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ORIGINAL ARTICLE

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Bringing creative psychotherapies to primary NHS Mental Health Services in the UK: A feasibility study on patient and staff experiences of arts for the blues workshops delivered at Improving Access to Psychological Therapies (IAPT) services

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Abstract

There have been several arguments for the need to generate evidence-based creative forms of psychological interventions in Improving Access to Psychological Services (IAPT), the main primary mental health provider in hospitals in England, UK. In this feasibility study, we sought to identify helpful and unhelpful factors of a new creative group psychotherapy, titled Arts for the Blues. We also wanted to find out whether the research tools used were acceptable and sensitive. We therefore engaged a group of seven patients attending an IAPT service in the North West of England, and a group of six staff working in the same service, to attend one creative workshop each, followed by a focus group. The two focus groups were transcribed and analysed using thematic analysis. We also collected pre- and post-measures of depression (PHQ-9) and anxiety (GAD-7), measures commonly used in IAPT services, plus measures of well-being (WHO-5), the PANAS, and goal-setting, which were considered for acceptability and sensitivity. We received largely positive responses from service users and staff in the use of creative methods in psychotherapy. Although the measures used had limitations due to the short duration of one-off creative workshops, we found that they were sensitive enough, easy to complete and, thus, were acceptable. We concluded that Arts for the Blues is a promising intervention in IAPT, especially since it is shaped by service users and staff working in these services. Further work is needed to establish the effectiveness of this new intervention.

KEYWORDS
creativity, evidence-based forms, feasibility, IAPT, primary care, psychotherapy

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1 | INTRODUCTION

Depression affects more than 280 million people globally. It is a leading cause of disability worldwide and a major contributor to the overall global burden of disease (WHO, 2021). In the UK, depression affects 4.5% of people and is one of the leading causes of disability (NICE, 2022). It is the most common mental health condition, which often brings people into contact with primary care mental health services within the National Health Service (NHS). In England, this mainly involves the provision of cognitive behavioural therapy (CBT), an intervention that largely relies on people talking about their problems and readjusting maladaptive thoughts. However, Omylinska-Thurston et al. (2019) found that thinking and talking are not always relevant to the diverse populations that primary care teams in England serve. People from different socio-economic, educational or ethnic backgrounds, those whose English may be limited and those with learning difficulties may find CBT unhelpful. As a result, it is not surprising that the dropout rates from Improving Access to Psychological Therapies (IAPT) services, the main primary care provider of psychological support, are high, reaching 63% in 2021 (NHS Digital, 2021). Still, however, within IAPT services, forms of psychotherapy that rely less on talking and more on non-verbal communication, such as art psychotherapies, remain largely unexplored.

Art psychotherapies, otherwise known as art therapies or creative art therapies, is a generic term used to refer to music, art, drama and dance movement psychotherapy, forms of psychotherapy that draw on the arts and creativity. Art, drama and music psychotherapies are regulated by the Health Professions Council (HCPC), while dance movement psychotherapists are registered under the UK Council for Psychotherapy (UKCP) (Karkou & Sanderson, 2006). There are also other forms of psychotherapy that use creative methods as a way of communicating, exploring and processing issues that may integrate the use of different forms of arts and creativity in psychotherapy, such as expressive art therapies (Rogers, 1997) and integrative art therapy (Ross, 2012), all of which will be referred to collectively hereafter as creative psychotherapies. Karkou and Sanderson (2006) have defined these interventions as:

> … the creative use of the artistic media as a vehicle for non-verbal and/or symbolic communication, within a holding environment encouraged by a well-defined client–therapist relationship, in order to achieve personal and/or social therapeutic goals appropriate for the individual.
>
> (p. 48)

As the above definition suggests, although verbalisations are possible, creative psychotherapists tend to communicate difficulties non-verbally and symbolically through the artistic media and creativity. They also pay attention to the emotional and social aspects of this communication, alongside cognitive elements. As a result, when art making is encouraged within an agreed therapy contract, in an established relationship and in the presence of a qualified therapist, it can offer not only an opportunity for expressing one's distress but also the means to work through distressing issues and thus achieve a resolution which is beneficial for the client.

A recent publication by Millard et al. (2021) reports that over 60% of service users and the general public participating in a national survey would like to see creative forms of psychological interventions available when they contact services. However, creative psychotherapies are often offered in a very patchy way, despite the growing evidence and associated guidelines that recommend these interventions for different mental health concerns. For example, two Cochrane Reviews in dance movement psychotherapy (Meekums et al., 2015) and music therapy (Aalbers et al., 2017) indicate that, despite methodological limitations, these creative psychotherapies can have a positive impact on symptoms of depression. Still, within primary care and IAPT services in particular, creative psychotherapies remain largely unavailable. The new draft NICE guidelines for depression (due to be published in 2022) suggest that a wider variety of psychological therapies should be made available to meet the psychological needs of diverse populations. The need to provide research evidence of the effectiveness of creative psychotherapies within this context is therefore essential before these interventions are recommended as a therapy choice within primary care.

Following the Medical Research Council's (MRC, 2006) guidelines for complex interventions, and their recent update (MRC/NIHR, 2021), we have embarked on a journey of developing the Arts for the Blues model, a new evidence-based, pluralistic, structured group intervention for depression (Karkou, Omylinska-Thurston, et al., 2022). As an evidence-based practice, it is based on identifying helpful and

Implications for practice

- The Arts for the Blues model is a promising intervention, shaped by service users and staff in Improving Access to Psychological Therapies (IAPT) services.
- Service users found the creative workshop highly attractive, indicating that a creative psychological intervention such as the Arts for the Blues has the capacity to meet the needs of the diverse population IAPT services work with.
- It is possible that once the model is fully developed and its effectiveness established, psychotherapists working in IAPT services can use this intervention in their practice.

Implications for policy

- Since it is the first time that a creative psychological intervention such as the Arts for the Blues has been introduced in IAPT services, further research on this intervention is needed to extend the range of evidence-based psychological interventions currently available in primary care.

unhelpful factors from published literature, mainly patient reports but also randomised controlled trials in psychological interventions already recommended for primary care psychological services (CBT, counselling for depression, short-term psychodynamic psychotherapy) and creative psychotherapies for depression (Parsons et al., 2019). Unlike other structured interventions commonly available in primary care in the NHS in England, the Arts for the Blues model consists of key ingredients that are delivered flexibly through art-based activities including drama, visual art, dance, music and creative writing (Omylinska-Thurston et al., 2020). Following the pluralistic tradition (Cooper & McLeod, 2011), it is goal-oriented and draws on CBT, person-centred, psychodynamic and integrative psychotherapies. As a group intervention, it draws on group theory, and Yalom (1983), in particular, and retains an overall relational character.

In this paper, we cover a key aspect of the process of developing this innovative model and establishing its acceptability within primary care mental health services. More specifically, we asked the following two research questions:

1. What are the helpful and unhelpful factors of creative group workshops according to the service users and staff in an IAPT service in the North West of England?
2. How acceptable and sensitive are the research tools used in the study?

In order to answer these questions, the following methodology was adopted.

2 | METHODOLOGY

For this early development phase (MRC, 2006), and given the research questions above, we conducted a feasibility study (Orsmond & Cohn, 2015), which attempted to both refine the model and establish the acceptability of the model and the research methods used. Overall, it followed a mixed-methods approach (Creswell et al., 2004) with a strong qualitative component that allowed the research team to explore the service users' and staff's experiences. The involvement of service users and staff when novel interventions are introduced to a service is not new. Anderson et al. (2019), for example, have involved patients and staff in their development of a stepped-care mental health service in Australia. Similarly, the introduction of mental health interventions in primary care in Sri Lanka (Siriwardhana et al., 2016) and Nigeria (Gureje et al., 2015) has involved participatory research with staff to inform these new interventions. In our study, it was seen as important that service users and staff were offered a creative group workshop based on early versions of this model as a taster of the full intervention. This allowed us to refine the development of the Arts for the Blues model and establish its acceptability within primary care services in the NHS.

We decided to facilitate two creative workshops, one with service users ($n = 7$) and another with staff ($n = 6$), followed by a focus group for each of these groups. This way, we were able to capture service users' and staff's experiences of the Arts for the Blues model. Quantitative measures commonly used in primary care services were also employed to measure depression and anxiety (PHQ-9 and GAD-7), alongside measures of well-being (WHO-5) and positive/negative affect (PANAS) before and immediately after each workshop. Each participant also set a personal goal before the workshop, and the degree to which this was reached by the end of the workshop was captured numerically.

2.1 | Participants

Suitable participants (service users and staff) (defined by the inclusion and exclusion criteria below) were identified from within IAPT. Service users were recruited by IAPT (high-intensity therapists [HITs]/CBT therapists, counsellors and mental health practitioners [MHPs]). Staff could self-refer. The research was advertised in the service's internal mail, so practitioners could get in touch with the researchers in regard to both their interest in participating in the study and referring service users. The pathway of recruitment involved the practitioners asking identified service users if they wanted to be involved in the research. Details of service users who were interested were passed on to researchers who sent them the Participants' Information Sheet (PIS) and a Reply Slip to send/email back if they wished to be contacted to discuss the research. Participants who wanted to discuss the research further were contacted, and if they agreed to take part in a workshop/focus group, initial assessment dates were given. The consent form was signed prior to the initial assessment. During the initial assessment, the following areas were discussed: inclusion/exclusion criteria, the research project including workshop/focus group, risk issues, previous therapy including group work and working with creative approaches, personal motivation for taking part in the research, medication, brief psychiatric history and expectations for the workshops. A brief creative activity was used to ascertain whether the participant was able to engage in creative therapy. If the assessment session went well and the participant wanted to take part in the workshop/focus group, the details of the time and location were given. The participants were given as much time as they need (minimum 24 h) to consider participation, and they could withdraw at any point (prior to the workshop/focus group). The demographics and occupations of service users and staff who agreed to participate are included in Table 1.

2.2 | Inclusion/exclusion criteria

Those asked to take part were aged 18 years or older and were current or past clients of IAPT, IAPT practitioners and other psychological therapists working in the Trust. Clients had to be able to communicate in English.

At the point of recruitment, the exclusion criteria were as follows:

- Service users/staff who were severely psychologically distressed;

TABLE 1 Participant demographics and occupations

	Age (in years)	Gender	*n*	Occupation	*N*
Service users					
M	49.9	Female	5	Unemployed	6
				Part-time employment	1
SD	7.6	Male	2		
Min	34.0	other	0		
Max	56.0				
Staff					
M	47.7	Female	4	CBT therapist	1
SD	9.3	Male	2	Counsellor	2
Min	35.0	Other	0	Trainee CBT therapist	1
Max	59.0			Trainee counsellor	2

- Service users/staff who were at risk of harming self or others;
- Service users/staff who regularly made heavy or dependent use of alcohol or other recreational drugs;
- Service users/staff who were having psychotic experiences;
- Service users/staff who had any condition which would make participation in the research workshop and focus group difficult, such as significant dissociation, severe social anxiety, paranoia, difficulties in comprehension, difficulties in emotional regulation, severe personality disorder, and severe depression; and
- Service users/staff who were too physically unwell to attend the focus group or workshop.

2.3 | Ethical issues

The study received ethics approval from the Research Ethics Committee of Edge Hill University and the NHS Health Research Authority. All participants were informed that any personal data that had been collected would be stored confidentially and any published results would not reveal their identity. However, confidentiality could be breached if a risk of harm to self or others was apparent. All participants received information regarding the research (PIS), as well as the dissemination of findings. No financial or other inducements were offered. The participants were not coerced to participate, and they could withdraw at any point prior to the workshop and focus group. The second phase of the study involved experiential workshops and the focus groups. The workshop and focus group were recorded using digital means and were transcribed. Photographs were taken of the artwork/creations that participants produced. All identifiable data were anonymised, locked in a secure cabinet at Edge Hill University, or kept on a password-protected server. The collected data will be stored for 10 years, unless requested otherwise, and will be confidentially destroyed after this time. Informed consent was sought from those participating in the workshop and focus groups. The workshop and focus groups were not intended to be therapy; however, these sessions had the potential to have a therapeutic effect. If a participant became distressed, or an unmet clinical need was apparent, the researchers were clinically qualified (the facilitators were qualified as a counselling psychologist and a counsellor, there was an art therapist and two nurses, and one was a mental health nurse alongside their research roles) and were able to respond appropriately, including discussing relevant referral.

2.4 | Workshop

Following an initial set up and contracting, the content of the 90-min session was structured with a beginning, a middle and an end, which was outlined to the participants.

Beginning: As a warm-up, participants were encouraged to explore their feeling state using words and body expressions. A realistic and appropriate goal to work on for the workshop was identified and rated. The goal was explored creatively, checking for where it may be felt in the body. Connecting with the body and embodied emotions were practised using creative methods such as body scan, and the use of images and colours.

Middle: Participants were invited to explore their goal using a flow of creative methods, which were guided and explained. These involved the use of movement and props, art making using a variety of art materials, and creative writing. After the activities, participants were supported to reflect on their work with another participant (guidance was given for this).

End: Participants were encouraged to share their reflections in a larger group if they wanted to. They were asked to go back and re-rate their goal. The workshop closed with a creative activity inviting the participants to share their experience of the session. This creative activity took the form of a group drawing, a body sculpture or a musical arrangement.

2.5 | Focus group

Focus groups were used to explore the central topics of our study (i.e. development of the model and acceptability of the intervention

and the research methods used) (Morgan & Krueger, 1998) and as a 'collective sense-making in action' (Wilkinson, 1998, p. 181).

During the focus group, the participants were invited to share thoughts about the workshop through (i) a creative activity and (ii) a group discussion.

For the creative activity, participants were asked to consider how they found the workshop and to share their experiences through, for example, individual or group drawings or poetic language.

The discussion included some questions on the following topics:

- How did you find the workshop?
- What was helpful about the workshop and why?
- What was unhelpful about the workshop and why?
- Which aspects of the workshop helped you get closer to your goal?
- Which aspects of the workshop did you find were not helpful to reach your goal?
- Is there anything you would like to have done more of in the workshop? Why?
- Do you feel there was anything missing from the workshop?
- What was your experience of completing the measures?
- Is there anything else that you would like to share?
- What was it like to participate in this focus group?

All participants were invited to speak, and varied views were encouraged in order to reduce group reporting effects. All views were welcomed and considered.

2.6 | Measures

The following measures were used before and after each workshop; the first two are routinely used in primary care mental health services in the UK:

Patient Health Questionnaire-9 (PHQ-9): Consists of nine items, each of which is scored from 0–3, providing a severity score from 0 to 27.

Generalized Anxiety Disorder-7 (GAD-7): The higher the score, the higher the anxiety. The total score for the seven items ranges from 0 to 21.

WHO-5 Well-Being Index (WHO-5): The total raw score, ranging from 0 to 25, is multiplied by 4 to give the final score, with 0 representing the worst imaginable well-being and 100 representing the best imaginable well-being. The higher the score, the higher the feeling of well-being and quality of life.

Positive and Negative Affect Schedule (PANAS): This is a 20-point scale that consists of different words that describe feelings and emotions (minimum 10 and maximum 50). A 5-point Likert scale is then used for scoring. Higher scores represent higher levels of positive affect.

Personal goal attainment: The goal was marked on a scale of 1–10, with a higher score suggesting one being closer to achieving their goal.

All measures are self-completed measures. Unlike the PHQ-9 and GAD-7, commonly used within primary care services in England, we decided to include the WHO-5 because it focuses on perceived well-being rather than symptoms of distress. Similarly, we included the PANAS measure as a tool to establish both positive affect and negative affect. PHQ-9, GAD-7 and WHO-5 are retrospective measures that capture long-term change, inherent in the wording of the questions ('…over the last 2 weeks') and the response options ('Several days/More than half the days', 'More than half of the time', etc.). Unlike these three measures, PANAS captured perceived affect at the time of its completion. So, the non-standardised personal goal attainment scale was introduced in the beginning of the workshop and revisited towards the end.

2.7 | Analyses

The focus groups were transcribed and analysed using thematic analysis (Braun & Clarke, 2006), a process that involved five steps: becoming familiar with the data through reading and re-reading the transcripts, generating initial codes, searching for themes, reviewing themes and defining themes.

Acceptability was established through questions asked during the focus group.

Although inferential statistics were not calculated as the sample was too small, the sensitivity of each of the tools used to assess change was established through descriptive statistics.

Capturing the participants' acceptability of the model and measures, as well as sensitivity of the measures, was important in terms of the feasibility of the study.

3 | FINDINGS

3.1 | Service users

For service users, the creative workshop offered opportunities for active engagement, learning skills, developing relationships and expressing emotions.

On the whole, the fact that the arts were used to encourage **emotional expression** ('Freedom to express yourself' [P7, 8]) was received very positively by participants. They found the experience of attending this workshop very different from participating in other arts and crafts classes where the focus was on the art product. Even though more sessions were needed to allow them 'to feel at ease' (P6, 25), they saw an opportunity, through the use of the arts, to not only explore emotions of distress but also to have fun ('Fun is important' [P1, 97]).

Participants also suggested that **learning skills**, and practical skills in particular, was important. One participant suggested that their confidence could grow if they acquired some skills: 'Need practical course to teaching art as people think they are not good enough' (P2, 237). It is possible that this was linked with the fact that

they were not totally clear about what to expect: one assumed that it was going to be an art class ('Expectation that you are going be taught art' [P6, 232]), while others assumed that the workshop was going to involve only visual art as therapy, rather than a combination of different art modalities ('Perception it was art therapy' [P2, 29; P1, 29; P1, 42; P3, 44]). Either way, the supportive role of the therapist was apparent: 'May need some encouragement when you feel held back from experimenting' (P6, 174) and '[Therapist] needs to help people feel comfortable with making marks' (P6, 177).

Despite the need to adjust their expectations while in the workshop, there were participants who commented on how helpful it was to **actively engage** with the different art forms. One highlighted how much they enjoyed the 'opportunity to move during the body scan rather than sitting' (P4, 76), and another talked about mark making ('Happy with simple mark making' [P7, 4]). However, active engagement did not come without its challenges. Although there were participants who valued that 'nobody judged what you did' (P7, 4), some participants felt that they were 'put on the spot' (P6, 17; P2, 29). For example, one participant reminded us that 'focusing on the body and physical symptoms [can be] stressful for [an] anxious person' (P4, 76). Another talked about 'not understanding the reason for gesturing' (P7, 108) and expressed a desire for further explanations (P6, 118). On the opposite side of the spectrum, there were participants who thought that there was 'Too little movement, you can't jump up, gesturing too small' (P3, 122) and there was 'Not enough time for art' (P2, 29; P7, 64). Several expressed their desire for the workshop to include a greater range of art forms and proposed the use of music, photography, poetry and painting to music as additional ways in which people could express themselves (P3, 85; P2, 243; P3, 244; P1, 97). There was also a suggestion that there could be a goal and a project they worked towards (P4, 160), for example gardening where growth can be seen over time (P3, 162).

Another theme that emerged from the service users' focus group was the value in **developing relationships**. Talking after completing creative activities and discussions in the group consolidated the development of relationships (P6, 11; P6, 17; P2, 29). Some were ready to start the creative part sooner; they found that there was 'too much talking at the beginning' (P2, 29; P7, 58). However, as one participant described, this was a 'small group and intimate atmosphere' (P3, 95; 100), and as such, there was considerable value in 'sharing with somebody sitting opposite to you at the large table, feeling close and connected' (P3, 95).

In terms of the **duration** of the workshop, there were differing views: one was 'happy with the amount of time' (P, 131), another felt that there was 'A lot to cram in' (P1, 70), while a third felt that 'It would be helpful to have more sessions in the future as the main issue with therapy is that it ends' (P6, 218) and '… you lose all the good habits' (P6, 220).

From the participants' responses, it was clear that the **environment and the materials** used were important and needed attention. We held the service users' workshop and focus group in a church hall. However, when we arrived we found that the large room we initially booked was not available. We were asked to use a smaller room that was normally used for arts and crafts, but as two participants pointed out, the chairs were not as comfortable (P3, 81) and the light was 'terrible', leading to migraines (P3, 81; P7, 253) and stress (P3, 81; P7, 256). Although, on the whole, the service users were very understanding of the situation, the physical environment and the materials appeared important to them. For example, another participant pointed out that she would have preferred a large table, a bigger paper to work on (P2, 29) and a wider variety of materials (P2, 35).

On the whole, most participants found their experience positive: 'it was interesting' (P5, 131), 'Enjoyed coming' (P7, 256), 'Great to see other people' (P7, 261), and 'Would like more of this' (P7, 261). They felt that it was 'Good to have space for creative activities' (P4, 146) and these activities were 'important in the NHS' (P7, 212). The need to research them thoroughly and offer choice in hospital treatment programmes was also highlighted. One participant, for example, argued that creative approaches need to be 'trialled' (P6, 216) in order 'to choose which approach is right for you' (P6, 216), a position also echoed by others (P7, 231). Similarly, participants argued for the need to have access to creative approaches to therapy through GP surgeries: 'Structured creative therapy for depression should be prescribed by GP' (P6, 272) 'for people who can't walk and also can't do art by themselves' (P3, 276), 'for people working full time' (P4, 167), 'encouraging men to attend' (P7, 188; P6, 192; P3, 193) and 'people from different age groups' (P3, 191).

In all cases, there was perceived value of these approaches because of the non-verbal component of this work: 'It is good for people who can't express themselves verbally; it is lacking in the NHS' (P2, 241). Comparisons with verbal therapies were also made. One participant argued that creative therapy was more useful because 'in talking therapy you go over and over the same thing and nothing changes' (P4, 150). There was a plea for more of this type of therapy: 'Please push for more of this but with more art and better environment' (P7, 266), 'with better atmosphere' (P3, 269).

Despite the difficulties encountered with the room, in all the measures used before and after the workshop, there were changes in a favourable direction. As shown in Table 2, post-scores for both the PHQ-9 and GAD-7 decreased, indicating a perceived decrease in depressive symptoms and anxiety, respectively. PANAS showed that there was a small increase in positive feelings post-workshop and a small decrease in negative feelings at the same time. It was, however, the WHO-5 measure that picked up the largest change, with a 13.3-point increase in the mean score of well-being after the workshop.

Six of the seven participants were able and willing to complete all the pre–post measures. One completed the personal goal attainment only as this participant arrived late and missed the initial part of the workshop. Another participant suggested that they would have liked to have been given explanations of what the pre- and post-scores meant (P1, 66).

3.2 | Staff

The six staff participating in the study were happy to talk about the **therapeutic framing** of the work in the first instance. They found it

TABLE 2 Pre- and post-workshop scores of service users

	M	*SD*	*M* score diff.
Personal goal attainment (*N* = 7)			
Pre	2.1	1.6	1.7
Post	3.9	2.4	
PANAS positive affect (*N* = 6)			
Pre	23.2	11.7	0.3
Post	23.5	13.9	
PANAS negative affect (*N* = 6)			
Pre	16.5	9.1	−1.3
Post	15.2	7.5	
GAD-7 (*N* = 6)			
Pre	13.0	3.4	−3.5
Post	9.5	5.8	
PHQ-9 (*N* = 6)			
Pre	14.5	6.2	−2.5
Post	12.0	6.3	
WHO-5 (*N* = 6)			
Pre	24.7	11.4	13.3
Post	38.0	28.9	

helpful that 'things were framed as invitation so there isn't a pressure to do it; [this is] helpful for people with depression due to negative thoughts' (P3, 26). One found that 'setting the stage' was 'too risk averse' (P2, 931), with a danger of the 'mood dropping in the group' (P2, 945)—'it sets the tone that it is dangerous' (P2, 951). The same person suggested that it is 'useful to present the artwork as challenging but fun and opening' (P2, 951). They also offered useful suggestions for practising in between sessions: 'Would be useful to do practices between sessions' (P4, 876), such as 'movement' or 'drawing demonstrating your mood' (P4, 861), 'drawing your movement' (P4, 883), 'diary' (P5, 869) and 'mindfulness' (P3, 888). Participant 4 suggested that engaging in tasks in between sessions 'maintains connection to the group' (P4, 866), while Participant 3 suggested that it 'keeps expressive part alive', supporting service users to engage in 'practice they can take beyond the group' (P3, 886).

They also commented on the use of the **goal**: 'Small goal [was] helpful for the workshop' (P6, 108). One suggested that she needed more time to work on her goal: 'Did not feel settled in the body to notice where the goal was located in the body' (P4, 385), but found it important to return to the goal at the end when working with people with depression as 'evidence that this is working (e.g. body feels more settled, I feel better)' (P4, 407). She also added that this was particularly relevant because 'people with depression often think "it is not going to make any difference"' (P4, 439).

Staff participating in the workshop also found several components of the work helpful, identified areas that needed further work and made useful suggestions. Their comments were thematically grouped under active engagement, learning skills, expressing emotions and developing relationships.

Regarding **active engagement,** they commented on the movement work, the art and the combination of these with talking. Similar to comments from service users, they found it useful that the body scan was done in motion: 'Glad to stand up for the body scan as it helped to move around' (P3, 308). Offering a choice of sitting or standing was flagged up by another as a further consideration for the facilitators ('Asking to stand up during body scan rather than giving a choice and then others were standing so it was more difficult to sit down' [P6, 271]) because 'people with depression might prefer to follow rules and might be people pleasing' (P4, 283). Summarising her experience of the use of movement, Participant 3 suggested that 'Movement [is] good for working with depression – uplifting and moving away from comfort zone' (P3, 313).

Value was also placed on the use of drawing: 'Drawing is private and safe; nobody knows what it is' (P4, 698). However, one of the participants warned that, 'Pressure to having to come up with an image leading to not being able to do this and feelings of inadequacy' (P6, 116), while another suggested that any discomfort can be visualised in the art form: 'Use art to picture this; acknowledge this rather than avoid it' (P2, 185). Combining the two modalities was regarded as helpful too. For this participant, while she was drawing, 'shifting positions helped [her] to relax' (P4, 206). The same participant, however, also warned that 'people with depression may struggle with engaging initially' (P4, 206).

In all cases, the need to support service users to engage and **learn** relevant **skills** was introduced with particular reference to the use of movement. In the first instance, one of the participating staff argued that, 'Closing eyes was helpful not to feel conscious to be viewed by others' (P3, 374) and 'helps with feeling connected to own space' (P3, 383). She suggested that 'It can feel a threat if you said to people you are going to be doing movement in the next hour' (P3, 228). Another suggested that, 'movement can be odd and scary' (P6, 111), while a third suggested that movement can trigger people to think '"I can't do this" as opposed to being free and open' (P4, 198). Other suggestions included the introduction of a 'nice physical ice breaker' (P4, 1075) such as '[saying] your name with movement' (P6, 1081), which can take the form of saying one's name, being shy and covering the face (P6, 1088).

Using visual arts to **express emotions** was also discussed. Participant 6 suggested that, 'Art can be freeing and allow inner child to come out' (P6, 140), while another warned that, 'When drawing you feel out of control and if you go with that process you may end up feeling vulnerable' (P3, 249).

Combining art forms was also highly valued by participants, who argued that combining movement with art can support the expression of feelings ('Moving the experience "I can't do it" and drawing it could be a movement in itself and then talk about it; helps in expression of feelings' [P4, 220]). Even more help with expressing feelings could be provided with a combination of moving, drawing and talking (P4, 220; P1, 609).

Supporting new groups to 'explain how they are feeling and building trust' (P6, 678) was flagged by one of the participants, while another proposed that, 'Being an observer with benign curiosity, not intruding or wanting to know more, is a good model for working with depression' (P4, 727). At the same time, another participant flagged the value of sharing experiences verbally: 'Sharing is really important for people with depression, empowering, as it might be the only conversation they had all day, being seen' (P2, 720). For this to happen, they need to '[create] a safe space for people… so they share comfortably with each other; they are likely to come back if it feels safe' (P5, 641). Participant 4 argued that this can be done more easily if they shared in pairs first, before being invited to share with the whole group (P4, 713). In all cases, however, it is important that they share only what, and when, they feel comfortable to share and that they have permission not to share verbally at all (P6, 662, 668).

Another theme discussed by the staff participating in this focus group was the **development of relationships**. Their discussion centred on pair work bringing to the foreground that, 'learning that somebody has similar feelings helps in feeling less alone' (P5, 631), a discovery that is particularly relevant for people with depression. During the workshop, they flagged the limited time they had to share with others (P6, 770; P1, 765; P5, 772; P4, 774) and proposed that it could have been easier to share with one person '"that was alright" rather than sharing in front of others' (P6, 678).

The final topic that participants discussed in this focus group was the use of measures. Some claimed that the IAPT measures, that is the PHQ-9 and GAD-7, felt 'like a bit of constraint as sleep and appetite would not change in one workshop' (P3, 566), with others agreeing with this (P6, 577). They did, however, acknowledge that these measures can be meaningful over the course of a greater number of sessions (P3, 571). One of the participants commended on PANAS, suggesting that it was 'more meaningful to measure feeling states than GAD-7/PHQ-9' (P4, 414). In all cases, there were arguments that service users should be able to take copies of these measures home as a reminder of their improvement, as those with depression may have difficulties with their memory (P2, 535; P2, 541). As one participant stated, 'It is an evidence and you can't deny it' (P2, 546). Other participants suggested that one can chart their own progress: 'you can see shifts and changes' (P4, 552) and 'countering the negative thinking' (P3, 560).

Despite the limitations of the use of these measures in this context, the participants' own scores also changed for all measures, as shown in Table 3.

There was a reduction in symptoms of depression on the PHQ-9 and anxiety on the GAD-7. There was also a decrease in scores on the negative feelings subscale on the PANAS measure, and an increase in positive feelings. Similarly, there was an increase in scores on the WHO-5 measure, indicating improvements in well-being. Two of the scores stand out in this case: the decrease in anxiety scores on the GAD-7 by 3.5 points and the decrease in negative feelings post-workshop on the PANAS measure by 5.2 points. It is also worth noting that there was a change in achieving the workshop goal of 3.3 points.

TABLE 3 Pre- and post-workshop scores of staff (all $n = 6$)

	M	*SD*	*M* score diff.
Personal goal attainment			
Pre	2.8	1.6	3.3
Post	6.1	2.4	
PANAS positive affect			
Pre	30.3	7.5	2.7
Post	32.9	6.9	
PANAS negative affect			
Pre	17.0	3.7	−5.2
Post	11.8	4.0	
GAD-7			
Pre	6.3	2.9	−3.5
Post	2.8	2.1	
PHQ-9			
Pre	4.1	2.0	−0.2
Post	3.9	1.9	
WHO-5			
Pre	57.3	14.7	8.0
Post	65.3	9.4	

4 | DISCUSSION

This study aimed to identify helpful and unhelpful aspects of a creative workshop offered at an IAPT service in the North West of England. A number of important components of the Arts for the Blues model were identified. As a model that encouraged participants with depression to '**actively engage'** in artmaking processes, it was received positively by both service users and staff for the vitality it generated, which is important when working with depression. Since people with depression are often perceived as lacking vitality and energy (NHS, 2022), 'recharging one's batteries' is an important first stage before any further work can take place. The relationship between active engagement in artmaking and vitality has been discussed in the published literature. Karkou et al. (2019), for example, talk about embodiment within dance movement psychotherapy and argue that active engagement in movement creates immediate emotional shifts and generates vitality for people with depression. De Witte et al. (2021) also refer to vitality as a by-product of embodiment, an important therapeutic factor for all forms of creative psychotherapy. Similarly, Haire and MacDonald (2021) talk about 'humour' in music therapy, Persons (2009) about enjoyment in art therapy and Koch et al. (2007) about joy in dance movement therapy, both prerequisites and outcomes of active engagement in artmaking. Encouraging active engagement is one of the key ingredients identified in the Arts for the Blues model (Omylinska-Thurston et al., 2020). Links between active engagement and behavioural activation, an effective component in CBT for depression (Ekers et al., 2014), have already been made, encouraging depressed people to reconnect with activities that provide positive reinforcement.

This active engagement, however, does not always come easily. As service users and staff reported in this study, it can generate fear: the fear of movement or kinesiophobia (Shim et al., 2017) or, in the case of the visual work, the fear of the 'blank page' (Chilton, 2007), both of which were raised by service users and staff in this research. It is possible that the combination of art forms within sessions can meet different preferences for art media, as reported by service users and the general public in recent studies (Millard et al., 2021). Combining art forms can also, as Natalie Rogers (1997) argued, offer new and useful perspectives on the issues explored.

The use of different art forms in the workshops in this study also led the service users to highlight the value of acquiring practical skills in artmaking processes. As some participants attended arts and crafts groups, they asked questions about the use of gesturing, posturing and movement at the same time as appreciating the value of learning how to use different art media. Art psychotherapists have long debated the difference between teaching and therapy and have drawn clear lines between these two practices (Karkou & Sanderson, 2000, 2006). Differentiating between an emphasis on the process (therapy) and product (teaching) is an important distinction, drawing clear distinctions between the focus of attention in each case and the associated professional boundaries. However, since, in our emerging model, we used multiple art forms to meet different needs and offer different perspectives, and given the value placed on gaining practical skills by service users, we adopted '**learning skills**' as a key ingredient in the Arts for the Blues model (Omylinska-Thurston et al., 2020). This ingredient is not only limited to learning skills that advance artistic repertoire and artistic vocabulary, but also to learning skills with direct psychological value such as breathing exercises to regulate anxiety, mindful practices to become aware of one's body-based feelings, grounding activities to bring someone into the here and now, imagination to create a safe space and artmaking to safely offload distressing feelings. As argued previously (Omylinska-Thurston et al., 2020), this ingredient is essential when working with depression as learning skills help clients to challenge negative beliefs about themselves, including self-criticism and sense of worthlessness, which can lead to improved mood. Learning skills for emotional expression can also help with dealing with difficult emotional states which are also common when working with depression (Gautam et al., 2020).

Both service users and staff placed value in '**developing relationships**', but acknowledged that the workshop was not long enough to do this. There is a substantial body of research identifying the therapeutic relationship as a fundamental aspect of therapy which facilitates change across therapeutic modalities (e.g. Norcross, 2011; Hubble et al., 2003). Developing relationships is also one of the key ingredients in the Arts for the Blues model (Omylinska-Thurston et al., 2020). In addition, service users already knew each other from their engagement in the arts and crafts group taking place in the same setting; it seemed that a brief workshop could not add further knowledge and understanding about each other above what they already had. For staff, being talking psychotherapists who understood verbal one-to-one interactions, developing relationships through artistic group interactions may not have been of apparent value in relationship building. Either way, it was apparent that a longer intervention was needed to allow for deeper relationship building. Within the Arts for the Blues intervention, we encourage clients to link with each other and with the group as we understand the importance of developing relationships, especially when working with depression where there is tendency to withdraw socially. By developing relationships, clients have an opportunity to challenge their negative beliefs (often linked with social interactions), feel supported and regain their vitality and engagement with life, all of which lead to improved mood (Ekers et al., 2014; Gautam et al., 2020).

It was also apparent for both service users and staff that creative engagement could allow for '**emotional expression**' in immediate ways, which is also a key ingredient of the Arts for the Blues model (Omylinska-Thurston et al., 2020). Study participants considered ways in which emotional expression can take place safely, with service users advocating for a more immediate engagement with the arts, while staff debated how to balance risk-taking with safety. Staff, in particular, talked about the value of each of the art forms separately and in combination to contributing towards emotional expression. Feelings of sadness, guilt, anger, and anxiety are very common in depression. Emotional expression is one of the key aspects in art psychotherapies (Karkou & Sanderson, 2006). Offering a safe and structured opportunity to access and express these feelings can lead to cathartic expression and a sense of experiential relief. From the person-centred perspective (Sanders & Hill, 2014), emotional expression can also lead to exploration of conditions of worth, challenging negative self-image and dissatisfaction with life. Through this work, clients can become more self-aware of their needs and feelings, which can result in them readjusting their lives, leading to improved mood and well-being.

Another important point made by service users was the role of the environment in supporting creativity. Rollo May (1975) talked about preconditions for creative engagement, including not only a lack of judgement and a sense of safety, but also the presence of a suitable physical environment. Although this seems a minor point from the point of view of therapeutic models, this issue should be considered in a creative intervention such as this, and was also highlighted as a therapeutic factor in creative psychotherapies by De Witte et al. (2021). Working in the public sector often involves working in old and uncomfortable environments due to a lack of funding and resources. Old chairs and small spaces can often be uncomfortable to sit in for long periods, which can be especially difficult for clients with long-term health conditions. Additionally, working in these environments can add to a sense of feeling unworthy and uncared for, which can perpetuate feelings of low mood associated with depression.

Supporting the views of over 60% of the participants in the survey of service users and members of the public who value creative methods in psychotherapy (Millard et al., 2021), the service users participating in this study also championed the need for creative psychotherapies in the NHS. It could be argued that the group of service users in this study, as a self-selected convenience sample

that were already attendees of an arts and crafts group, could skew the findings presented here. However, it is also possible that their prior experience allowed them to have an informed and clear opinion about the value of creative psychotherapies in the NHS, leading to diverse provision as a way of meeting the needs of service users such as those included in the study. This will also have implications across the whole mental health sector, including other contexts such as charities and schools, as there is very limited provision of art psychotherapies in general.

Staff participating in this study were also interested and well informed, offering useful suggestions of how to improve the therapeutic framing, the goals and the intervention itself. By shaping the intervention in collaboration with the service users, the resulting model is more likely to be relevant to their needs. Their contribution also offers reassurance that therapists can be trained in the Arts for the Blues model when it is ready for adoption within other NHS trusts (AHSN, 2021).

The quantitative measures used were generally accepted and were completed by 12 of the 13 participants. The PHQ-9 and GAD-7 are used routinely in IAPT services, and as such, despite associated limitations, they were easily accepted. Furthermore, the WHO-5, a short questionnaire consisting of only five items, offered an opportunity for participants to report positive symptoms relating to well-being, highlighting that creative methods do not simply alleviate ill health, but also improve well-being, an important shift in thinking that has already been emphasised in relevant literature (Bech et al., 2003). However, all three measures were designed to capture change over a period of time, and as such, they informed our question around acceptability and sensitivity only while preparing to run a 12-week intervention. Nonetheless, the fact that almost all participants completed these measures (one service user needed to leave earlier than originally planned and did not complete the post-workshop measures) and regarded them easy to complete, suggests that the measures were acceptable. The numerical improvements we saw in most of these self-reported measures post-workshop (particularly on the WHO-5 for service users and the GAD-7 for staff) suggests that the measures were sensitive enough to identify change and thus suitable for a longer group intervention.

It should be noted that both the PANAS and the personal goal attainment measure were perceived to be important measures since they captured positive/negative affect and goal attainment, respectively, at the time of their completion. The PANAS, for example, showed that there was an increase in positive feelings post-workshop and a decrease in negative feelings for both service users and, especially, members of staff. The PANAS was also regarded as being particularly meaningful given the one-off nature of the workshop, but also because of the fresh perspective it offered.

Staff commented on the use of goals, for which they also indicated a substantial change post-workshop. This, along with the other measures used, was seen by staff as concrete evidence of changing patterns, which may otherwise go unnoticed by people with depression.

Finally, the staff's high change scores on these measures (in particular, a decrease in anxiety and negative feelings) suggested that this creative intervention was useful for them too. Although the workshop was offered to staff as an experience of what service users would be offered, we considered an additional line of inquiry developing an adapted version of the Arts for the Blues for NHS staff affected by the COVID-19 pandemic. It became important that their well-being was also attended to, not only within IAPT services, but also within the NHS in general (Karkou, Sajnani, et al., 2022), speaking directly to the BACP Ethical Framework that regards self-care as a professional imperative.

5 | CONCLUSIONS

The small feasibility study reported in this paper provides useful and largely positive feedback from both service users and staff on the use of creative methods in psychotherapy within the context of IAPT services. The helpful factors explored in this study, which transformed into key ingredients of the Arts for the Blues intervention, included active engagement, learning skills, developing relationships and expressing emotions, which constituted four of the eight ingredients of the model. The additional four ingredients of Arts for the Blues such as processing at a deeper level, gaining understanding, experimenting with different ways of being and integrating useful material were also identified and included in the model (Omylinska-Thurston et al., 2020; Thurston et al., under review).

The measures used had limitations due to the short duration of the one-off creative workshop, but still captured change, suggesting that the tools were sensitive enough to do so. However, a longer intervention is needed to generate more meaningful numerical data relating to the capacity of the intervention to positively change scores on depression, anxiety, well-being and positive/negative affect measures. In all cases, the measures appeared easy to complete and were acceptable, capturing changes both in the decrease in negative symptoms and the increase in positive feelings.

This study contributed to the development of the Arts for the Blues intervention for people with depression prior to establishing its effectiveness through a pilot RCT, as recommended by the MRC (2006) for research on complex interventions. However, other unexpected results also transpired. For example, staff also appeared to benefit from the workshop, leading to further research in this area will complement current studies on self-care for mental health professionals that often focus on individual interventions. A group intervention would add a level of social support and encourage self-care amongst busy professionals.

On the whole, the creative workshop was received very well, suggesting that the Arts for the Blues, a creative intervention rooted in primary care and shaped for people with depression and staff from IAPT services, may be a suitable psychological intervention.

As one participant put it:

'I definitely felt a change which enthused me, but it was not in my awareness/how I was thinking about change' (P4, 414). She later

added: 'even though the world did not change, I feel better about facing it' (P4, 530).

If this is an outcome from a one-off workshop, it is highly likely that a full psychological intervention can result in important changes in the lives of people with depression and is worthy of future development and research.

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Kerry Nair currently works as a senior counsellor and supervisor in South Manchester IAPT, part of the Greater Manchester Mental Health NHS Trust. She offers a person-centred approach when engaging in a therapeutic relationship with a client. However, she also offers the use of creative media with her clients such as the use of art materials; miniature figures and objects; psychodrama chair work; and working with emotions in the body using mindfulness techniques. Kerry facilitates mindfulness groups within the service and has also worked alongside secondary care well-being provision to provide art well-being groups for clients. Kerry has completed a foundation course in art therapy.

Jennifer Starkey is a research assistant at the Research Centre for Arts and Wellbeing, Edge Hill University, having been involved in several research projects over several years including the Arts for the Blues project. Jen comes from an events management background and has worked with vulnerable groups in the community before joining Edge Hill University and the Arts for the Blues team. She has also been instrumental in the development of the interactive website for the project for the University of Salford and supported the digital delivery of workshops for the public, training programmes for therapists, and therapy sessions for clients.

Shelly Haslam has worked in the mental health sector for over 20 years, with experience across sectors. Shelly is currently leading several programmes focused on delivering psychologically informed training to the expanding psychological therapies workforce. She has a keen interest in alternate and complementary approaches to addressing mental ill health in adults, in particular within community-based services. She is currently completing a PhD exploring factors affecting intervention implementation in mental health services.

Scott Thurston is a director of the English Language, Literature and Creative Practice Research Group at the University of Salford. He is a widely published poet and critic and is currently researching the relationship between dance and poetry. He co-created the Vital Signs Festival with dancer Sarie Mairs Slee (www.vitalsigns.org) and is the co-founder of the Arts for the Blues project.

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