to demands of work'.

Level 2:

The level 2 workshops took place in two teams, a community respiratory team and a team of mainly clinical psychologists. The community respiratory team participated in person in their main offices, the clinical psychology team attended two online sessions and a session in a hospital meeting room. Some examples of creative activities from these workshops included choosing objects or images from a selection offered to participants that represented existing strengths, strengths they needed further development and resources required (see Figure 3), throwing a ball of wool to the person they knew best and those they would like to get to

know better, and engaging in guided meditation visioning their future as a team.

The most helpful components of this work involved *building team relationships*, and gaining both *personal* and *team benefits*. For example, participants opened up and learned about other team members, sharing information creatively. They felt the team was bonding. One participant described how they were:

[...] given the opportunity to see a different side to the team members and being able to be more open in a safe environment.

Some participants reflected on their needs and strengths, sharing values and visions as a team. They talked again about 'team bonding' and 'sharing with the others from the team our ideas and thoughts on where we see the team going.' Others also reported high levels of personal satisfaction from being part of the workshops. They felt they were offered 'time to reflect and ground [themselves].'

However, the benefits from working creatively with colleagues did not come without difficulties. In the presence of colleagues, creative engagement was not always easy: 'Initially felt a little awkward ...'. Others found it difficult to relax at work, while there were some tasks that certain people found difficult.

Overall, there was relatively low attendance given the level of need identified by the managers of the teams participating in the study. However, for those who did attend, participation appeared positive.

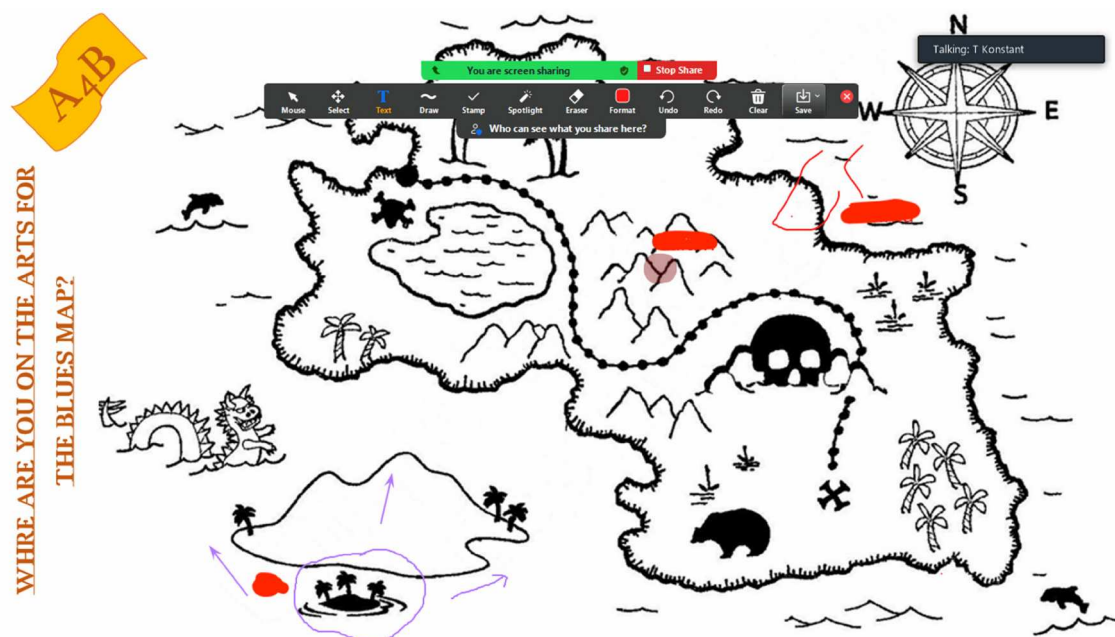
Level 3:

Participants at level 3 had the most in-depth experiences and the greatest commitment (12 bi-weekly sessions of 1.5 h each = 18 h). Participants engaged with the whole Arts for the Blues model with all eight ingredients and four phases. However, given the reasons for their referral (i.e. being off sick with stress or concerned about work-related stress) the sessions were offered online (via Zoom) so that participants could engage without the pressure of the work environment. Some of the activities used included making a group agreement together, placing oneself on the group map (see Figure 4), using tactile materials to create compositions and move with props and objects, creating group mandalas, developing a six-part story, developing images, dances and songs that summarised their group journey.



Invitation: Choose objects to represent a. strengths; b. strengths to develop; c. resources you need

Figure 3. Example of a creative activity used at level 2. Invitation: Choose objects to represent (a) team strengths; (b) strengths to develop as a team; (c) resources you need as a team.



Invitation: Place yourself on a group map

Figure 4. Example of a creative activity used at level 3. Invitation: Place yourself on a group map.

Participants participating in the group appreciated the *manualised character of the intervention*:

I [...] found it really beneficial to have a specific topic on every session.

They also appreciated the *pace* at which the sessions unfolded.

The *creative content* of the sessions and the use of the imagination were reported as particularly helpful. Similarly, the diverse forms of artistic media were named as important:

The most helpful aspects of the session was the power of art and movement to express feelings.

Both the support from the facilitators and from other groups members were also highly appreciated. One participant named feelings associated with being in this group:

...support, kind tenderness and nourishment of the group, shared lived experience ...

As a result, participants reported several *personal benefits*, which were clearly captured in the outcome measures used for this study and summarised in the following quote:

[I] developed sense of self, agency and autonomy, flourish, live with hope.

Unhelpful aspects of the group therapy sessions were associated with the *online* mode of delivery. 'Being sat in an arm-chair with laptop in front on a stool' appeared to be a challenge. This may have been exacerbated given that the group took place soon after the end of the pandemic and participants were very keen to meet in person after months of online interactions.

However, participants seemed to be fully committed to the sessions and appeared to benefit from the group to such a degree that no other unhelpful aspects of the group were reported.

The above key findings of how participants experienced the creative psychological intervention were shared with Tenderfoot Theatre company who synthesised these experiences

in a verbatim theatre piece titled 'Break' (see Figure 5): https://www.youtube.com/watch?v=_ZvhWXihUI8.

The piece was performed at the launch of the Research Centre for Arts and Wellbeing, Edge Hill University, in June 2023, making the work accessible to a diverse audience. Staff participating in the study were also invited to attend.

Discussion

Although clinical staff welcomed the intervention, finding time to participate in the study was not easy. Pressured workloads and difficulty taking breaks were often cited as reasons for this. However, another reason for the difficulties in recruitment may have been what BPS (2020) described as a 'heroic' stance. It is possible that healthcare workers, dedicating their work to caring for others, struggled with the idea that they might also benefit from receiving support. The brief respite at level 1 might have provided some support to participants without needing to be seen requesting formal treatment. Also, since the short creative activities at level 1 were not therapy and did not take place in groups, it is possible that a larger number of participants engaged without being seen by colleagues. Level 1 also saw significant improvements in terms of moral injury or moral distress (Cacchione, 2020; Williamson et al., 2021). The large effect size of the intervention, based on the Moral Distress Thermometer, indicated that even after brief creative activities it was possible for participants to experience a valuable mental break including lifted mood and released tension. NHS England (2021) refers to wobble, rest and reflection rooms for decompression. These spaces could include creative interventions carefully designed and staffed by qualified arts psychotherapists. Permanent spaces designated for this type of work have been reported in the literature (Wiltshire & Prescott, 2023) and could bypass some of the environmental limitations raised as unhelpful by participants.



Figure 5. 'Break' by Tenderfoot Theatre company.

Level 1 was not designed to deal with problems experienced either at a team or personal level. However, levels 2 and 3 of the intervention did create opportunities for more in-depth engagement highlighting that interventions that do not focus solely on individuals are needed (Clauser et al., 2012; Cleary et al., 2012). Military research suggests that overcoming trauma requires a buddy system (Williamson et al., 2021): understanding and support from people with similar experiences. Level 2 of our intervention certainly improved measures on wellbeing (WHO-5) and resilience (BRCS), while level 3 showed clinically significant changes on all measures used with reductions on anxiety (GAD-7), depression (PHQ-9) and PTSD (PCL-5).

At level 2, personal benefits were balanced with team benefits. Despite the 'awkwardness' experienced by working creatively in front of colleagues, participants acquired a sense of team building, much-needed particularly during the post pandemic era when the study took place. Creative engagement offered participants opportunities to 'speak' and reflect on their creative 'products' while keeping an 'aesthetic distance' (Karkou & Sanderson, 2006), a concept celebrated in the arts therapies literature as having therapeutic value whilst retaining safety.

Further therapeutic benefits were achieved at level 3. Participants gained more in-depth benefits, addressing underlying problems and finding ways forward. Their references to creativity and imagination resonated with De Witte et al.'s (2021) scoping review that refers to them as important therapeutic factors in arts psychotherapies.

The multi-modal character of the intervention was also considered a positive outcome. This work was facilitated by three different arts psychotherapists (an art psychotherapist in each case and either a dance movement psychotherapist (level 1 and 3) or a dramatherapist (level 2)), who were able to ensure safe engagement with the different arts modalities as well as appropriate and suitable diversity to meet the needs and preferences of the participants.

Although the online character of the intervention was seen by some as a limitation, online delivery offers significant

positive opportunities particularly relevant for those participants struggling with their mental health because of work. Meeting online with clinical staff from different services allowed them to share common ground. At the same time, they were in a neutral environment (on Zoom) and were supported by arts psychotherapists who were not staff members at the Trust where they worked. The distance of the facilitators' role from the participants' daily experience was important in creating a safe space where they could be 'brave' enough to open up and explore their most difficult thoughts and feelings.

Limitations of the study

The number of participants in the study was small. Also, the invitation did not target specific teams but was open to any clinical staff. There is therefore limited capacity to gauge whether the intervention had an impact on the environment and whether benefits of the intervention are transferable outside the NHS. Ultimately, this was a feasibility study that focused on the development of the intervention and, as such, the degree to which we can generalise its findings is limited. We can say with certainty, however, that those who participated did regard the intervention as highly valuable and demonstrated positive changes in all the measures used.

Specifically, the research methods used were relevant for the different levels of the intervention. The different outcome measures used for levels 2 and 3 captured either statistically significant (WHO-5 and BRCS: level 2) or clinically significant changes (GAD-7, PHQ-9, PCL-5: level 3) and were good candidates for use in future research. The Moral Distress Thermometer, common across all levels, was an easily used tool to capture change, particularly during level 1. However, these measures captured data before and after each of the different levels and did not evaluate the multi-levelled package as a whole, mainly because participants were recruited from a large number of different teams, services and trusts, and had diverse professional backgrounds.

Implications for practice, policy and research

For future research, it will be important that specific services and/or specific professional groups are considered as the target audience, to establish whether the complexity of the intervention and its multi-levelled focus can impact the system as a whole. The need for a randomised controlled trial design is also a requirement to establish effectiveness, alongside the presence of measures such as burnout or job satisfaction currently missing from this reported study. These are all important research developments prior to scaling up this intervention to a wider range of healthcare and non-healthcare workplaces.

It is interesting that some participants valued learning new skills. This finding has triggered discussion in the current research team about offering psychoeducational opportunities for healthcare workers to use the arts and creativity for self-care without the presence of a qualified practitioner. This may be particularly relevant to healthcare professionals who do not work in a fixed context, e.g., doctors in training, who learn skills they can use as needed in different clinical contexts.

In all cases, the study highlights new roles for the practice of art psychotherapists that are not limited to working with patients. It is likely that there is mileage in expanding current role descriptions, making contributions to improving the wellbeing of staff, reducing burnout as suggested in the growing research literature in this field (Huet & Holttum, 2016; Tjasink & Soosaipillai, 2019) as well as proposing safe uses of the arts in psychoeducational programmes such as those on doctors in training. Working closely with other arts psychotherapists can expand the repertoire of current practice suggesting not only visual creative methods and approaches that can enhance engagement in participatory arts psychotherapies experiences, but they can also work collaboratively with other arts psychotherapies to advance their creative repertoire in terms of embodied, musical or drama-based creative practice. This is also suggested in recent literature on this topic (Havsteen-Franklin et al., 2023), and reflects a wider trend in arts psychotherapies where collaborative work across disciplines is highlighted (Karkou et al., 2022b, 2022c; Carr et al., 2021; De Witte et al., 2021).

Conclusions

The multi-levelled approach adopted could provide solutions to the complex problem of the wellbeing of healthcare staff as recommended by the Health and Wellbeing NHS National framework (NHS England, 2021). Despite difficulties with recruitment, when participants engaged with the interventions they achieved a mental break, improvements in their mood, release of tension and learning new skills (level 1), they were able to build team relationships (level 2) and observe benefits at a personal and group level (level 2 and 3). The themed and activity-based character of the intervention, the creative and imaginative content and the use of diverse art forms heavily outweighed any challenges reported. It is argued that the creative, multi-levelled intervention package offers an acceptable intervention contributing towards the development of psychologically healthy workplaces particularly needed in the post-pandemic era in the NHS.

Overall, the intervention created opportunities to support the healthcare workforce, suggesting that this type of work can be acceptable and potentially effective, expanding on the role of art psychotherapy from working exclusively with patients to considering diverse ways of enhancing the workplace environment. Although the results from the study cannot be generalised, we know that the intervention had a positive impact on the participants. At the very least, it provided a much-appreciated respite, as one of the level 1 participants put it:

having a pause, and the opportunity to pause, is a luxury. Thanks for the opportunity. (L1A11)

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- Performers: Fran Clover, Chrissie Handley, Joseph Roberts
- Voice: Kate-Elizabeth Carey

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Notes on contributors

Prof **Vicky Karkou** is the Director of the Research Centre for Arts and Wellbeing at Edge Hill University and an internationally known academic and researcher in the arts and arts psychotherapies with external funding successes of over £10million. She leads the new project *Arts4Us*, one of the largest research awards on the arts, arts therapies and children's mental health funded by the UK Research and Innovation (UKRI) involving over 50 collaborators and partners. This project builds on the *Arts for the Blues*, an evidence-based creative group psychotherapy for people with depression, which, in collaboration with the University of Salford and funding from the Arts and Humanities Research Council (AHRC), has been scaled up in the North West of England. With funding from the Wellcome Trust and collaboration with colleagues from India and the Caribbean, she has supervised a systematic review on arts interventions to support the mental health of helping professionals which underpinned the proposed study. She is also a co-founding member of the International Creative Arts Therapies Research Alliance, working on international commissioned projects from the WHO Arts and Health Office. Vicky was the Principal Investigator for this study.

Emma Perris is a lecturer in therapeutic skills at Edge Hill University, a dance movement psychotherapist and a PhD candidate. She is involved in several projects as a researcher for the Research Centre for Arts and Wellbeing including projects on supporting the wellbeing of doctors in training through creative interventions, arts therapies with children and young people, working on scaling up arts interventions and so on. Her own research involves exploring the use of dance movement psychotherapy as an intervention for mothers who just gave birth. Emma was the main researcher in this study.

Dr **Joanna Omylinska-Thurston** is a counselling psychologist with NHS Talking Therapies, Greater Manchester Mental Health NHS Trust, and a lecturer in Counselling and Psychotherapy at the University of Salford. She is a co-founder of the Arts for the Blues model, which is currently being tested

with clients with depression and staff affected by COVID-19. Joanna has developed the digital adaptation of Arts for the Blues and is leading the systematic review of digital interventions for depression. She also a Co-investigator on the AHRC-funded scaling up study of the Arts for the Blues in the North West and a Co-Investigator for the new Arts4Us study on mobilising community assets to support the mental health of children and young people through the arts and arts therapies. Joanna was involved in all stages of this study from the development of the intervention to its delivery and evaluation and writing up.

Tania Konstant is a trauma-informed art psychotherapist, working as a freelance practitioner with mental health charities and community organisations. She trained as an art psychotherapist at the University of Chester. Since then and in addition to her clinical practice, she worked as an associate tutor at Edge Hill University and contributed to several research projects as a therapist and an Arts for the Blues trainer under the Research Centre for Arts and Wellbeing. She is currently working with adult survivors of childhood sexual abuse (CSA). In this study she was involved in all levels of the intervention as a co-facilitator.

Lee-Anne Widnall is a senior lecturer in Counselling and Psychotherapy at Edge Hill University, a dramatherapist, cognitive behavioural therapist and integrative psychotherapist. She leads the MSc in Psychotherapy and Counselling: Contemporary Creative Approaches. Before commencing her first degree in Drama and Psychology she worked in Community Theatre. After completing her postgraduate diploma in dramatherapy in 1992, she worked in mental health charities and Adult Education with Adults with learning disabilities in London and then with a touring theatre company in Hertfordshire. She moved to the north and began working in a mental health charity in Manchester and following this, she went to work in Child and Adolescent Mental Health Services as a specialist therapist for 15 years, where she completed her postgraduate certificate in Clinical Supervision. She then worked for three years in Adult Psychological Therapies (IAPT) before starting at Edge Hill University in 2020. Lee-Anne was involved in the study as one of the facilitators for the workshops offered with staff (level 2).

Shirley Brocklehurst is a qualified dance movement psychotherapist, practising for over 10 years as a private practitioner and a freelance therapist. She has contributed to several research projects as a therapist and an Arts for the Blues trainer under the Research Centre for Arts and Wellbeing. She is currently working with adult survivors of childhood sexual abuse (CSA). In this study she was involved as a co-facilitator for the provision of therapy to individuals who needed in-depth support (level 3).

Ken Fletcher is a psychologist, working as a researcher under the Research Centre for Arts and Wellbeing. She has worked on projects related to the wellbeing of University/College students, surveys of children and young people, their families and healthcare professionals on their mental health preferences and on digital projects relating to the arts and arts therapies. In this project he was involved in the quantitative analysis and editing of the paper.

Chloe Hird is an Associate Psychological Practitioner at the Department of Clinical Health Psychology, Liverpool University Hospitals NHS Foundation Trust (LUHFT). She is involved in triaging psychology referrals, liaising with different healthcare professionals, and external companies to provide sufficient support to LUHFT staff. In this study she offered practical support with referrals of staff into the study as well as with the delivery and evaluation of the intervention.

Dr **Jane Hutton** is a consultant clinical psychologist and clinical lead at Liverpool University Hospitals NHS Foundation Trust (LUHFT). She is leading psychological services in this trust since 2019, after 15 years of experience working as a consultant clinical psychologist at King's College Hospital in London. She is trained in cognitive-behavioural and interpersonal therapies and she is also an experienced mindfulness teacher. She is interested in the benefits of psychology and mindfulness for healthcare professionals, as well as for people living with cancer and other illnesses. Jane has been involved in this study from the very beginning of the work, the idea all the way to the writing up stage and has been responsible for embedding the study in existing services.

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