Creating Transitions: Barriers to Engagement in Creative Health Programmes for Mental Wellbeing

Arts, Health & Wellbeing Centre Showcase Event
5th November 2025

Cath East - Executive Director, Artlift; **Sam Hughes** - Project Research Lead, University of Gloucestershire (UoG); **Ali Coles -** Senior Psychological Therapist/NIHR Developing Research Leader, Gloucestershire Health and Care NHSFT; **Kim Hill** - Senior Project Manager, Art Shape; **Jazmine Parrott** & **Victoria Witherington -** Research Assistants, UoG

Overview of the Project

There is established evidence demonstrating the effectiveness of creative health programmes for people who engage.

Existing Evidence

Enhances quality of life, health and well-being, including for people with multi-morbidity

Increases social connectedness, sense of belonging, purpose and meaning in life, engenders an identity beyond illness

Decreases in anxiety from clinically diagnosable to subclinical

Programmes are not based on diagnostic classification (non-disclosure); attendees are not viewed by their illness labels or anchored to their disability

(Crone et al., 2018; Hughes et al., 2019; Redmond et al., 2018; Sumner et al., 2019; Sumner et al., 2021)

Artlift

Art Shape

Despite the acknowledged benefits of engaging in creative health programmes, a significant number of people who are referred by statutory health professionals to Artlift and Art Shape do not engage.

Identification of Non-Engagement

Aims of the Project

The Creating Transitions Project aimed to understand more about the barriers to engagement by addressing the following research questions (RQ):

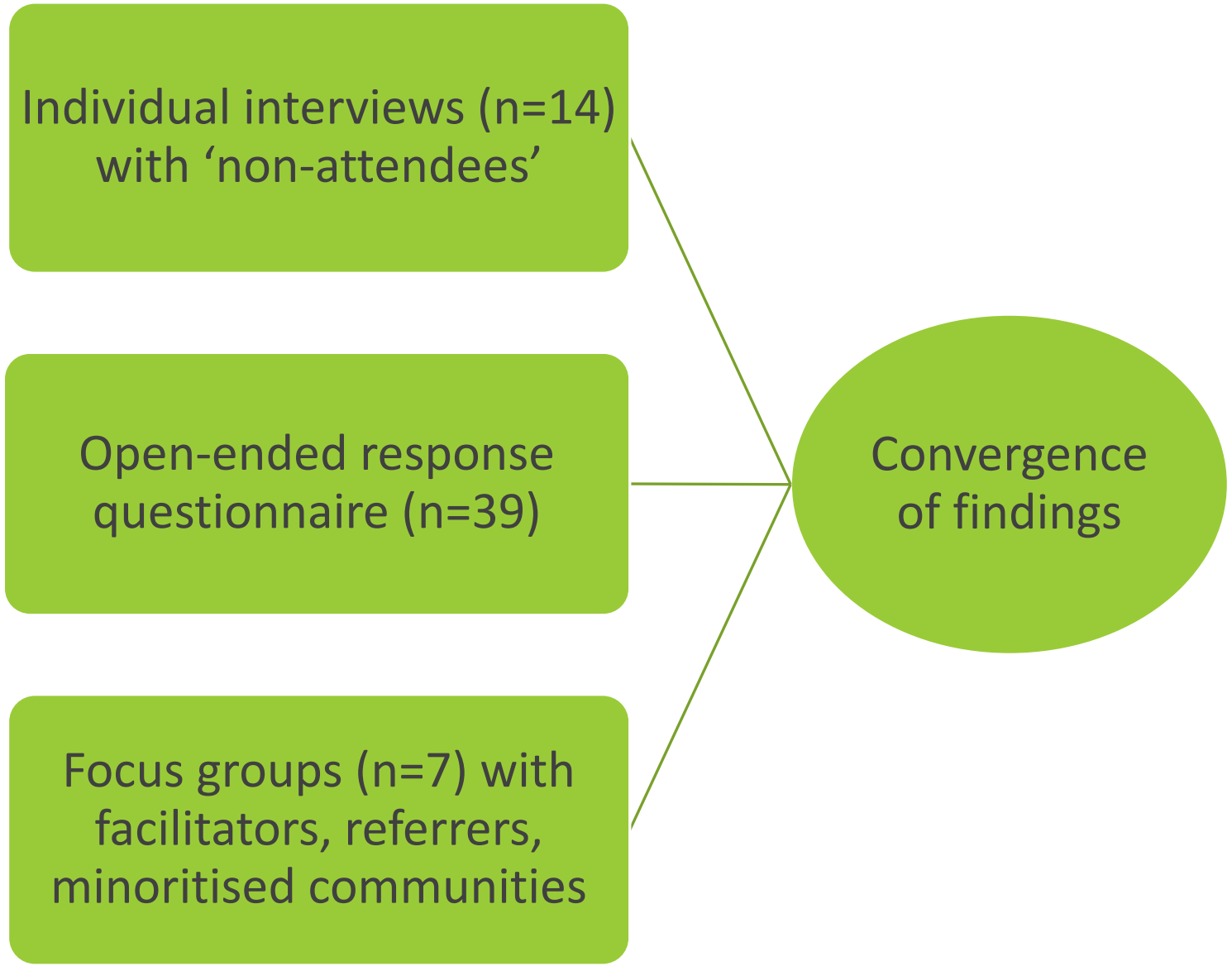
1. *What are the barriers preventing adults from engaging in creative health programmes?*
2. *How can we more seamlessly support the transition into creative health services?*

Methods

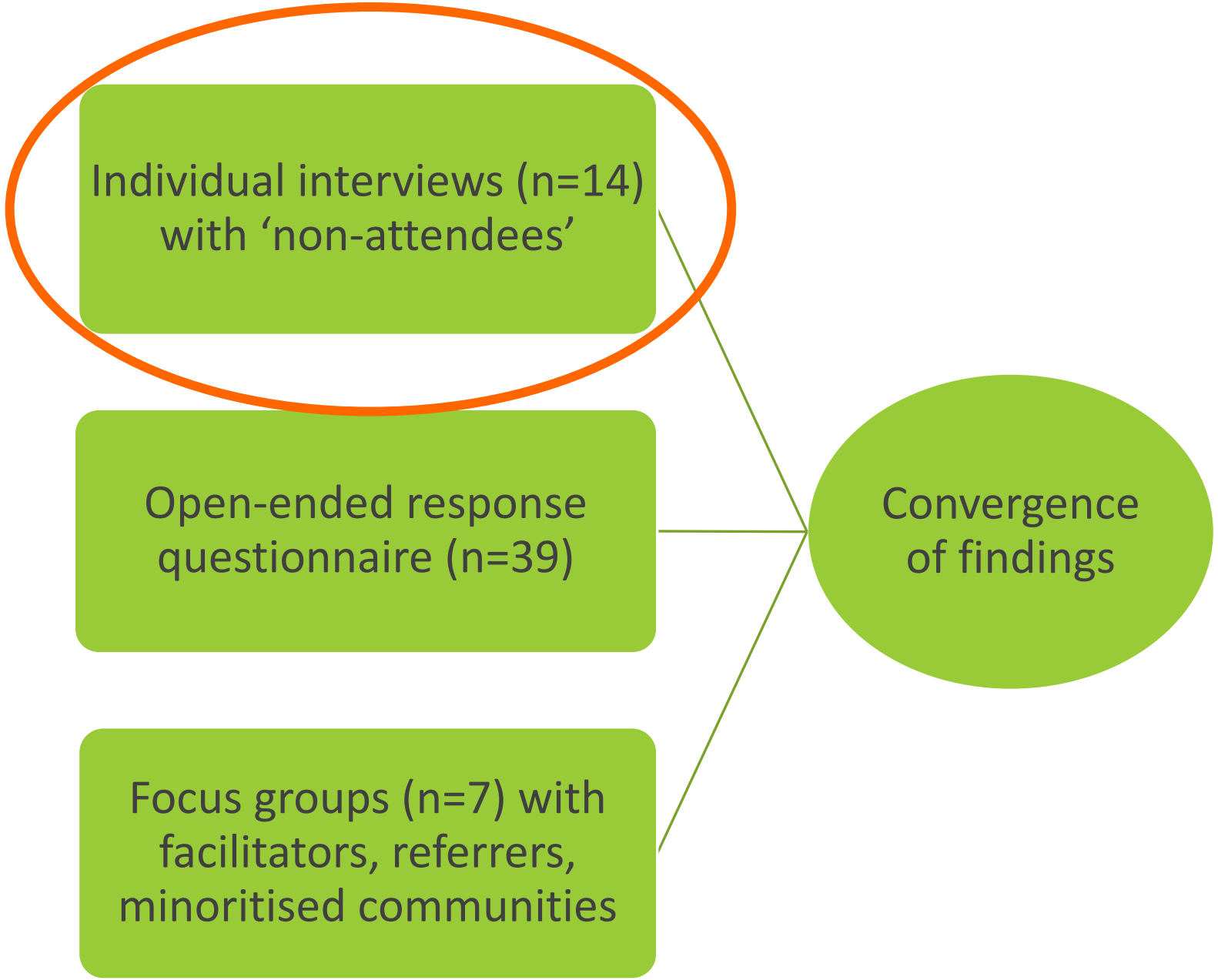
Qualitative multi-method design.

Thematic analysis to analyse the data.

Data from each method is analysed individually. The findings from each are then brought together to consider the findings as a whole.



Interview Findings



Interview Findings

Accommodating diverse needs	Accessibility challenges	Fear of the unknown	Communication and administration	Group dynamics
Some participants expressed that there was only a limited choice of activity available to them, particularly in comparison to their preconceived expectations.	Some participants found it difficult to attend sessions due to the course locations, their life circumstances or their physical/ mental health.	Some participants expressed anxieties about perceived judgements from others, and not knowing what to expect from the course/ venue.	Some participants felt that there was a long wait between initial contact and starting a course, with limited communication in-between; this often resulted in feelings of abandonment.	Some participants reported that some other attendees were disruptive or caused them distress.

I struggled with the art, I'm not arty farty.

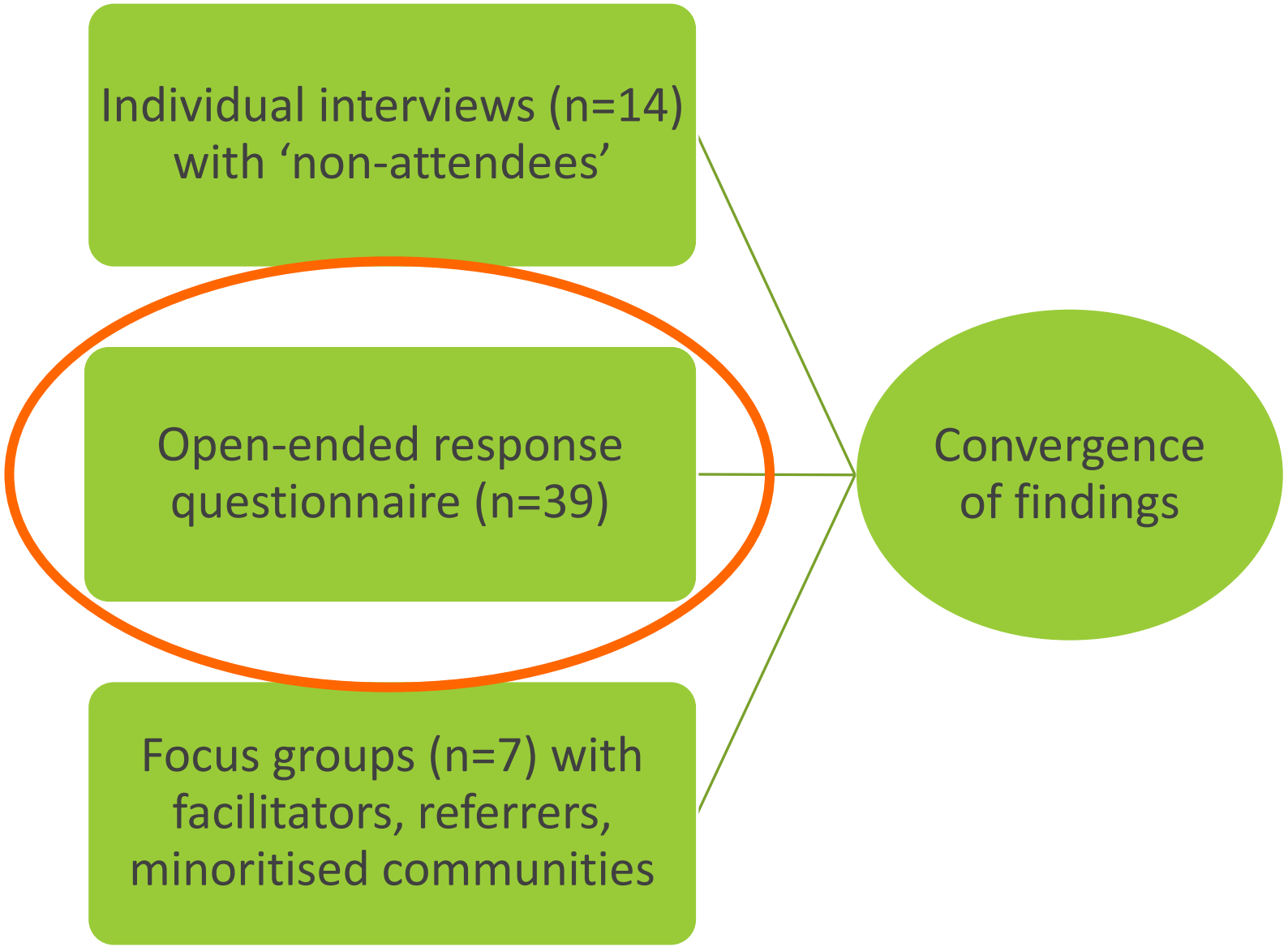
She said we haven't really got anything in your area.

Will the others like me? What if I can't find the place?

I was waiting a long time - November until April.

A girl said she had cancer, she didn't, I [have], it upset me

Questionnaire Findings



Accessibility challenges	Fear of the unknown	Communication and administration	Meeting access and cultural needs
Accessibility challenges represented the most reported barrier. Some found it difficult to attend sessions due to course locations, time of day or life circumstances and physical/ mental health also featured within this theme.	Some participants expressed anxieties regarding the venue, specifically not knowing what amenities were available and whether these would meet their needs. Fear of attending the course for the first time on their own was a significant barrier as well as perceived judgements from others.	For some there was a long wait between initial contact and starting a course, with limited communication in-between. Some would have liked more information regarding the venue, travel and accessibility, course content and the aims of creative health more generally.	Some participants perceived a lack of understanding, information and/or provision in meeting their access and cultural needs. As such, some participants expressed that they did not feel safe to disclose their access or cultural needs.

Courses are quite often far away from where I live

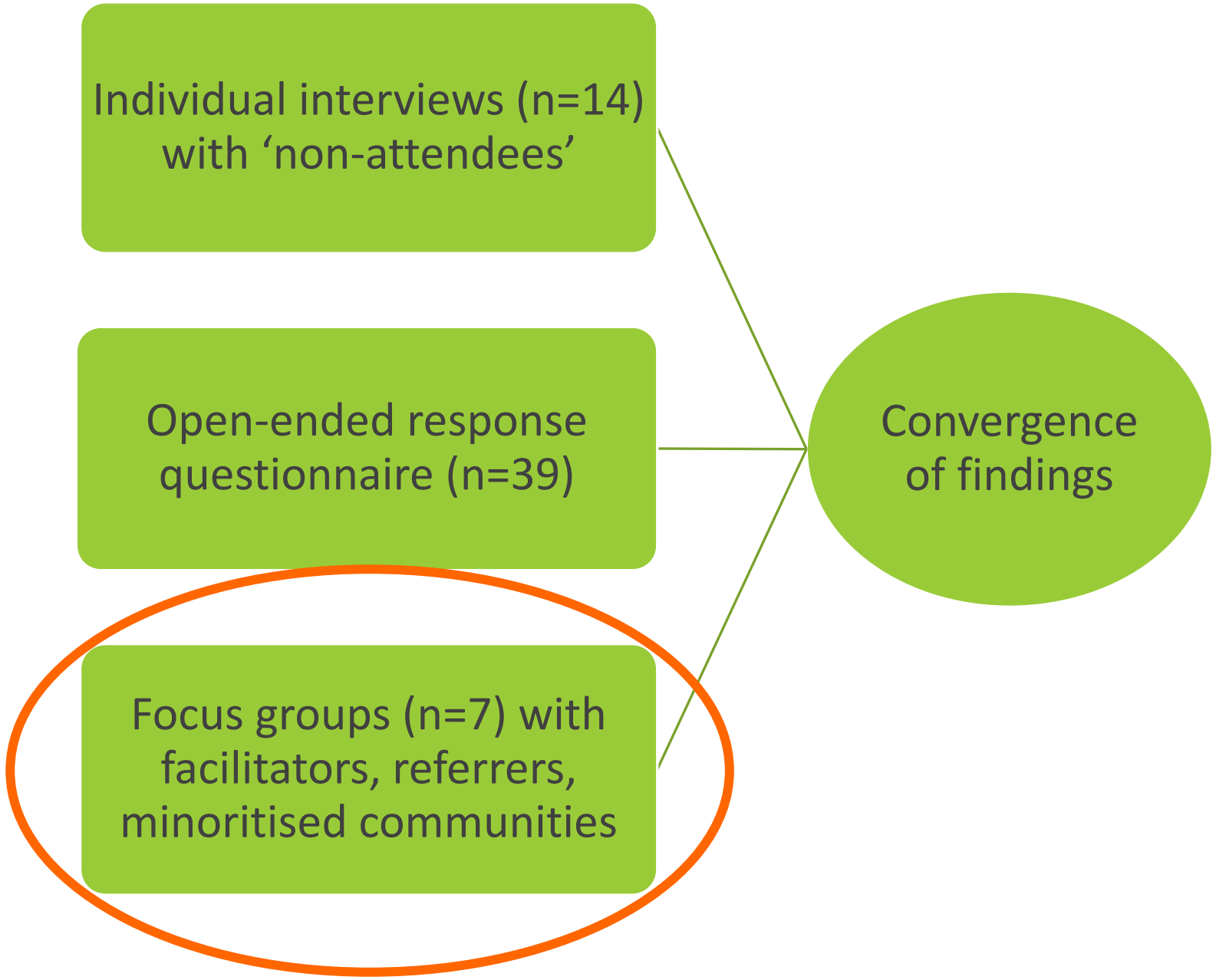
I was anxious I'm not very good around other people

It felt like a long wait to know when I'd get a place on the course

I'm not sure they ever have understood my cultural requirements

Questionnaire Findings

Focus Group Findings



Theme	Sub-theme
Complexities of creative health referral process	Difficult to understand referral processes
	Difficult to understand the person's needs/motivation
	Comprehending the (in)eligibility of referrals
Contact and communication	Information giving - not enough/ too much/ unclear/ complex (off putting)
	Information gathering - inaccurate/ missing details/ lack of follow-up information
	Expectations, knowledge and awareness (not aligned/different)
	Referral form (wording could be refined and/or more specific to encourage patients to provide more detailed information)
Accessibility challenges	Travel and associated costs
	Time and location of course
	Physical and mental health
Fear and anxieties of the unknowns	What to expect from the venue
	Judgements from others

Focus Group Findings: **Referrer/Referrer Processor**

Theme	Sub-theme
Communication	Understanding the needs of and getting to know participants
	More communication needed between all involved - referrers, internal communication, communication with patients
It's just not the right time	Not the right time for participants to start, they're either not ready or something else gets in the way
	Location problems
Illness and personal circumstances	Illness as a barrier
	Personal barriers interfering with the course
Other people on the course	Other participants as a barrier to course attendance

Focus Group Findings: **Facilitator**

Theme	Sub-theme
Accommodating a diverse range of needs	Communication needs
	Participants expectations/pre-conceptions
	Facilitator needs awareness
Accessibility challenges	Challenges with referral forms
	Making information accessible for all
	Venue accessibility
Fear of the unknown	Commuting fears
	Venue fears
Referral challenges	Complex

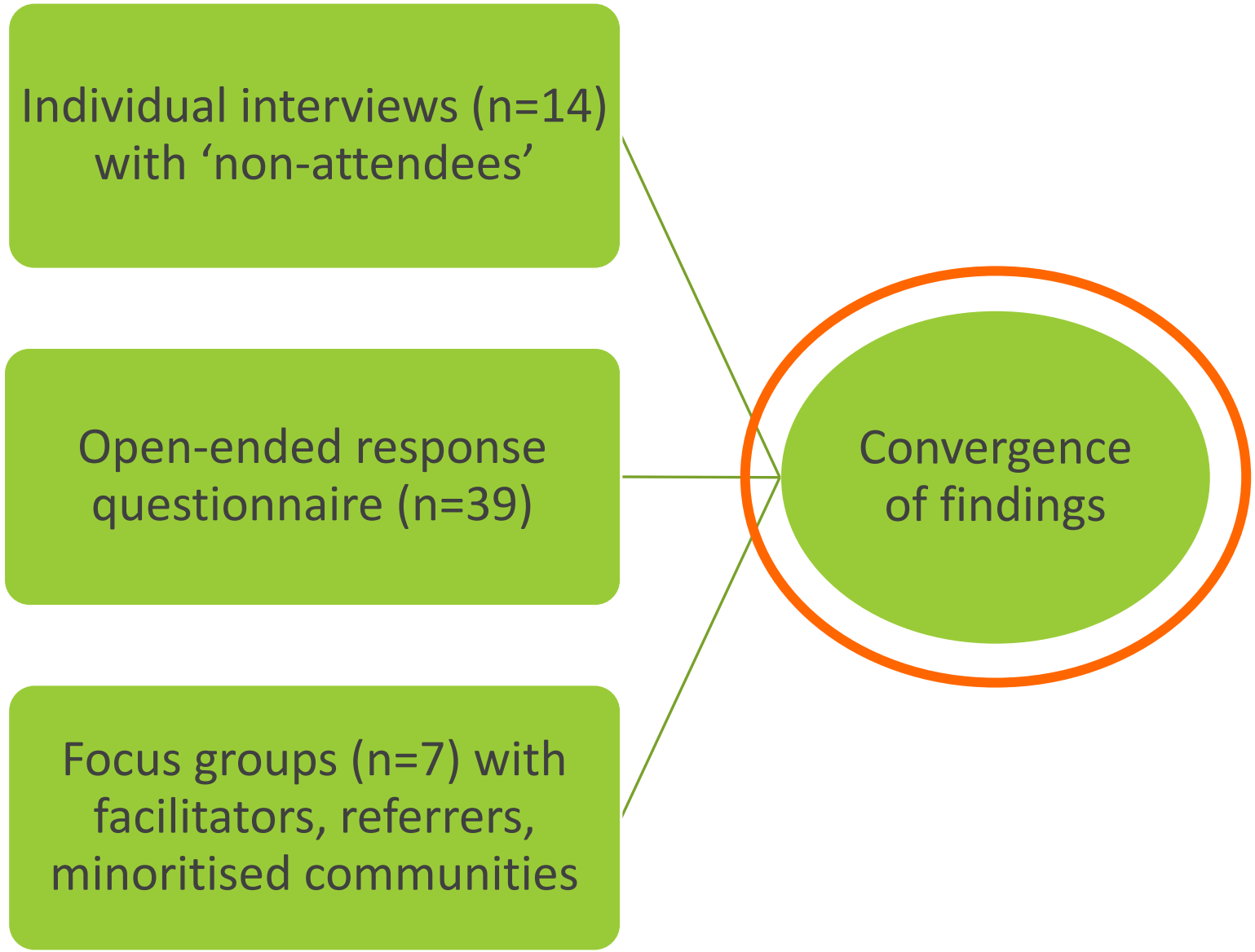
Focus Group Findings: **Disability**

Theme	Sub-theme
Making sure everyone knows	Spreading the word and the need for more advertising
	Importance of taster sessions
	Making sure health providers know
Accommodating a diverse range of needs	Group accommodations
	Accommodating varying availability and travel situations
	Language accommodations
	Cultural/religious accommodations
Stigmas around doctors and mental health	Stigmas around doctors/GPs
	Stigma around mental health
	Building trust
Accessibility challenges	Making information accessible for all
	The importance of clarity
	Access to support
Ensuring inclusivity for all	Facilitator awareness
	Organisation awareness
Fear of trying something new	Individuals' anxieties

Focus Group Findings: **Minoritised by Ethnicity**

Bringing it all Together

Initial Converged Findings



Converged Findings: Recommendations

Clarity and transparency of information in an easily accessible format

Visibility of CH services and communication around programmes and processes

Continue investment in awareness/expertise around, and accommodation of, specific access and cultural requirements

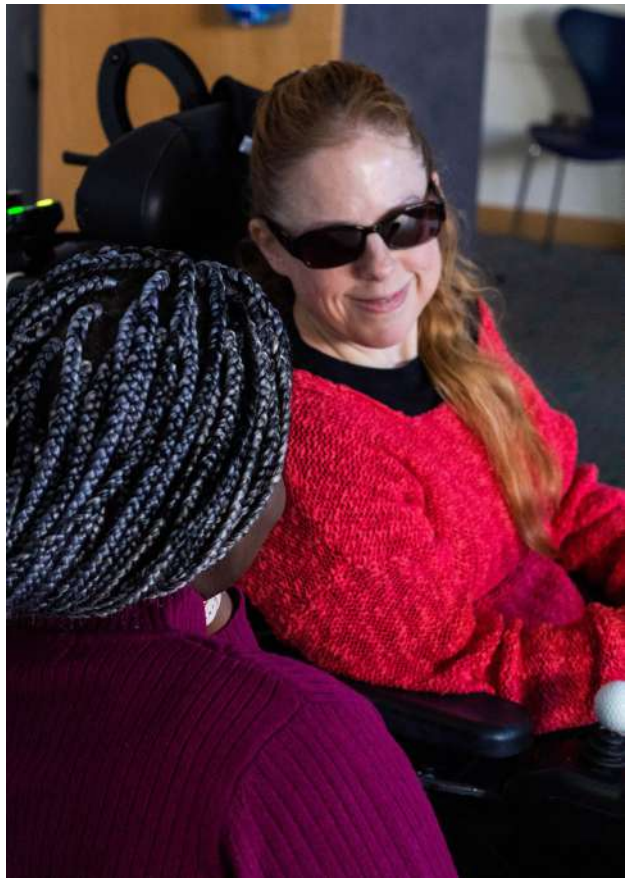
Recommendations: Information

- Better clarity around what Creative Health is (work with Consortium on awareness)
- Increase resource to keep information fully up-to-date (e.g. website)
- More consistent use of video walk throughs, including Facilitator introduction
- Clearer step-by-step guide re. what to expect and where to find information

Recommendations: Communication

- More up-front information to reassure people they won't be judged (inc. use ex-participant quotes in promo, info. on how group dynamics are managed)
- Make welcome packs more visual/user-friendly (e.g. fridge reminders)
- Explore better alignment of communications between service providers, referrers, and participants
- Review/refine referral processes/paperwork with co-producers
- Increase communication with participants where there's a long wait to start their course

Recommendations: Access and Inclusion



- More up-front information on how CH providers meet access and cultural needs (combat low expectations)
- Work with Experts by Experience on improved referral form (including wording of access questions)
- Combat mental health stigma & misperceptions of the arts / CH
- Continue cross-sector awareness training / sharing of practice
- Continue pilots/ tasters with minoritised communities
- Sustain max. possible course options (scale up where feasible to address geographic gaps and bring down waiting times)
- Sustain maximum possible flexibility to defer / rejoin when ready

Summary

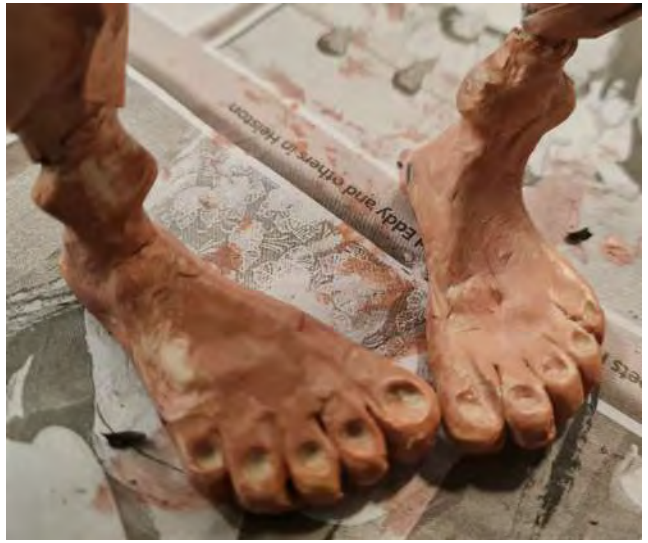
- Regardless of their engagement, participants continued to express the excellent service, provision and programmes that are offered by Artlift and Art Shape. Their dedication to promote inclusivity, their person-centred approach and their caring and understanding approaches were highly recognised and appreciated.
- Barriers were primarily perceived to be around communication challenges, need for clearer, more accessible information, and reassurance needed around access and cultural provision.
- Initial recommendations include the need for clear and accessible information, aligned communication around programmes and processes and continued investment to bring down access and cultural barriers.

Next Steps: Sharing to Date……

- British Psychological Society Department of Health Psychology Conference (Jun ‘25)
- University of Gloucestershire research week (Jun ’25)
- Artlift co-producers’ Arts on Prescription review meeting (Oct ‘25)

- This presentation - AHWC Small Grants showcase (Nov ‘25)!

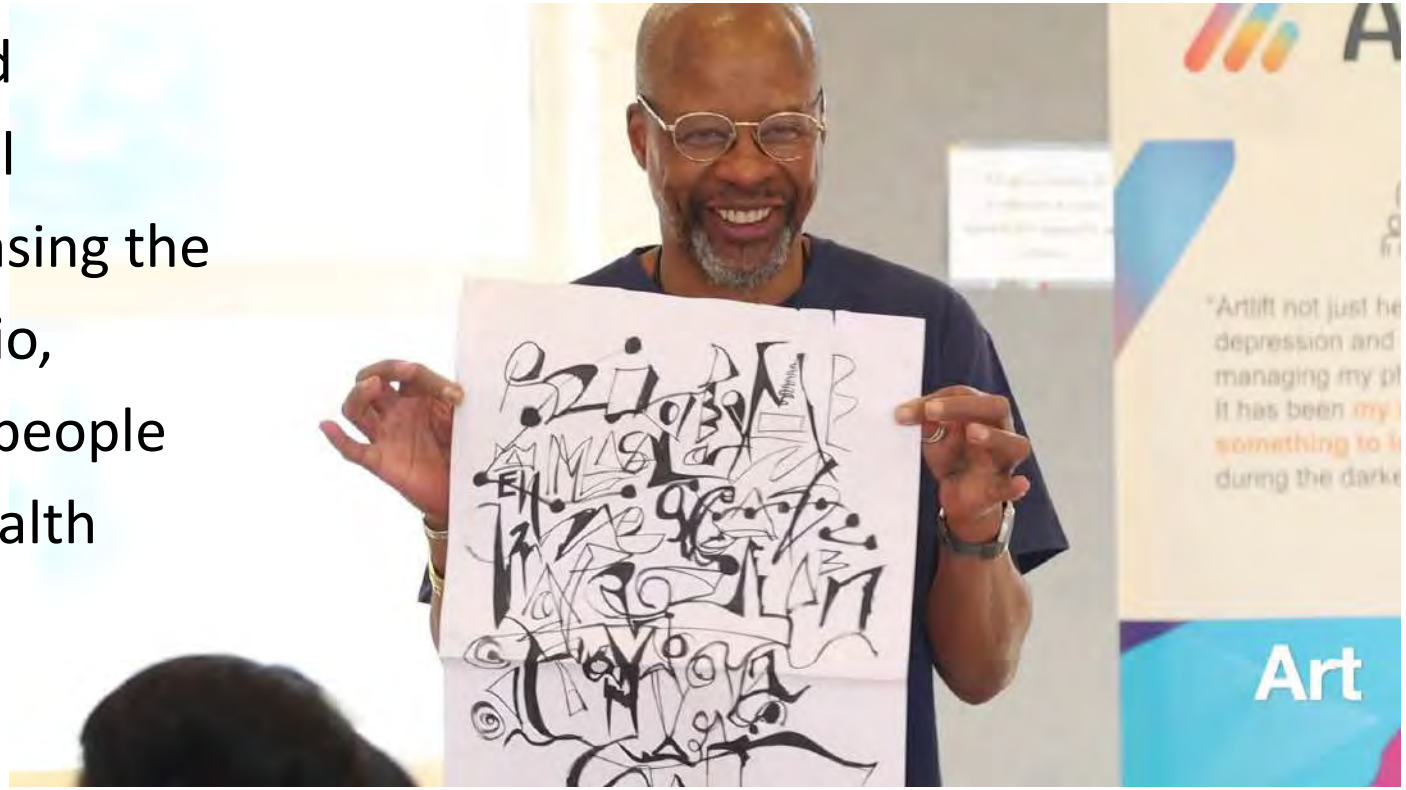
Next Steps: To be Done….



- Further refine and explore response to recommendations - integrate into programme and business planning
- Further share findings – with partners, referrers, investors, Glos Creative Health Consortium, national CH peers
- Explore with partners and commissioners how to bring down the wait in some areas between referral and starting a course
- Further share across Uni of Glos and other academic peers, potentially through publishing in academic journals
- Explore funding to support further co-production research to address Creating Transitions recommendations

Conclusion

The converged findings yield comprehensive and practical recommendations for increasing the ‘referral to engagement’ ratio, potentially leading to more people benefitting from creative health activities.



Psychological Therapy Group for Stroke Survivors: Including Experts by Experience and What Works When

Jessica Silver, Clinical Psychologist

Megan Hampton, Assistant Psychologist

5/11/25

Background

- Community Neurology Service, new GHC service October 2023 – Stroke Rehabilitation
- Some consequences of stroke: social isolation, emotional changes, discrimination, communication, reduced quality of life -> poor outcomes
- Developed a psychological therapy group for stroke January 2024
  - Run by psychologist
  - Online
  - Acceptance and Commitment Therapy (evidenced based therapy for stroke)
  - 8 weeks, handouts

  Issues: Poor engagement, high drop out, right time?, a need to bridge the gap between what we know can help and lived experience

Experts by Experience

The role of the EbE was created as an opportunity to be a co-facilitator of the psychological therapy group.

Responsibilities included:

- Sharing personal experiences of stroke recovery
- Delivering material and facilitating group discussion
- Shaping the content of the group
- Encouraging group participation

The Project Timeline

- Jan 24 – Groups started running
- Spring 24 - Collaboration with ReConnect
- Summer 24 – Research grant
- Sep 24 - Developing EbE co-facilitator role (see poster)
- Jan 25 - Running groups with EbE
- June 25 - Focus groups with EbE
- Summer/Autumn 25 - Initial evaluation

Research Questions

- Does having EbE involvement reduce drop out and increase uptake?
- Does it improve the patient experience?
- Does it improve patient outcomes?

- Is there a difference when the patient accesses the group post stroke?
- How does the EbE benefit from the role?

EbE Focus groups

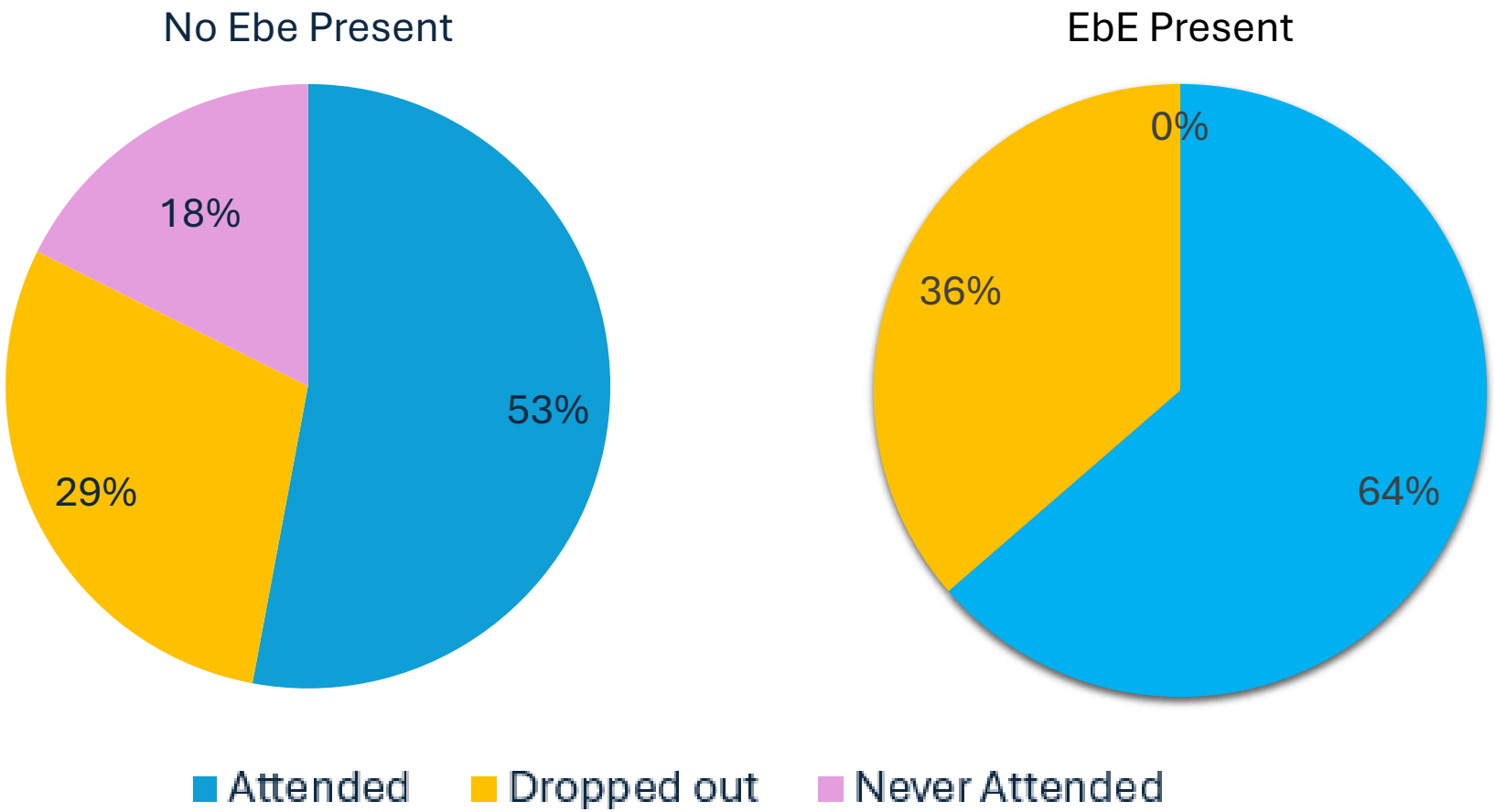
Discussion with 3 EbE's looking at group set-up, materials and themes

- What we learnt:
  - Clarity of information
  - Social connection
  - Building the 'toolkit'

- What we changed:
  - Physical work packs
  - Inclusion of metaphors suggested by EbEs
  - Extension of 'Week 0'

Initial Results

- Does having EbE involvement reduce drop out and increase uptake?



N=48

Does it improve the patient experience?

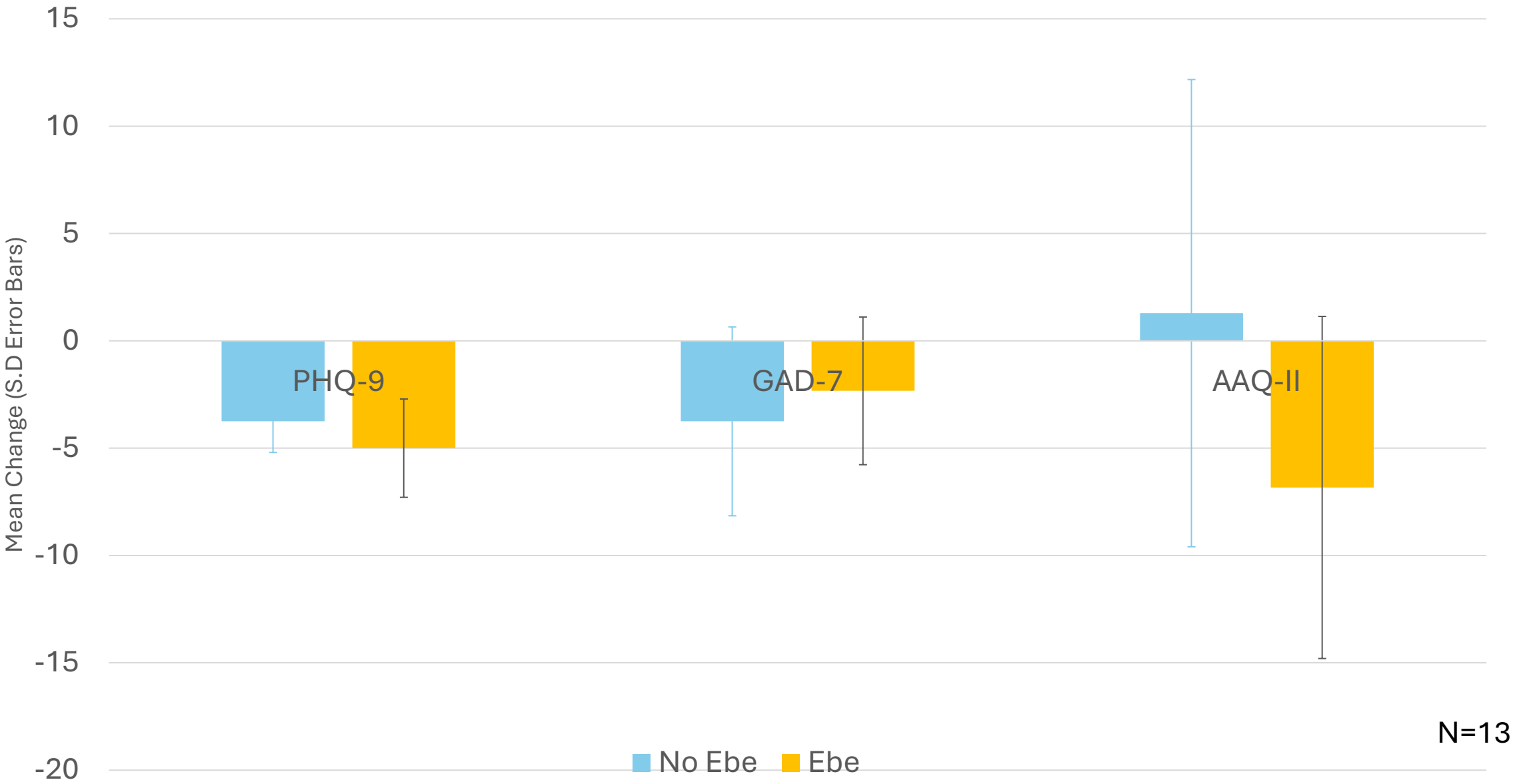
- Did you find it helpful having someone with lived experience of stroke within the group?
- 86% responded yes

N=7

'Gave a true reflection on what happens.'

'Helpful to have ___ who has this experience and is able to talk to us.'

Does it improve patient outcomes?



Benefits for the EbE

'I do feel very positive that so much time is being taken to listen and learn from users of the service. I'm sure that other areas of the NHS could benefit from similar approaches.'

'It was absolutely brilliant. It felt nice to feel valued and that my opinion counted.'

'I have developed ways of communicating that have helped me and I'm keen to pass that on.'

'I think this should be implemented in all avenues of NHS support. Simply being able to share a common issue makes such a huge difference to mental wellbeing. Given a little training this could be a very powerful tool for reform within the health service!'

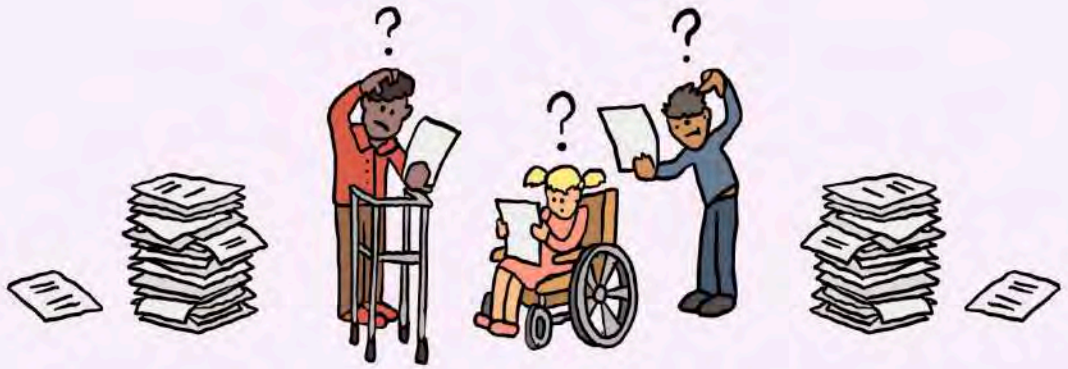
'I have more ambition to reach out online to people, and I have more of an incentive to get more qualifications and become more trained. This has been a step in the right direction for my future.'

Next steps

- Groups running with EbE co-facilitators.
- Initial Service Evaluation: results informing decisions to invest in EbE beyond research project.
- Continue data collection of outcomes and engagement.
  - Re-run analysis on outcomes and engagement.
  - Analysis of impact of timing of intervention.
- Qualitative project ongoing: *Understanding the experience of EbE co-facilitators in the context of their own stroke recovery*.
  - under ethical review
  - recruitment and interviews early next year
- Dissemination:
  - Quality improvement report for submission to Journal of Neuropsychology.
  - Conference presentations.

Acknowledgements

- Our Experts by Experience
- Megan Letch – prior Assistant Psychologist with GHC and now Trainee Clinical Psychologist undertaking Qualitative Project with EBEs
- Ben Kwapong – Clinical Psychologist in CNS running the groups
- Ellie Baldwin – Trainee Clinical Psychologist undertaken interim service evaluation
- Bella Blackburn – previous Assistant Psychologist
- ReConnect Gloucestershire – Coryn, Ged, Paula
- GHC Inclusion Team
- GHC R & D
- Anna Kearney CNS Operational Lead
- Stroke patients past and present



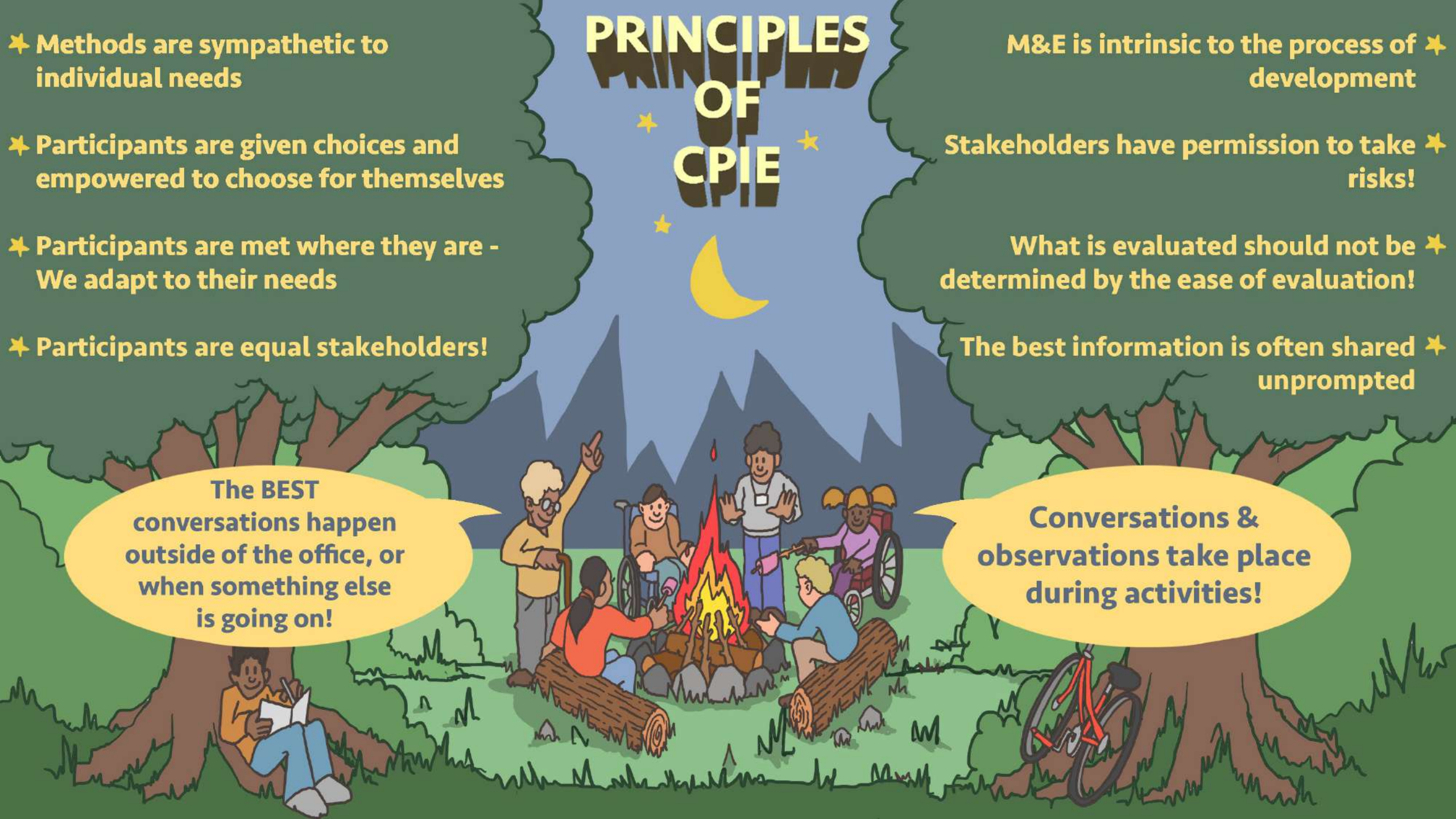
CO-PRODUCED INCLUSIVE EVALUATION (CPIE)

MAKING EVALUATION WORK FOR EVERYBODY


PARTICIPANTS
Meaningful
Compassionate
Personalised
Respectful
Community-Based
Equal Stakeholders
Equitable
Dignified
USEFUL!
COMMISSIONERS
PRACTITIONERS

PRINCIPLES OF CPIE

- Methods are sympathetic to individual needs
- Participants are given choices and empowered to choose for themselves
- Participants are met where they are - We adapt to their needs
- Participants are equal stakeholders!
- M&E is intrinsic to the process of development
- Stakeholders have permission to take risks!
- What is evaluated should not be determined by the ease of evaluation!
- The best information is often shared unprompted



CPIE outcomes

Participants:

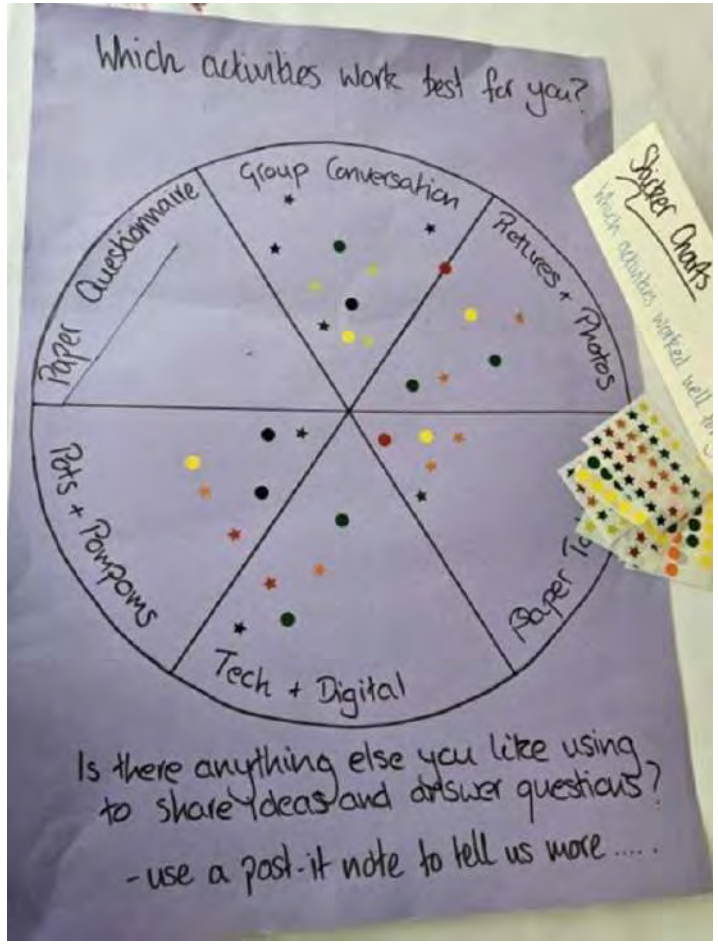
- Are more confident to communicate ideas & thoughts in a wider group
- Are able to recognise their own progress
- Can focus on Evaluation or Self-reflection for longer!
- Are more engaged with their Evaluation Process!

Practitioners:

- Gain a deeper understanding of participants' barriers
- Gain insight into a wider set of skills & confidences
- *Let go* of the ownership of achievements and responsibility
- Do not need to "Fill in the gaps", "Fudge", "Translate" or Work Harder than the Participants!

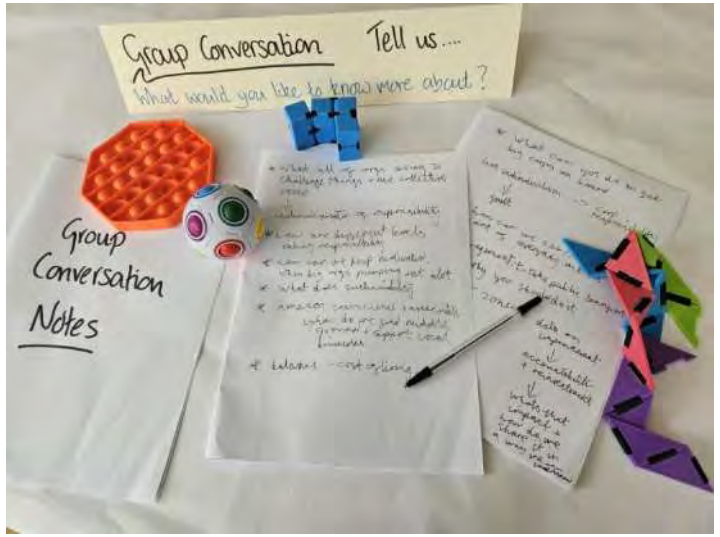
Choice

How do people feel about questionnaires?



Choice

Different ways for people to feedback on outcomes or questions



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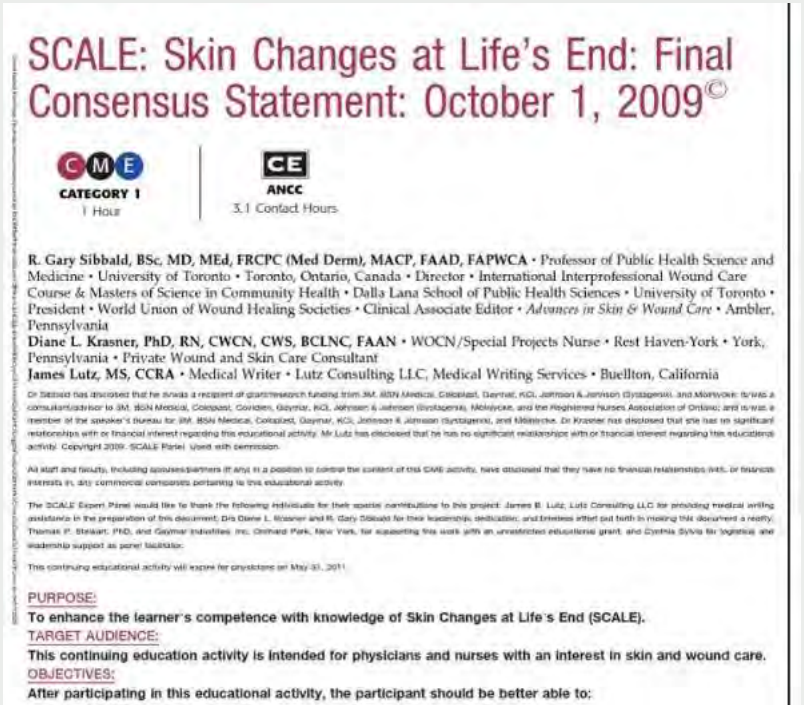
SCALE – PREVALENCE AND CHARACTERISTICS IN GLOUCESTERSHIRE POPULATION

Tina Wnukowska

- Definition of SCALE
- Current national approach
- Data for Gloucester
- Preliminary Recommendations



SCALE: Skin Changes at Life's End: Final Consensus Statement: October 1, 2009©

CME CATEGORY 1 1 Hour | CE ANCC 3.1 Contact Hours

R. Gary Sibbald, BSc, MD, MEd, FRCPC (Med Derm), MACP, FAAD, FAPWCA • Professor of Public Health Science and Medicine • University of Toronto • Toronto, Ontario, Canada • Director • International Interprofessional Wound Care Course & Masters of Science in Community Health • Dalla Lana School of Public Health Sciences • University of Toronto • President • World Union of Wound Healing Societies • Clinical Associate Editor • *Advances in Skin & Wound Care* • Ambler, Pennsylvania
Diane L. Krasner, PhD, RN, CWCN, CWS, BCLNC, FAAN • WOCN/Special Projects Nurse • Rest Haven-York • York, Pennsylvania • Private Wound and Skin Care Consultant
James Lutz, MS, CCRA • Medical Writer • Lutz Consulting LLC, Medical Writing Services • Buellton, California

PURPOSE:
To enhance the learner's competence with knowledge of Skin Changes at Life's End (SCALE).

TARGET AUDIENCE:
This continuing education activity is intended for physicians and nurses with an interest in skin and wound care.

OBJECTIVES:
After participating in this educational activity, the participant should be better able to:

Gloucestershire Health and Care NHS Foundation Trust

Definition

physiological deterioration of the skin due to reduced perfusion and organ failure, impacting patient comfort and care.

with you, for you

NHS
Gloucestershire Health and Care
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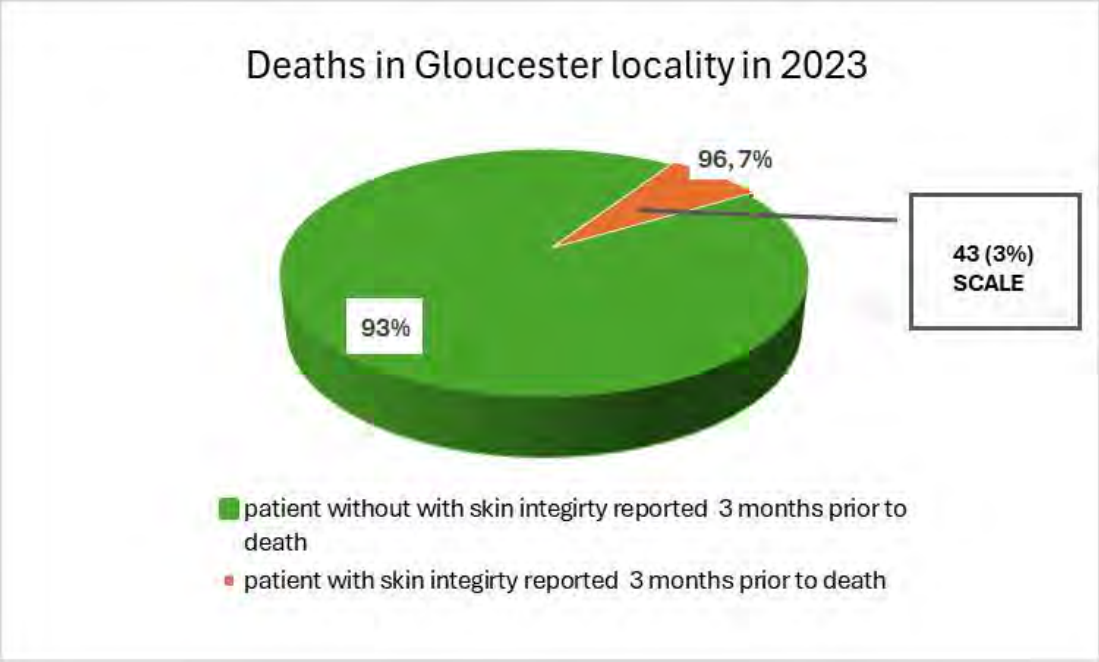
Current national and regional approach

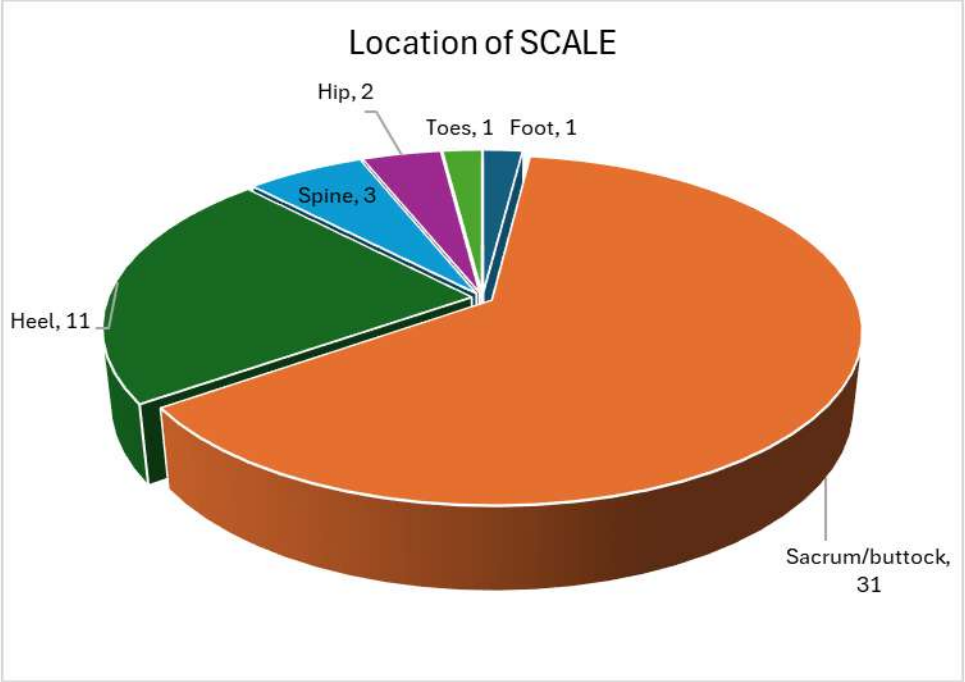
In 2018, the National Health Service Improvement (NHSI) 'Pressure ulcers: revised definition and measurement' document recommended that, in the UK, a pressure ulcer that has developed at end of life, due to 'skin failure' should not be referred to as a 'Kennedy Ulcer' and that pressure ulcers at the end of a patient's life should be classified in the same way as all pressure ulcers, and not given a separate category (NHSI, 2018)

GHC Pressure ulcer policy states only changes occurring 72 hours before death can be categorised as SCALE

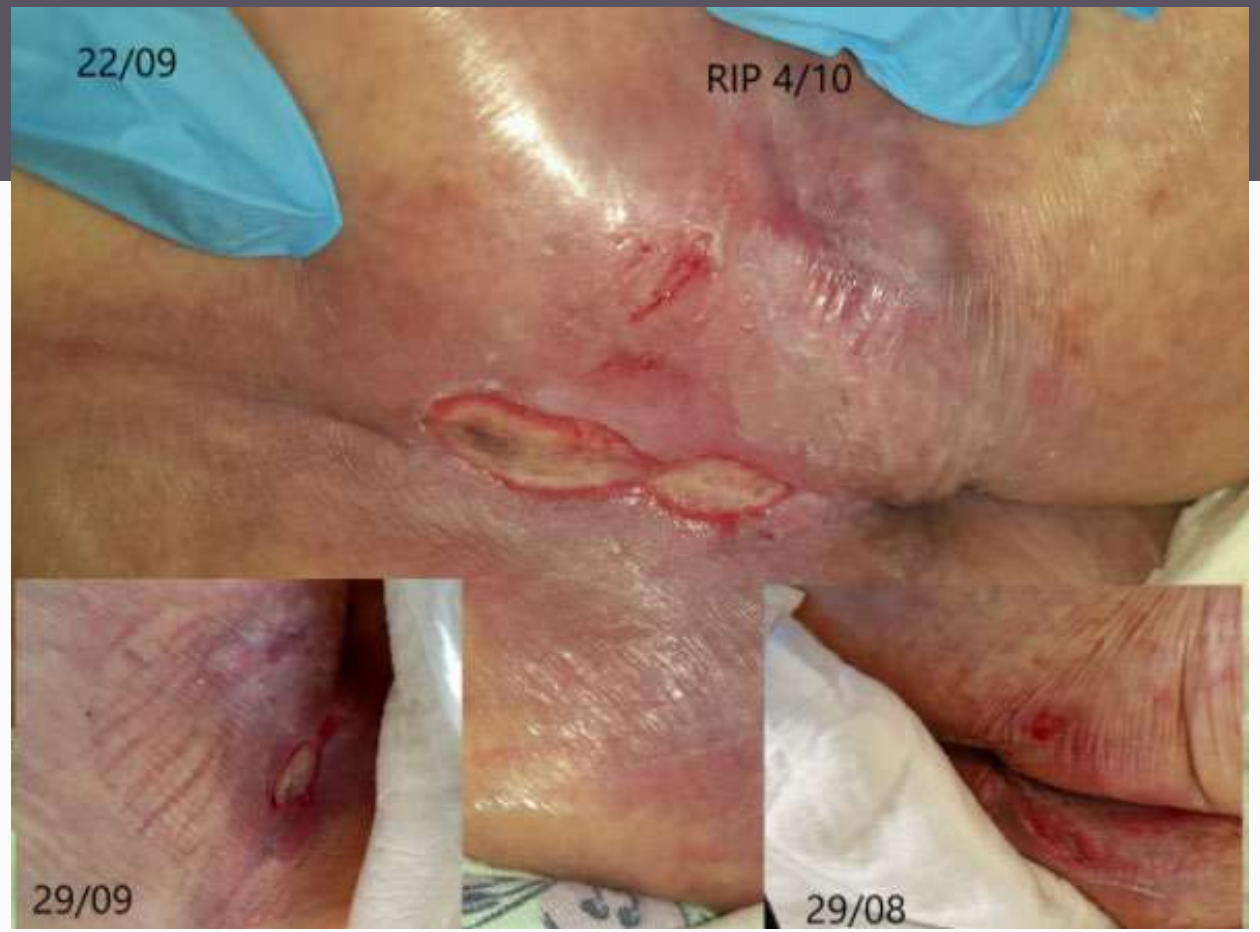
with you, for you

Gloucester





with you, for you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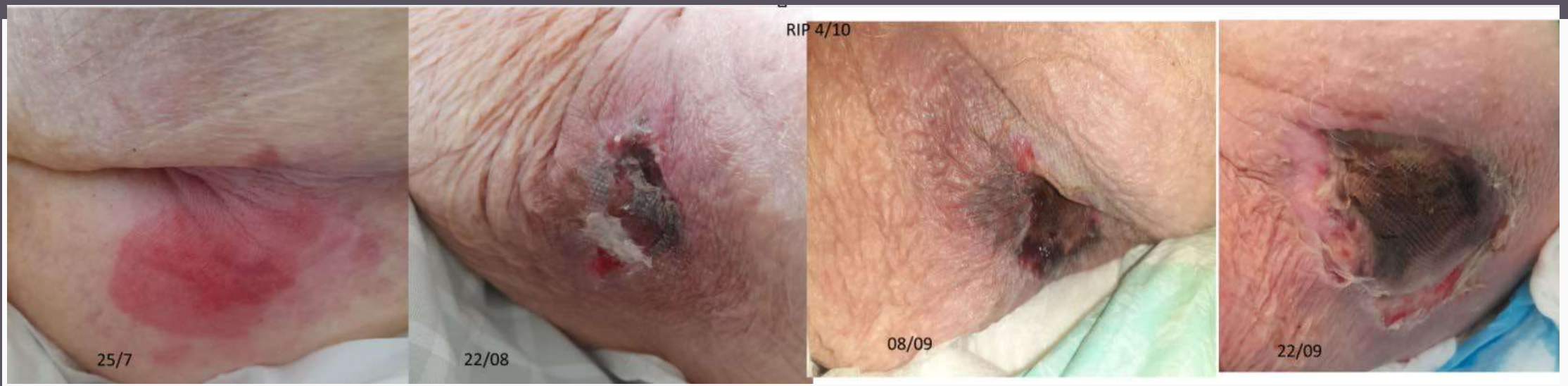
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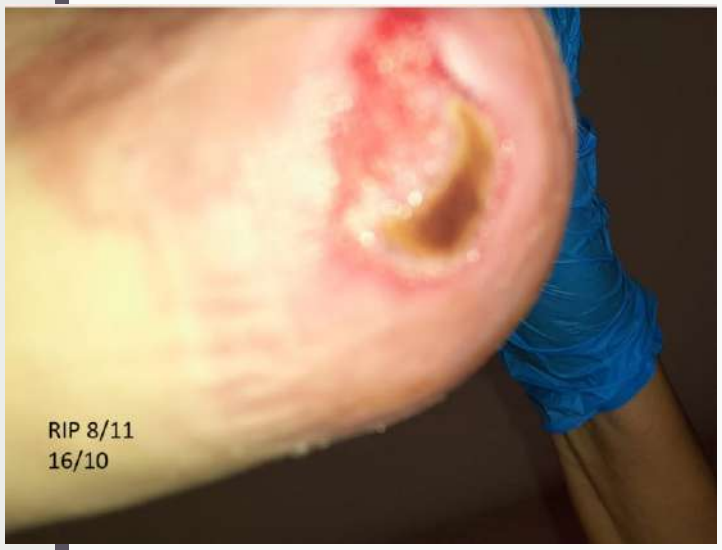
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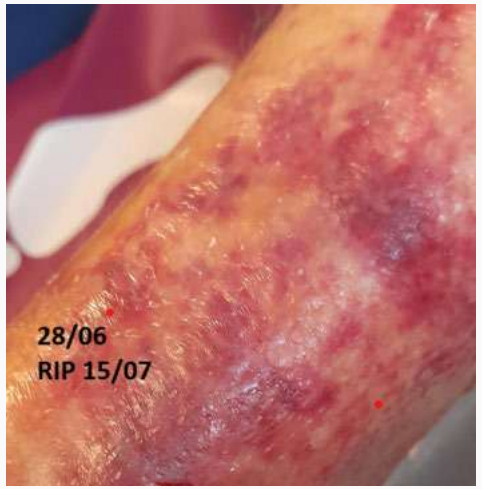
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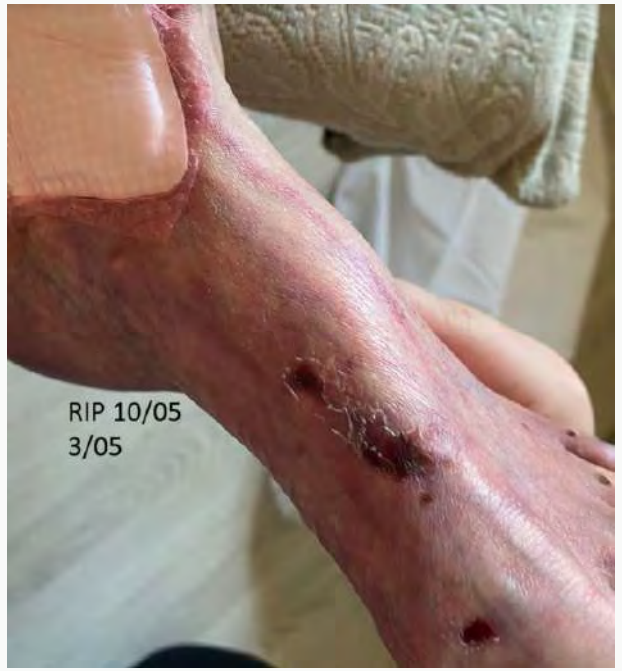
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Summary

- Low prevalence in presented sample
- Not well define characteristics including: mottling, marron, purple areas, sometimes looking like bruising but also slough and brown eschar
- Often (approx.. 90%) additional factor in preventing healing of pressure ulcer

Preliminary Recommendations

- Each patient to be reviewed on individual basis
- SCALE not to be treated as a pressure ulcer category as can appear anywhere on patient body
- SCALE should be treated as additional factor in managing existing pressure ulcers in palliative/end of life patients

Questions???

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- We now have **434** followers on the Arts, Health and Wellbeing Centre LinkedIn page. Here is the link to share with colleagues, etc.
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